

5472--A

2009-2010 Regular Sessions

I N S E N A T E

May 8, 2009

Introduced by Sens. BRESLIN, DUANE, DILAN, 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 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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 utilization review timeframes; and to amend chapter 451 of the laws of 2007 amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to the effectiveness thereof

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.

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

LBD12014-13-9

1 S 2. Subparagraph (G) of paragraph 1 of subsection (d) of section 3216
2 of the insurance law is amended to read as follows:

3 (G) PROOFS OF LOSS: Written proof of loss must be furnished to the
4 insurer at its said office in case of claim for loss for which this
5 policy provides any periodic payment contingent upon continuing loss
6 within ninety days after the termination of the period for which the
7 insurer is liable and in case of claim for any other loss within [nine-
8 ty] ONE HUNDRED TWENTY days after the date of such loss. Failure to
9 furnish such proof within the time required shall not invalidate nor
10 reduce any claim if it was not reasonably possible to give proof within
11 such time, provided such proof is furnished as soon as reasonably possi-
12 ble and in no event, except in the absence of legal capacity, later than
13 one year from the time proof is otherwise required.

14 S 3. 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:

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

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

47 S 4. The insurance law is amended by adding a new section 3217-d to
48 read as follows:

49 S 3217-D. GRIEVANCE PROCEDURE AND ACCESS TO SPECIALTY CARE. (A) AN
50 INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF
51 PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED
52 IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS
53 CHAPTER SHALL ESTABLISH AND MAINTAIN A GRIEVANCE PROCEDURE CONSISTENT
54 WITH THE REQUIREMENTS OF SECTION FOUR THOUSAND EIGHT HUNDRED TWO OF THIS
55 CHAPTER.

1 (B) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A
2 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT
3 AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE
4 OF THIS CHAPTER AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO
5 A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH
6 SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C)
7 AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER;
8 PROVIDED, HOWEVER, THAT NOTHING IN THIS SECTION SHALL BE CONSTRUED TO
9 REQUIRE THAT AN INSURER, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE
10 INSURER, MAKE A REFERRAL TO A PROVIDER THAT IS NOT IN THE INSURER'S
11 NETWORK.

12 (C) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A
13 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT
14 AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE
15 OF THIS CHAPTER SHALL PROVIDE ACCESS TO TRANSITIONAL CARE CONSISTENT
16 WITH THE REQUIREMENTS OF SUBSECTIONS (E) AND (F) OF SECTION FOUR THOU-
17 SAND EIGHT HUNDRED FOUR OF THIS CHAPTER.

18 S 5. Paragraph 9 of subsection (a) of section 3221 of the insurance
19 law is amended to read as follows:

20 (9) That in the case of claim for loss of time for disability, written
21 proof of such loss must be furnished to the insurer within thirty days
22 after the commencement of the period for which the insurer is liable,
23 and that subsequent written proofs of the continuance of such disability
24 must be furnished to the insurer at such intervals as the insurer may
25 reasonably require, and that in the case of claim for any other loss,
26 written proof of such loss must be furnished to the insurer within
27 [ninety] ONE HUNDRED TWENTY days after the date of such loss. Failure to
28 furnish such proof within such time shall not invalidate or reduce any
29 claim if it shall be shown not to have been reasonably possible to
30 furnish such proof within such time, provided such proof was furnished
31 as soon as reasonably possible.

32 S 6. The opening paragraph and subsections (a) and (b) of section
33 3224-a of the insurance law, as amended by chapter 666 of the laws of
34 1997, are amended to read as follows:

35 In the processing of all health care claims submitted under contracts
36 or agreements issued or entered into pursuant to THIS ARTICLE AND arti-
37 cles [thirty-two,] forty-two [and], forty-three AND FORTY-SEVEN of this
38 chapter and article forty-four of the public health law and all bills
39 for health care services rendered by health care providers pursuant to
40 such contracts or agreements, any insurer or organization or corporation
41 licensed or certified pursuant to article forty-three OR FORTY-SEVEN of
42 this chapter or article forty-four of the public health law shall adhere
43 to the following standards:

44 (a) Except in a case where the obligation of an insurer or an organ-
45 ization or corporation licensed or certified pursuant to article forty-
46 three OR FORTY-SEVEN of this chapter or article forty-four of the public
47 health law to pay a claim submitted by a policyholder or person covered
48 under such policy ("COVERED PERSON") or make a payment to a health care
49 provider is not reasonably clear, or when there is a reasonable basis
50 supported by specific information available for review by the super-
51 intendent that such claim or bill for health care services rendered was
52 submitted fraudulently, such insurer or organization or corporation
53 shall pay the claim to a policyholder or covered person or make a
54 payment to a health care provider within [forty-five] THIRTY days of
55 receipt of a claim or bill for services rendered THAT IS TRANSMITTED VIA
56 THE INTERNET OR ELECTRONIC MAIL, OR FORTY-FIVE DAYS OF RECEIPT OF A

1 CLAIM OR BILL FOR SERVICES RENDERED THAT IS SUBMITTED BY OTHER MEANS,
2 SUCH AS PAPER OR FACSIMILE.

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 OR
5 FORTY-SEVEN of this chapter or article forty-four 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 thirty calendar days of
15 the receipt of the claim:

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

18 (2) to request all additional information needed to determine liabil-
19 ity to pay the claim or make the health care payment.

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

26 S 7. The insurance law is amended by adding a new section 3224-c to
27 read as follows:

28 S 3224-C. COORDINATION OF BENEFITS. AN INSURER OR ORGANIZATION OR
29 CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR
30 FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH
31 LAW SHALL NOT DENY A CLAIM, EITHER IN WHOLE OR IN PART, ON THE BASIS
32 THAT IT IS COORDINATING BENEFITS AND ANOTHER INSURER OR ORGANIZATION OR
33 CORPORATION OR OTHER ENTITY IS LIABLE FOR THE PAYMENT OF THE CLAIM,
34 UNLESS IT HAS A REASONABLE BASIS TO BELIEVE THAT THE INSURED HAS OTHER
35 HEALTH INSURANCE COVERAGE WHICH IS PRIMARY FOR THAT BENEFIT. IF AN
36 INSURER OR ORGANIZATION OR CORPORATION DOES NOT HAVE CURRENT INFORMATION
37 FROM THE INSURED REGARDING OTHER COVERAGE, AND REQUESTS SUCH INFORMATION
38 IN ACCORDANCE WITH SUBSECTION (B) OF SECTION THREE THOUSAND TWO HUNDRED
39 TWENTY-FOUR-A OF THIS ARTICLE, AND NO INFORMATION IS RECEIVED WITHIN
40 FORTY-FIVE DAYS, THE CLAIM SHALL BE ADJUDICATED PROVIDED, HOWEVER, THE
41 CLAIM SHALL NOT BE DENIED BASED ON THE INSURER, OR ORGANIZATION OR
42 CORPORATION NOT HAVING RECEIVED SUCH INFORMATION.

43 S 8. Subsection (c) of section 3224-a of the insurance law, as amended
44 by chapter 666 of the laws of 1997, is amended to read as follows:

45 (c) [Each] (1) EXCEPT AS PROVIDED IN PARAGRAPH TWO OF THIS SUBSECTION,
46 EACH claim or bill for health care services processed in violation of
47 this section shall constitute a separate violation. In addition to the
48 penalties provided in this chapter, any insurer or organization or
49 corporation that fails to adhere to the standards contained in this
50 section shall be obligated to pay to the health care provider or person
51 submitting the claim, in full settlement of the claim or bill for health
52 care services, the amount of the claim or health care payment plus
53 interest on the amount of such claim or health care payment of the
54 greater of the rate equal to the rate set by the commissioner of taxa-
55 tion and finance for corporate taxes pursuant to paragraph one of
56 subsection (e) of section one thousand ninety-six of the tax law or

1 twelve percent per annum, to be computed from the date the claim or
2 health care payment was required to be made. When the amount of interest
3 due on such a claim is less than two dollars, and insurer or organiza-
4 tion or corporation shall not be required to pay interest on such claim.

5 (2) WHERE A VIOLATION OF THIS SECTION IS DETERMINED BY THE SUPERINTEN-
6 DENT AS A RESULT OF THE SUPERINTENDENT'S OWN INVESTIGATION, EXAMINATION,
7 AUDIT OR INQUIRY, AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR
8 CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER
9 OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL NOT BE SUBJECT TO A
10 CIVIL PENALTY PRESCRIBED IN PARAGRAPH ONE OF THIS SUBSECTION, IF THE
11 SUPERINTENDENT DETERMINES THAT THE INSURER OR ORGANIZATION OR CORPO-
12 RATION HAS OTHERWISE PROCESSED AT LEAST NINETY-EIGHT PERCENT OF THE
13 CLAIMS SUBMITTED IN A CALENDAR YEAR IN COMPLIANCE WITH THIS SECTION;
14 PROVIDED, HOWEVER, NOTHING IN THIS PARAGRAPH SHALL LIMIT, PRECLUDE OR
15 EXEMPT AN INSURER OR ORGANIZATION OR CORPORATION FROM PAYMENT OF A CLAIM
16 AND PAYMENT OF INTEREST PURSUANT TO THIS SECTION. THIS PARAGRAPH SHALL
17 NOT APPLY TO VIOLATIONS OF THIS SECTION DETERMINED BY THE SUPERINTENDENT
18 RESULTING FROM INDIVIDUAL COMPLAINTS SUBMITTED TO THE SUPERINTENDENT BY
19 HEALTH CARE PROVIDERS OR POLICYHOLDERS.

20 S 9. Section 3224-a of the insurance law is amended by adding two new
21 subsections (g) and (h) to read as follows:

22 (G) TIME PERIOD FOR SUBMISSION OF CLAIMS. (1) EXCEPT AS OTHERWISE
23 PROVIDED BY LAW, HEALTH CARE CLAIMS MUST BE INITIALLY SUBMITTED BY
24 HEALTH CARE PROVIDERS WITHIN ONE HUNDRED TWENTY DAYS AFTER THE DATE OF
25 SERVICE TO BE VALID AND ENFORCEABLE AGAINST AN INSURER OR ORGANIZATION
26 OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR
27 ARTICLE FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC
28 HEALTH LAW. PROVIDED, HOWEVER, THAT NOTHING IN THIS SUBSECTION SHALL
29 PRECLUDE THE PARTIES FROM AGREEING TO A TIME PERIOD OR OTHER TERMS WHICH
30 ARE MORE FAVORABLE TO THE HEALTH CARE PROVIDER. PROVIDED FURTHER THAT,
31 IN CONNECTION WITH CONTRACTS BETWEEN ORGANIZATIONS OR CORPORATIONS
32 LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER OR
33 ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND HEALTH CARE PROVIDERS
34 FOR THE PROVISION OF SERVICES PURSUANT TO SECTION THREE HUNDRED
35 SIXTY-FOUR-J OR THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW
36 OR TITLE I-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, NOTHING
37 HEREIN SHALL BE DEEMED: (I) TO PRECLUDE THE PARTIES FROM AGREEING TO A
38 DIFFERENT TIME PERIOD BUT IN NO EVENT LESS THAN NINETY DAYS; OR (II) TO
39 SUPERSEDE CONTRACT PROVISIONS IN EXISTENCE AT THE TIME THIS SUBSECTION
40 TAKES EFFECT EXCEPT TO THE EXTENT THAT SUCH CONTRACTS IMPOSE A TIME
41 PERIOD OF LESS THAN NINETY DAYS.

42 (2) THIS SUBSECTION SHALL NOT ABROGATE ANY RIGHT OR REDUCE OR LIMIT
43 ANY ADDITIONAL TIME PERIOD FOR CLAIM SUBMISSION PROVIDED BY LAW OR REGU-
44 LATION SPECIFICALLY APPLICABLE TO COORDINATION OF BENEFITS IN EFFECT
45 PRIOR TO THE EFFECTIVE DATE OF THIS SUBSECTION.

46 (H) (1) AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTI-
47 FIED PURSUANT TO ARTICLE FORTY-THREE OR ARTICLE FORTY-SEVEN OF THIS
48 CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL PERMIT A
49 PARTICIPATING HEALTH CARE PROVIDER TO REQUEST RECONSIDERATION OF A CLAIM
50 THAT IS DENIED EXCLUSIVELY BECAUSE IT WAS UNTIMELY SUBMITTED PURSUANT TO
51 SUBSECTION (G) OF THIS SECTION. THE INSURER OR ORGANIZATION OR CORPO-
52 RATION SHALL PAY SUCH CLAIM PURSUANT TO THE PROVISIONS OF PARAGRAPH TWO
53 OF THIS SUBSECTION IF THE HEALTH CARE PROVIDER CAN DEMONSTRATE BOTH
54 THAT: (I) THE HEALTH CARE PROVIDER'S NON-COMPLIANCE WAS A RESULT OF AN
55 UNUSUAL OCCURRENCE; AND (II) THE HEALTH CARE PROVIDER HAS A PATTERN OR

1 PRACTICE OF TIMELY SUBMITTING CLAIMS IN COMPLIANCE WITH SUBDIVISION (G)
2 OF THIS SECTION.

3 (2) AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED
4 PURSUANT TO ARTICLE FORTY-THREE OR ARTICLE FORTY-SEVEN OF THIS CHAPTER
5 OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW MAY REDUCE THE REIMBURSE-
6 MENT DUE TO A HEALTH CARE PROVIDER FOR AN UNTIMELY CLAIM THAT OTHERWISE
7 MEETS THE REQUIREMENTS OF PARAGRAPH ONE OF THIS SUBSECTION BY AN AMOUNT
8 NOT TO EXCEED TWENTY-FIVE PERCENT OF THE AMOUNT THAT WOULD HAVE BEEN
9 PAID HAD THE CLAIM BEEN SUBMITTED IN A TIMELY MANNER; PROVIDED, HOWEVER,
10 THAT NOTHING IN THIS SUBSECTION SHALL PRECLUDE A HEALTH CARE PROVIDER
11 AND AN INSURER OR ORGANIZATION OR CORPORATION FROM AGREEING TO A LESSER
12 REDUCTION. THE PROVISIONS OF THIS SUBSECTION SHALL NOT APPLY TO ANY
13 CLAIM SUBMITTED THREE HUNDRED SIXTY-FIVE DAYS AFTER THE DATE OF SERVICE,
14 IN WHICH CASE THE INSURER OR ORGANIZATION OR CORPORATION MAY DENY THE
15 CLAIM IN FULL.

16 S 10. Subsection (b) of section 3224-b of the insurance law, as added
17 by chapter 551 of the laws of 2006, is amended to read as follows:

18 (b) Overpayments to [physicians] HEALTH CARE PROVIDERS. (1) Other
19 than recovery for duplicate payments, a health plan shall provide thirty
20 days written notice to [physicians] HEALTH CARE PROVIDERS before engag-
21 ing in additional overpayment recovery efforts seeking recovery of the
22 overpayment of claims to such [physicians] HEALTH CARE PROVIDERS. Such
23 notice shall state the patient name, service date, payment amount,
24 proposed adjustment, and a reasonably specific explanation of the
25 proposed adjustment.

26 (2) A HEALTH PLAN SHALL PROVIDE A HEALTH CARE PROVIDER WITH THE OPPOR-
27 TUNITY TO CHALLENGE AN OVERPAYMENT RECOVERY, INCLUDING THE SHARING OF
28 CLAIMS INFORMATION, AND SHALL ESTABLISH WRITTEN POLICIES AND PROCEDURES
29 FOR HEALTH CARE PROVIDERS TO FOLLOW TO CHALLENGE AN OVERPAYMENT RECOV-
30 ERY. SUCH CHALLENGE SHALL SET FORTH THE SPECIFIC GROUNDS ON WHICH THE
31 PROVIDER IS CHALLENGING THE OVERPAYMENT RECOVERY.

32 (3) A health plan shall not initiate overpayment recovery efforts more
33 than twenty-four months after the original payment was received by a
34 [physician] HEALTH CARE PROVIDER. [Provided, however, that] HOWEVER, no
35 such time limit shall apply to overpayment recovery efforts [which] THAT
36 are: (i) based on a reasonable belief of fraud or other intentional
37 misconduct, or abusive billing, (ii) required by, or initiated at the
38 request of, a self-insured plan, or (iii) required OR AUTHORIZED by a
39 state or federal government program OR COVERAGE THAT IS PROVIDED BY THIS
40 STATE OR A MUNICIPALITY THEREOF TO ITS RESPECTIVE EMPLOYEES, RETIREES OR
41 MEMBERS. Notwithstanding the aforementioned time limitations, in the
42 event that a [physician] HEALTH CARE PROVIDER asserts that a health plan
43 has underpaid a claim or claims, the health plan may defend or set off
44 such assertion of underpayment based on overpayments going back in time
45 as far as the claimed underpayment. For purposes of this paragraph,
46 "abusive billing" shall be defined as a billing practice which results
47 in the submission of claims that are not consistent with sound fiscal,
48 business, or medical practices and at such frequency and for such a
49 period of time as to reflect a consistent course of conduct.

50 (4) FOR THE PURPOSES OF THIS SUBSECTION THE TERM "HEALTH CARE PROVID-
51 ER" SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE TWEN-
52 TY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY
53 LICENSED PURSUANT TO ARTICLE NINETEEN, THIRTY-ONE OR THIRTY-TWO OF THE
54 MENTAL HYGIENE LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED
55 OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

1 [(3)] (5) Nothing in this section shall be deemed to limit [an insurer's] A HEALTH PLAN'S right to pursue recovery of overpayments that
2 occurred prior to the effective date of this section where the [insurer]
3 HEALTH PLAN has provided the [physician] HEALTH CARE PROVIDER with
4 notice of such recovery efforts prior to the effective date of this
5 section.
6

7 S 11. Subparagraph (B) of paragraph 2 of subsection (e) of section
8 3231 of the insurance law, as added by chapter 501 of the laws of 1992,
9 is amended to read as follows:

10 (B) Each calendar year, an insurer shall return, in the form of aggregate
11 benefits for each policy form filed pursuant to the alternate
12 procedure set forth in this paragraph at least seventy-five percent of
13 the aggregate premiums collected for the policy form during that calendar
14 year. Insurers shall annually report, no later than May first of
15 each year, the loss ratio calculated pursuant to this paragraph for each
16 such policy form for the previous calendar year. In each case where the
17 loss ratio for a policy form fails to comply with the seventy-five
18 percent loss ratio requirement, the insurer shall issue a dividend or
19 credit against future premiums for all policy holders with that policy
20 form in an amount sufficient to assure that the aggregate benefits paid
21 in the previous calendar year plus the amount of the dividends and credits
22 shall equal seventy-five percent of the aggregate premiums collected
23 for the policy form in the previous calendar year. The dividend or credit
24 shall be issued to each policy HOLDER WHO HAD A POLICY which was in
25 effect [as of December thirty-first of] AT ANY TIME DURING the applicable
26 year [and remains in effect as of the date the dividend or credit is
27 issued]. THE DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT
28 PREMIUMS EARNED FOR THE APPLICABLE YEAR AMONG ALL POLICY HOLDERS ELIGIBLE
29 TO RECEIVE SUCH DIVIDEND OR CREDIT. AN INSURER SHALL MAKE A REASONABLE
30 EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVIDENDS OR
31 CREDITS TO, FORMER POLICY HOLDERS ENTITLED TO THE DIVIDEND OR CREDIT.
32 AN INSURER SHALL, WITH RESPECT TO DIVIDENDS OR CREDITS TO WHICH FORMER
33 POLICY HOLDERS THAT THE INSURER IS UNABLE TO IDENTIFY AFTER A REASONABLE
34 EFFORT WOULD OTHERWISE BE ENTITLED, HAVE THE OPTION, AS DEEMED ACCEPTABLE
35 BY THE SUPERINTENDENT, OF PROSPECTIVELY ADJUSTING PREMIUM RATES BY
36 THE AMOUNT OF SUCH DIVIDENDS OR CREDITS, ISSUING THE AMOUNT OF SUCH
37 DIVIDENDS OR CREDITS TO EXISTING POLICY HOLDERS, DEPOSITING THE AMOUNT
38 OF SUCH DIVIDENDS OR CREDITS IN THE FUND ESTABLISHED PURSUANT TO SECTION
39 FOUR THOUSAND THREE HUNDRED TWENTY-TWO-A OF THIS CHAPTER, OR UTILIZING
40 ANY OTHER METHOD WHICH OFFSETS THE AMOUNT OF SUCH DIVIDENDS OR CREDITS.
41 All dividends and credits must be distributed by September thirtieth of
42 the year following the calendar year in which the loss ratio requirements
43 were not satisfied. The annual report required by this paragraph
44 shall include an insurer's calculation of the dividends and credits, as
45 well as an explanation of the insurer's plan to issue dividends or credits.
46 The instructions and format for calculating and reporting loss
47 ratios and issuing dividends or credits shall be specified by the superintendent
48 by regulation. Such regulations shall include provisions for
49 the distribution of a dividend or credit in the event of cancellation or
50 termination by a policy holder.

51 S 12. Subsection (i) of section 3216 of the insurance law is amended
52 by adding a new paragraph 26 to read as follows:

53 (26)(A) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE
54 FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A
55 PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY

1 ON THE BASIS THAT THE HEALTH CARE PROVIDER ADMITTING OR RENDERING
2 SERVICES TO THE INSURED IS NOT A PARTICIPATING PROVIDER.

3 (B) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR
4 HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A
5 PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS OUT-OF-NETWORK
6 SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A
7 NON-PARTICIPATING HOSPITAL.

8 (C) FOR PURPOSES OF THIS PARAGRAPH, A "HEALTH CARE PROVIDER" IS A
9 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
10 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
11 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

12 (D) FOR PURPOSES OF THIS PARAGRAPH, A "MANAGED CARE HEALTH INSURANCE
13 POLICY" IS A POLICY THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVID-
14 ER PARTICIPATING IN THE INSURER'S NETWORK IN ORDER FOR THE INSURED TO
15 RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE POLICY.

16 S 13. Subsection (k) of section 3221 of the insurance law is amended
17 by adding a new paragraph 15 to read as follows:

18 (15)(A) NO GROUP OR BLANKET MANAGED CARE HEALTH INSURANCE POLICY THAT
19 PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE
20 THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS
21 OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE PROVID-
22 ER ADMITTING OR RENDERING SERVICES TO THE INSURED IS NOT A PARTICIPATING
23 PROVIDER.

24 (B) NO GROUP OR BLANKET MANAGED CARE HEALTH INSURANCE POLICY THAT
25 PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE
26 THAT SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS
27 OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE
28 RENDERED IN A NON-PARTICIPATING HOSPITAL.

29 (C) FOR PURPOSES OF THIS PARAGRAPH, A "HEALTH CARE PROVIDER" IS A
30 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
31 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
32 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

33 (D) FOR PURPOSES OF THIS PARAGRAPH, A "MANAGED CARE HEALTH INSURANCE
34 POLICY" IS A POLICY THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVID-
35 ER PARTICIPATING IN THE INSURER'S NETWORK IN ORDER FOR THE INSURED TO
36 RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE POLICY.

37 S 14. Section 4303 of the insurance law is amended by adding a new
38 subsection (ff) to read as follows:

39 (FF) (1) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPO-
40 RATION, HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPO-
41 RATION THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE
42 SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED
43 AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE
44 PROVIDER ADMITTING OR RENDERING SERVICES TO THE INSURED IS NOT A PARTIC-
45 IPATING PROVIDER.

46 (2) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPORATION,
47 HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPORATION
48 THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL
49 PROVIDE THAT SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE
50 COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES
51 ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

52 (3) FOR PURPOSES OF THIS SUBSECTION, A "HEALTH CARE PROVIDER" IS A
53 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
54 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
55 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

(4) FOR PURPOSES OF THIS SUBSECTION, A "MANAGED CARE CONTRACT" IS A CONTRACT THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVIDER PARTICIPATING IN THE CORPORATION'S NETWORK IN ORDER FOR THE SUBSCRIBER TO RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE CONTRACT.

S 15. Section 4305 of the insurance law is amended by adding a new subsection (1) to read as follows:

(1) A HEALTH CARE CLAIM FROM A SUBSCRIBER COVERED UNDER A CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL BE SUBMITTED WITHIN ONE HUNDRED TWENTY DAYS FROM THE DATE OF SERVICE; PROVIDED, HOWEVER, THAT IF IT WAS NOT REASONABLY POSSIBLE FOR THE SUBSCRIBER TO SUBMIT THE CLAIM WITHIN THAT TIMEFRAME, THEN THE CLAIM SHALL BE SUBMITTED AS SOON AS REASONABLY POSSIBLE.

S 16. Section 4306 of the insurance law is amended by adding a new subsection (n) to read as follows:

(N) A STATEMENT THAT A HEALTH CARE CLAIM FROM A SUBSCRIBER SHALL BE SUBMITTED WITHIN ONE HUNDRED TWENTY DAYS FROM THE DATE OF SERVICE; PROVIDED, HOWEVER, THAT IF IT WAS NOT REASONABLY POSSIBLE FOR THE SUBSCRIBER TO SUBMIT THE CLAIM WITHIN THAT TIMEFRAME, THEN THE CLAIM SHALL BE SUBMITTED AS SOON AS REASONABLY POSSIBLE.

S 17. The insurance law is amended by adding a new section 4306-c to read as follows:

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

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

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

S 18. Paragraph 2 of subsection (h) of section 4308 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(2) In each case where the loss ratio for a contract form fails to comply with the eighty-five percent minimum loss ratio requirement for individual direct payment contracts, or the seventy-five percent minimum loss ratio requirement for small group and small group remittance

1 contracts, as set forth in paragraph one of this subsection, the corpo-
2 ration shall issue a dividend or credit against future premiums for all
3 contract holders with that contract form in an amount sufficient to
4 assure that the aggregate benefits incurred in the previous calendar
5 year plus the amount of the dividends and credits shall equal no less
6 than eighty-five percent for individual direct payment contracts, or
7 seventy-five percent for small group and small group remittance
8 contracts, of the aggregate premiums earned for the contract form in the
9 previous calendar year. The dividend or credit shall be issued to each
10 contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as
11 of December thirty-first of] AT ANY TIME DURING the applicable year [and
12 remains in effect as of the date the dividend or credit is issued]. THE
13 DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED
14 FOR THE APPLICABLE YEAR AMONG ALL CONTRACT HOLDERS OR SUBSCRIBERS ELIGI-
15 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. A CORPORATION SHALL MAKE A
16 REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVI-
17 DENDS OR CREDITS TO, FORMER CONTRACT HOLDERS OR SUBSCRIBERS ENTITLED TO
18 THE DIVIDEND OR CREDIT. A CORPORATION SHALL, WITH RESPECT TO DIVIDENDS
19 OR CREDITS TO WHICH FORMER CONTRACT HOLDERS THAT THE CORPORATION IS
20 UNABLE TO IDENTIFY AFTER A REASONABLE EFFORT WOULD OTHERWISE BE ENTI-
21 TLED, HAVE THE OPTION, AS DEEMED ACCEPTABLE BY THE SUPERINTENDENT, OF
22 PROSPECTIVELY ADJUSTING PREMIUM RATES BY THE AMOUNT OF SUCH DIVIDENDS OR
23 CREDITS, ISSUING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS TO EXISTING
24 CONTRACT HOLDERS, DEPOSITING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS IN
25 THE FUND ESTABLISHED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED
26 TWENTY-TWO-A OF THIS ARTICLE, OR UTILIZING ANY OTHER METHOD WHICH
27 OFFSETS THE AMOUNT OF SUCH DIVIDENDS OR CREDITS. All dividends and cred-
28 its must be distributed by September thirtieth of the year following the
29 calendar year in which the loss ratio requirements were not satisfied.
30 The annual report required by paragraph one of this subsection shall
31 include a corporation's calculation of the dividends and credits, as
32 well as an explanation of the corporation's plan to issue dividends or
33 credits. The instructions and format for calculating and reporting loss
34 ratios and issuing dividends or credits shall be specified by the super-
35 intendent by regulation. Such regulations shall include provisions for
36 the distribution of a dividend or credit in the event of cancellation or
37 termination by a contract holder or subscriber.

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

42 (G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A
43 CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY
44 THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE
45 INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS
46 DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT
47 CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE
48 CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE
49 SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY,
50 WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE
51 INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON
52 THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE
53 PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE"
54 SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A
55 MATERIAL ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH
56 CARE PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A

1 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
2 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS
3 SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED
4 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS
5 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR
6 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE AMERICAN
7 MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES,
8 REPORTING GUIDELINES AND CONVENTIONS; OR (B) SUCH CHANGE IS EXPRESSLY
9 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
10 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
11 OR PAYMENT POLICY INDEXING MECHANISM.

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

15 S 20. Subsection (a) of section 4803 of the insurance law, as amended
16 by chapter 551 of the laws of 2006, is amended to read as follows:

17 (a) (1) An insurer which offers a managed care product shall, upon
18 request, make available and disclose to health care professionals writ-
19 ten application procedures and minimum qualification requirements which
20 a health care professional must meet in order to be considered by the
21 insurer for participation in the in-network benefits portion of the
22 insurer's network for the managed care product. The insurer shall
23 consult with appropriately qualified health care professionals in devel-
24 oping its qualification requirements for participation in the in-network
25 benefits portion of the insurer's network for the managed care product.
26 An insurer shall complete review of the health care professional's
27 application to participate in the in-network portion of the insurer's
28 network and, within ninety days of receiving a health care profes-
29 sional's completed application to participate in the insurer's network,
30 will notify the health care professional as to [(i)]: (A) whether he or
31 she is credentialed; or [(ii)] (B) whether additional time is necessary
32 to make a determination in spite of THE insurer's best efforts or
33 because of a failure of a third party to provide necessary documenta-
34 tion, or non-routine or unusual circumstances require additional time
35 for review. In such instances where additional time is necessary
36 because of a lack of necessary documentation, an insurer shall make
37 every effort to obtain such information as soon as possible.

38 (2) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE
39 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO
40 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS
41 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF
42 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK, IS
43 NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH
44 ONE OF THIS SUBSECTION, SUCH HEALTH CARE PROFESSIONAL SHALL BE DEEMED
45 "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NETWORK
46 PORTION OF AN INSURER'S NETWORK; PROVIDED, HOWEVER, THAT A PROVISIONALLY
47 CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN INSURED'S PRIMARY
48 CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDEN-
49 TIALED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY CREDENTIALLED
50 HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH
51 DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE
52 FINAL CREDENTIALING DETERMINATION IS MADE BY THE INSURER. A HEALTH CARE
53 PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE
54 GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTIFIES THE INSURER IN
55 WRITING THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE HEALTH
56 CARE PROFESSIONAL OR THE GROUP PRACTICE: (A) SHALL REFUND ANY PAYMENTS

1 MADE BY THE INSURER FOR IN-NETWORK SERVICES PROVIDED BY THE PROVI-
2 SIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL THAT EXCEED ANY
3 OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE INSURED'S CONTRACT WITH THE
4 INSURER; AND (B) SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED, EXCEPT
5 TO COLLECT THE COPAYMENT OR COINSURANCE THAT OTHERWISE WOULD HAVE BEEN
6 PAYABLE HAD THE INSURED RECEIVED SERVICES FROM A HEALTH CARE PROFES-
7 SIONAL PARTICIPATING IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK.
8 INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED
9 TWENTY-FOUR-A OF THIS CHAPTER SHALL NOT BE ASSESSED BASED ON THE DENIAL
10 OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL
11 WAS PROVISIONALLY CREDENTIALLED; PROVIDED, HOWEVER, THAT NOTHING HEREIN
12 SHALL PREVENT AN INSURER FROM PAYING A CLAIM FROM A HEALTH CARE PROFES-
13 SIONAL WHO IS PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM.
14 AN INSURER SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED
15 BY A PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE
16 GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

17 S 21. Section 4900 of the insurance law is amended by adding a new
18 subsection (g-7) to read as follows:

19 (G-7) "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION
20 OR DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH
21 STUDY BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL
22 RESEARCH NETWORK; OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED
23 STATES RESIDENTS PER YEAR; AND (2) FOR WHICH THERE DOES NOT EXIST A
24 STANDARD HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN
25 THAT IS MORE CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR
26 TREATMENT. A PHYSICIAN, OTHER THAN THE INSURED'S TREATING PHYSICIAN,
27 SHALL CERTIFY IN WRITING THAT THE CONDITION IS A RARE DISEASE AS
28 DEFINED IN THIS SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A
29 LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN
30 THE AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED'S RARE DISEASE.
31 THE CERTIFICATION SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE
32 DISEASE IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE
33 NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK;
34 OR (2) THAT THE INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED
35 THOUSAND UNITED STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY
36 ON MEDICAL AND SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH
37 SERVICE OR PROCEDURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A
38 STATEMENT THAT, BASED ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS
39 NO STANDARD TREATMENT THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO
40 THE INSURED THAN THE REQUESTED HEALTH SERVICE OR PROCEDURE AND THE
41 REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE INSURED
42 IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO
43 THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE.
44 THE CERTIFYING PHYSICIAN SHALL DISCLOSE ANY MATERIAL FINANCIAL OR
45 PROFESSIONAL RELATIONSHIP WITH THE PROVIDER OF THE REQUESTED HEALTH
46 SERVICE OR PROCEDURE AS PART OF THE APPLICATION FOR EXTERNAL APPEAL OF
47 DENIAL OF A RARE DISEASE TREATMENT. IF THE PROVISION OF THE REQUESTED
48 HEALTH SERVICE OR PROCEDURE AT A HEALTH CARE FACILITY REQUIRES PRIOR
49 APPROVAL OF AN INSTITUTIONAL REVIEW BOARD, AN INSURED OR INSURED'S
50 DESIGNEE SHALL ALSO SUBMIT SUCH APPROVAL AS PART OF THE EXTERNAL APPEAL
51 APPLICATION.

52 S 22. Subsection (c) of section 4903 of the insurance law, as added by
53 chapter 705 of the laws of 1996, is amended to read as follows:

54 (c) A utilization review agent shall make a determination involving
55 continued or extended health care services, [or] additional services for
56 an insured undergoing a course of continued treatment prescribed by a

1 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-
2 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination
3 to the insured or the insured's designee, which may be satisfied by
4 notice to the insured's health care provider, by telephone and in writ-
5 ing within one business day of receipt of the necessary information
6 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT
7 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY
8 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND
9 OR HOLIDAY. Notification of continued or extended services shall
10 include the number of extended services approved, the new total of
11 approved services, the date of onset of services and the next review
12 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL
13 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR
14 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS
15 SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF
16 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME
17 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW
18 AGENT IS PENDING.

19 S 23. Subsection (b) of section 4904 of the insurance law, as added by
20 chapter 705 of the laws of 1996, paragraph 2 as amended by chapter 586
21 of the laws of 1998, is amended to read as follows:

22 (b) A utilization review agent shall establish an expedited appeal
23 process for appeal of an adverse determination involving (1) continued
24 or extended health care services, procedures or treatments or additional
25 services for an insured undergoing a course of continued treatment
26 prescribed by a health care provider or HOME HEALTH CARE SERVICES
27 FOLLOWING DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO
28 SUBSECTION (C) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTI-
29 CLE OR (2) an adverse determination in which the health care provider
30 believes an immediate appeal is warranted except any retrospective
31 determination. Such process shall include mechanisms which facilitate
32 resolution of the appeal including but not limited to the sharing of
33 information from the insured's health care provider and the utilization
34 review agent by telephonic means or by facsimile. The utilization review
35 agent shall provide reasonable access to its clinical peer reviewer
36 within one business day of receiving notice of the taking of an expe-
37 dited appeal. Expedited appeals shall be determined within two business
38 days of receipt of necessary information to conduct such appeal. Expe-
39 dited appeals which do not result in a resolution satisfactory to the
40 appealing party may be further appealed through the standard appeal
41 process, or through the external appeal process pursuant to section four
42 thousand nine hundred fourteen of this article as applicable.

43 S 24. Section 4906 of the insurance law, as amended by chapter 586 of
44 the laws of 1998, is amended to read as follows:

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

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

54 S 25. The opening paragraph of subsection (b) of section 4910 of the
55 insurance law, as added by chapter 586 of the laws of 1998, is amended
56 to read as follows:

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

4 S 26. Subparagraphs (B) and (C) of paragraph 2 of subsection (b) of
5 section 4910 of the insurance law, as added by chapter 586 of the laws
6 of 1998, are amended to read as follows:

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

14 (C) the insured's attending physician, who must be a licensed, board-
15 certified or board-eligible physician qualified to practice in the area
16 of practice appropriate to treat the insured's life-threatening or disa-
17 bling condition or disease, must have recommended either (a) a health
18 service or procedure (including a pharmaceutical product within the
19 meaning of subparagraph (B) of paragraph two of subsection (e) of
20 section four thousand nine hundred of this article) that, based on two
21 documents from the available medical and scientific evidence, is likely
22 to be more beneficial to the insured than any covered standard health
23 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE
24 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION FOUR
25 THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE
26 INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN MAY
27 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO
28 BENEFIT THE INSURED IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND
29 THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH
30 SERVICE OR PROCEDURE; or (b) a clinical trial for which the insured is
31 eligible. Any physician certification provided under this section shall
32 include a statement of the evidence relied upon by the physician in
33 certifying his or her recommendation, and

34 S 27. Paragraphs 2 and 3 of subsection (b) of section 4914 of the
35 insurance law, as added by chapter 586 of the laws of 1998, are amended
36 to read as follows:

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

49 (3) Notwithstanding the provisions of paragraphs one and two of this
50 subsection, if the insured's attending physician states that a delay in
51 providing the health care service would pose an imminent or serious
52 threat to the health of the insured, the external appeal shall be
53 completed within three days of the request therefor and the external
54 appeal agent shall make every reasonable attempt to immediately notify
55 the insured, THE INSURED'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and

1 the health plan of its determination by telephone or facsimile, followed
2 immediately by written notification of such determination.

3 S 28. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of
4 subsection (b) of section 4914 of the insurance law, as added by chapter
5 586 of the laws of 1998, is amended to read as follows:

6 (a) that the patient costs of the proposed health service or procedure
7 shall be covered by the health care plan either: when a majority of the
8 panel of reviewers determines, BASED upon review of the applicable
9 medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES,
10 THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION
11 FOUR THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS
12 THE INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN
13 MAY PRESENT (or upon confirmation that the recommended treatment is a
14 clinical trial), the insured's medical record, and any other pertinent
15 information, that the proposed health service or treatment (including a
16 pharmaceutical product within the meaning of subparagraph (B) of para-
17 graph two of subsection (e) of section four thousand nine hundred of
18 this article is likely to be more beneficial than any standard treatment
19 or treatments for the insured's life-threatening or disabling condition
20 or disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR
21 PROCEDURE IS LIKELY TO BENEFIT THE INSURED IN THE TREATMENT OF THE
22 INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS
23 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a
24 clinical trial, is likely to benefit the insured in the treatment of the
25 insured's condition or disease); or when a reviewing panel is evenly
26 divided as to a determination concerning coverage of the health service
27 or procedure, or

28 S 29. Subsection (d) of section 4914 of the insurance law, as added by
29 chapter 586 of the laws of 1998, is amended to read as follows:

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

42 (2) IF AN INSURED'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 WHOLE, PAYMENT FOR THE
45 EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PROVIDER IN THE MANNER
46 AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH
47 ONE OF THIS SUBSECTION.

48 (3) IF AN INSURED'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL
49 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT
50 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE
51 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND
52 THE INSURED'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL AND
53 SHALL BE MADE BY THE HEALTH CARE PLAN AND THE INSURED'S HEALTH CARE
54 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS
55 SET FORTH IN PARAGRAPH ONE OF THIS SUBSECTION; PROVIDED, HOWEVER, THAT
56 THE SUPERINTENDENT MAY, UPON A DETERMINATION THAT HEALTH CARE PLANS OR

1 HEALTH CARE PROVIDERS ARE EXPERIENCING A SUBSTANTIAL HARDSHIP AS A
2 RESULT OF PAYMENT FOR THE EXTERNAL APPEAL WHEN THE EXTERNAL APPEAL AGENT
3 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, IN CONSULTATION
4 WITH THE COMMISSIONER OF HEALTH, PROMULGATE REGULATIONS TO LIMIT SUCH
5 HARDSHIP.

6 (4) IF AN INSURED'S HEALTH CARE PROVIDER WAS ACTING AS THE INSURED'S
7 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
8 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
9 ON A STANDARD FORM DEVELOPED BY THE SUPERINTENDENT IN CONSULTATION WITH
10 THE COMMISSIONER OF HEALTH PURSUANT TO SUBSECTION (E) OF THIS SECTION.
11 THE SUPERINTENDENT SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL
12 APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECES-
13 SARY, IN WHICH CASE THE SUPERINTENDENT SHALL MAKE AT LEAST TWO WRITTEN
14 REQUESTS TO THE INSURED TO CONFIRM THE DESIGNATION. THE INSURED SHALL
15 HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE INSURED FAILS TO
16 RESPOND TO THE SUPERINTENDENT WITHIN THE SPECIFIED TIMEFRAME, THE SUPER-
17 INTENDENT SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
18 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
19 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
20 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT'S REQUESTS
21 WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL REJECT THE
22 APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE SUPERINTENDENT'S
23 REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE IN ACCORDANCE
24 WITH PARAGRAPHS TWO AND THREE OF THIS SUBSECTION.

25 S 30. The insurance law is amended by adding a new section 4917 to
26 read as follows:

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

33 S 31. Subdivisions 3 and 4 of section 4406 of the public health law,
34 subdivision 3 as renumbered by chapter 538 of the laws of 1993, are
35 renumbered subdivisions 4 and 5 and a new subdivision 3 is added to read
36 as follows:

37 3. (A) NO CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL PROVIDE THAT
38 SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK
39 SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE PROVIDER ADMITTING OR
40 RENDERING SERVICES TO THE ENROLLEE IS NOT A PARTICIPATING PROVIDER.

41 (B) NO CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL PROVIDE THAT
42 SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS
43 OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE
44 RENDERED IN A NON-PARTICIPATING HOSPITAL.

45 (C) FOR PURPOSES OF THIS SUBDIVISION, A "HEALTH CARE PROVIDER" IS A
46 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
47 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
48 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

49 S 32. Subdivision 5-c of section 4406-c of the public health law is
50 relettered subdivision 5-d and a new subdivision 5-c is added to read as
51 follows:

52 5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT
53 CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE
54 PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE
55 CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH
56 WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY

1 THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF
2 THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE
3 CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE
4 HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE
5 NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR
6 HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION
7 DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS
8 SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A
9 PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A MATERIAL
10 ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH CARE
11 PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
12 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
13 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS
14 SUBDIVISION SHALL NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED
15 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS
16 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR
17 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE AMERICAN
18 MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES,
19 REPORTING GUIDELINES AND CONVENTIONS; OR (II) SUCH CHANGE IS EXPRESSLY
20 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
21 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
22 OR PAYMENT POLICY INDEXING MECHANISM.

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

26 S 33. Subdivision 1 of section 4406-d of the public health law, as
27 amended by chapter 551 of the laws of 2006, is amended to read as
28 follows:

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

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

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

27 S 34. Section 4900 of the public health law is amended by adding a new
28 subdivision 7-g to read as follows:

29 7-G. "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION OR
30 DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY
31 BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH
32 NETWORK OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED STATES
33 RESIDENTS PER YEAR, AND (2) FOR WHICH THERE DOES NOT EXIST A STANDARD
34 HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN THAT IS MORE
35 CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR TREATMENT. A
36 PHYSICIAN, OTHER THAN THE ENROLLEE'S TREATING PHYSICIAN, SHALL CERTIFY
37 IN WRITING THAT THE CONDITION IS A RARE DISEASE AS DEFINED IN THIS
38 SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A LICENSED, BOARD-CERTI-
39 FIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN THE AREA OF PRACTICE
40 APPROPRIATE TO TREAT THE ENROLLEE'S RARE DISEASE. THE CERTIFICATION
41 SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE DISEASE IS CURRENTLY
42 OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE NATIONAL INSTITUTES OF
43 HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK; OR (2) THAT THE
44 INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED
45 STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY ON MEDICAL AND
46 SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH SERVICE OR PROCE-
47 DURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A STATEMENT THAT, BASED
48 ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS NO STANDARD TREATMENT
49 THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO THE ENROLLEE THAN THE
50 REQUESTED HEALTH SERVICE OR PROCEDURE AND THE REQUESTED HEALTH SERVICE
51 OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE
52 ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS
53 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE. THE CERTIFYING PHYSICIAN
54 SHALL DISCLOSE ANY MATERIAL FINANCIAL OR PROFESSIONAL RELATIONSHIP WITH
55 THE PROVIDER OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AS PART OF THE
56 APPLICATION FOR EXTERNAL APPEAL OF DENIAL OF A RARE DISEASE TREATMENT.

1 IF THE PROVISION OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AT A
2 HEALTH CARE FACILITY REQUIRES PRIOR APPROVAL OF AN INSTITUTIONAL REVIEW
3 BOARD, AN ENROLLEE OR ENROLLEE'S DESIGNEE SHALL ALSO SUBMIT SUCH
4 APPROVAL AS PART OF THE EXTERNAL APPEAL APPLICATION.

5 S 35. Subdivision 3 of section 4903 of the public health law, as added
6 by chapter 705 of the laws of 1996, is amended to read as follows:

7 3. A utilization review agent shall make a determination involving
8 continued or extended health care services, [or] additional services for
9 an enrollee undergoing a course of continued treatment prescribed by a
10 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-
11 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination
12 to the enrollee or the enrollee's designee, which may be satisfied by
13 notice to the enrollee's health care provider, by telephone and in writ-
14 ing within one business day of receipt of the necessary information
15 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT
16 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY
17 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND
18 OR HOLIDAY. Notification of continued or extended services shall
19 include the number of extended services approved, the new total of
20 approved services, the date of onset of services and the next review
21 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL
22 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR
23 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS
24 SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF
25 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME
26 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW
27 AGENT IS PENDING.

28 S 36. Subdivision 2 of section 4904 of the public health law, as added
29 by chapter 705 of the laws of 1996, paragraph (b) as amended by chapter
30 586 of the laws of 1998, is amended to read as follows:

31 2. A utilization review agent shall establish an expedited appeal
32 process for appeal of an adverse determination involving:

33 (a) continued or extended health care services, procedures or treat-
34 ments or additional services for an enrollee undergoing a course of
35 continued treatment prescribed by a health care provider HOME HEALTH
36 CARE SERVICES FOLLOWING DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION
37 PURSUANT TO SUBDIVISION THREE OF SECTION FORTY-NINE HUNDRED THREE OF
38 THIS ARTICLE; or

39 (b) an adverse determination in which the health care provider
40 believes an immediate appeal is warranted except any retrospective
41 determination. Such process shall include mechanisms which facilitate
42 resolution of the appeal including but not limited to the sharing of
43 information from the enrollee's health care provider and the utilization
44 review agent by telephonic means or by facsimile. The utilization review
45 agent shall provide reasonable access to its clinical peer reviewer
46 within one business day of receiving notice of the taking of an expe-
47 dited appeal. Expedited appeals shall be determined within two business
48 days of receipt of necessary information to conduct such appeal. Expe-
49 dited appeals which do not result in a resolution satisfactory to the
50 appealing party may be further appealed through the standard appeal
51 process, or through the external appeal process pursuant to section
52 forty-nine hundred fourteen of this article as applicable.

53 S 37. Section 4906 of the public health law, as amended by chapter 586
54 of the laws of 1998, is amended to read as follows:

55 S 4906. Waiver. 1. Any agreement which purports to waive, limit,
56 disclaim, or in any way diminish the rights set forth in this article,

1 except as provided pursuant to section four thousand nine hundred ten of
2 this article shall be void as contrary to public policy.

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

8 S 38. The opening paragraph of subdivision 2 of section 4910 of the
9 public health law, as added by chapter 586 of the laws of 1998, is
10 amended to read as follows:

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

14 S 39. Subparagraphs (ii) and (iii) of paragraph (b) of subdivision 2
15 of section 4910 of the public health law, as added by chapter 586 of the
16 laws of 1998, are amended to read as follows:

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

24 (iii) the enrollee's attending physician, who must be a licensed,
25 board-certified or board-eligible physician qualified to practice in the
26 area of practice appropriate to treat the enrollee's life threatening or
27 disabling condition or disease, must have recommended either (a) a
28 health service or procedure (including a pharmaceutical product within
29 the meaning of subparagraph (B) of paragraph [b] (B) of subdivision five
30 of section forty-nine hundred of this article) that, based on two docu-
31 ments from the available medical and scientific evidence, is likely to
32 be more beneficial to the enrollee than any covered standard health
33 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE
34 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION
35 FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROL-
36 LEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY
37 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO
38 BENEFIT THE ENROLLEE IN THE TREATMENT OF THE ENROLLEE'S RARE DISEASE AND
39 THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS THE RISKS OF SUCH HEALTH
40 SERVICE OR PROCEDURE; or (b) a clinical trial for which the enrollee is
41 eligible. Any physician certification provided under this section shall
42 include a statement of the evidence relied upon by the physician in
43 certifying his or her recommendation, and

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

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

determination within two business days of the rendering of such determination.

(c) Notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, if the enrollee's attending physician states that a delay in providing the health care service would pose an imminent or serious threat to the health of the enrollee, the external appeal shall be completed within three days of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the enrollee, THE ENROLLEE'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 41. Item 1 of clause (ii) of subparagraph (B) of paragraph (d) of subdivision 2 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(1) 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, BASED upon review of the applicable medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES, THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROLLEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY PRESENT (or upon confirmation that the recommended treatment is a clinical trial), the enrollee'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 (b) of subdivision five of section forty-nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the enrollee's life-threatening or disabling condition or disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a clinical trial, is likely to benefit the enrollee in the treatment of the enrollee'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 42. Subdivision 4 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

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

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

1 (C) IF AN ENROLLEE'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL
2 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT
3 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE
4 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND
5 THE ENROLLEE'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL
6 AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE
7 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS
8 SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION; PROVIDED, HOWEVER, THAT
9 THE COMMISSIONER MAY, UPON A DETERMINATION BY THE SUPERINTENDENT OF
10 INSURANCE THAT HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENC-
11 ING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL
12 APPEAL WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S
13 DETERMINATION IN PART, IN CONSULTATION WITH THE SUPERINTENDENT, PROMUL-
14 GATE REGULATIONS TO LIMIT SUCH HARDSHIP.

15 (D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S
16 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
17 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
18 ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH
19 THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS
20 SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON
21 RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST
22 OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT OF
23 INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO
24 CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO
25 EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTEN-
26 DENT OF INSURANCE WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF
27 INSURANCE SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
28 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
29 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
30 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE
31 REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE
32 SHALL REJECT THE APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE
33 SUPERINTENDENT'S REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE
34 IN ACCORDANCE WITH PARAGRAPHS (B) AND (C) OF THIS SUBDIVISION.

35 S 43. The public health law is amended by adding a new section 4917 to
36 read as follows:

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

43 S 44. Subdivision 2 of section 20 of chapter 451 of the laws of 2007,
44 amending the public health law, the social services law and the insur-
45 ance law relating to providing enhanced consumer and provider
46 protections, is amended to read as follows:

47 2. sections two, three and twelve of this act shall take effect on
48 January 1, 2008; provided, however, that subparagraph (iii) of paragraph
49 (1) of subsection (a) of section 3238 of the insurance law as added in
50 section twelve of this act shall expire and be deemed repealed December
51 31, [2009] 2011;

52 S 45. Intentionally omitted.

53 S 46. Intentionally omitted.

54 S 47. Intentionally omitted.

55 S 48. This act shall take effect January 1, 2010; provided, however,
56 that:

1 1. sections twenty and thirty-three of this act shall take effect
2 October 1, 2009, and shall apply to applications submitted after that
3 date, and shall not apply to applications submitted prior to such date
4 if such application is resubmitted in substantially similar form on or
5 after October 1, 2009;

6 2. provided, further, that the amendments to subsection (i) of section
7 3217-b of the insurance law made by section three of this act shall not
8 affect the repeal of such subsection and shall be deemed repealed there-
9 with;

10 3. provided, further, that the amendments to subsection (i) of section
11 4325 of the insurance law made by section nineteen of this act shall not
12 affect the repeal of such subsection and shall be deemed repealed there-
13 with;

14 4. provided, further, that the amendments to subdivision 5-d of
15 section 4406-c of the public health law made by section thirty-two of
16 this act shall not affect the repeal of such subdivision and shall be
17 deemed repealed therewith;

18 5. provided further that sections eight and forty-four of this act
19 shall take effect immediately;

20 6. provided further that section nine of this act shall apply to dates
21 of service on or after April 1, 2010; and

22 7. provided further that sections two, four, five, fifteen, sixteen
23 and seventeen of this act shall take effect January 1, 2011.