

6016

2009-2010 Regular Sessions

I N S E N A T E

June 19, 2009

Introduced by Sen. BRESLIN -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

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.
14 S 2. Subparagraph (G) of paragraph 1 of subsection (d) of section 3216
15 of the insurance law is amended to read as follows:
16 (G) PROOFS OF LOSS: Written proof of loss must be furnished to the
17 insurer at its said office in case of claim for loss for which this
18 policy provides any periodic payment contingent upon continuing loss
19 within ninety days after the termination of the period for which the

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

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1 insurer is liable and in case of claim for any other loss within [nine-
2 ty] ONE HUNDRED TWENTY days after the date of such loss. Failure to
3 furnish such proof within the time required shall not invalidate nor
4 reduce any claim if it was not reasonably possible to give proof within
5 such time, provided such proof is furnished as soon as reasonably possi-
6 ble and in no event, except in the absence of legal capacity, later than
7 one year from the time proof is otherwise required.

8 S 3. Subsections (g) and (h) of section 3217-b of the insurance law,
9 subsection (g) as relettered by chapter 586 of the laws of 1998, are
10 relettered subsections (h) and (i) and a new subsection (g) is added to
11 read as follows:

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

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

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

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

50 (B) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES AN
51 EXCLUSIVE NETWORK OF PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS
52 NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION
53 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL
54 PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIRE-
55 MENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR,
56 SUBSECTION (G-6) OF SECTION FOUR THOUSAND NINE HUNDRED, SUBSECTION (A-1)

1 OF SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF
2 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH
3 FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF
4 THIS CHAPTER.

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

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

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

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

35 S 6. The opening paragraph and subsections (a) and (b) of section
36 3224-a of the insurance law, as amended by chapter 666 of the laws of
37 1997, are amended to read as follows:

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

47 (a) Except in a case where the obligation of an insurer or an organ-
48 ization or corporation licensed or certified pursuant to article forty-
49 three OR FORTY-SEVEN of this chapter or article forty-four of the public
50 health law to pay a claim submitted by a policyholder or person covered
51 under such policy ("COVERED PERSON") or make a payment to a health care
52 provider is not reasonably clear, or when there is a reasonable basis
53 supported by specific information available for review by the super-
54 intendent that such claim or bill for health care services rendered was
55 submitted fraudulently, such insurer or organization or corporation
56 shall pay the claim to a policyholder or covered person or make a

1 payment to a health care provider within [forty-five] THIRTY days of
2 receipt of a claim or bill for services rendered THAT IS TRANSMITTED VIA
3 THE INTERNET OR ELECTRONIC MAIL, OR FORTY-FIVE DAYS OF RECEIPT OF A
4 CLAIM OR BILL FOR SERVICES RENDERED THAT IS SUBMITTED BY OTHER MEANS,
5 SUCH AS PAPER OR FACSIMILE.

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

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

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

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

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

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

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

48 (c) [Each] (1) EXCEPT AS PROVIDED IN PARAGRAPH TWO OF THIS SUBSECTION,
49 EACH claim or bill for health care services processed in violation of
50 this section shall constitute a separate violation. In addition to the
51 penalties provided in this chapter, any insurer or organization or
52 corporation that fails to adhere to the standards contained in this
53 section shall be obligated to pay to the health care provider or person
54 submitting the claim, in full settlement of the claim or bill for health
55 care services, the amount of the claim or health care payment plus
56 interest on the amount of such claim or health care payment of the

1 greater of the rate equal to the rate set by the commissioner of taxa-
2 tion and finance for corporate taxes pursuant to paragraph one of
3 subsection (e) of section one thousand ninety-six of the tax law or
4 twelve percent per annum, to be computed from the date the claim or
5 health care payment was required to be made. When the amount of interest
6 due on such a claim is less than two dollars, and insurer or organiza-
7 tion or corporation shall not be required to pay interest on such claim.

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

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

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

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

49 (H) (1) AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTI-
50 FIED PURSUANT TO ARTICLE FORTY-THREE OR ARTICLE FORTY-SEVEN OF THIS
51 CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL PERMIT A
52 PARTICIPATING HEALTH CARE PROVIDER TO REQUEST RECONSIDERATION OF A CLAIM
53 THAT IS DENIED EXCLUSIVELY BECAUSE IT WAS UNTIMELY SUBMITTED PURSUANT TO
54 SUBSECTION (G) OF THIS SECTION. THE INSURER OR ORGANIZATION OR CORPO-
55 RATION SHALL PAY SUCH CLAIM PURSUANT TO THE PROVISIONS OF PARAGRAPH TWO
56 OF THIS SUBSECTION IF THE HEALTH CARE PROVIDER CAN DEMONSTRATE BOTH

1 THAT: (I) THE HEALTH CARE PROVIDER'S NON-COMPLIANCE WAS A RESULT OF AN
2 UNUSUAL OCCURRENCE; AND (II) THE HEALTH CARE PROVIDER HAS A PATTERN OR
3 PRACTICE OF TIMELY SUBMITTING CLAIMS IN COMPLIANCE WITH SUBDIVISION (G)
4 OF THIS SECTION.

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

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

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

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

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

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

1 MENTAL HYGIENE LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED
2 OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

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

9 S 11. Subparagraph (B) of paragraph 2 of subsection (e) of section
10 3231 of the insurance law, as added by chapter 501 of the laws of 1992,
11 is amended to read as follows:

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

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

55 (26)(A) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE
56 FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A

1 PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY
2 ON THE BASIS THAT THE HEALTH CARE PROVIDER ADMITTING OR RENDERING
3 SERVICES TO THE INSURED IS NOT A PARTICIPATING PROVIDER.

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

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

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

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

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

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

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

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

38 S 13-a. The insurance law is amended by adding a new section 3241 to
39 read as follows:

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

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

55 (FF) (1) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPO-
56 RATION, HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPO-

1 RATION THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE
2 SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED
3 AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE
4 PROVIDER ADMITTING OR RENDERING SERVICES TO THE INSURED IS NOT A PARTIC-
5 IPATING PROVIDER.

6 (2) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPORATION,
7 HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPORATION
8 THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL
9 PROVIDE THAT SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE
10 COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES
11 ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

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

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

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

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

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

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

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

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

45 (B) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS
46 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT
47 ISSUES A COMPREHENSIVE CONTRACT THAT UTILIZES AN EXCLUSIVE NETWORK OF
48 PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS NOT A MANAGED CARE
49 HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR
50 THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO
51 OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION

52 (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR, SUBSECTION (G-6) OF
53 SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTION (A-1) OF
54 SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF SUBSECTION
55 (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH FOUR OF

1 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS
2 CHAPTER.

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

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

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

26 (2) In each case where the loss ratio for a contract form fails to
27 comply with the eighty-five percent minimum loss ratio requirement for
28 individual direct payment contracts, or the seventy-five percent minimum
29 loss ratio requirement for small group and small group remittance
30 contracts, as set forth in paragraph one of this subsection, the corpo-
31 ration shall issue a dividend or credit against future premiums for all
32 contract holders with that contract form in an amount sufficient to
33 assure that the aggregate benefits incurred in the previous calendar
34 year plus the amount of the dividends and credits shall equal no less
35 than eighty-five percent for individual direct payment contracts, or
36 seventy-five percent for small group and small group remittance
37 contracts, of the aggregate premiums earned for the contract form in the
38 previous calendar year. The dividend or credit shall be issued to each
39 contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as
40 of December thirty-first of] AT ANY TIME DURING the applicable year [and
41 remains in effect as of the date the dividend or credit is issued]. THE
42 DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED
43 FOR THE APPLICABLE YEAR AMONG ALL CONTRACT HOLDERS OR SUBSCRIBERS ELIGI-
44 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. A CORPORATION SHALL MAKE A
45 REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVI-
46 DENDS OR CREDITS TO, FORMER CONTRACT HOLDERS OR SUBSCRIBERS ENTITLED TO
47 THE DIVIDEND OR CREDIT. A CORPORATION SHALL, WITH RESPECT TO DIVIDENDS
48 OR CREDITS TO WHICH FORMER CONTRACT HOLDERS THAT THE CORPORATION IS
49 UNABLE TO IDENTIFY AFTER A REASONABLE EFFORT WOULD OTHERWISE BE ENTI-
50 TLED, HAVE THE OPTION, AS DEEMED ACCEPTABLE BY THE SUPERINTENDENT, OF
51 PROSPECTIVELY ADJUSTING PREMIUM RATES BY THE AMOUNT OF SUCH DIVIDENDS OR
52 CREDITS, ISSUING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS TO EXISTING
53 CONTRACT HOLDERS, DEPOSITING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS IN
54 THE FUND ESTABLISHED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED
55 TWENTY-TWO-A OF THIS ARTICLE, OR UTILIZING ANY OTHER METHOD WHICH
56 OFFSETS THE AMOUNT OF SUCH DIVIDENDS OR CREDITS. All dividends and cred-

1 its must be distributed by September thirtieth of the year following the
2 calendar year in which the loss ratio requirements were not satisfied.
3 The annual report required by paragraph one of this subsection shall
4 include a corporation's calculation of the dividends and credits, as
5 well as an explanation of the corporation's plan to issue dividends or
6 credits. The instructions and format for calculating and reporting loss
7 ratios and issuing dividends or credits shall be specified by the super-
8 intendent by regulation. Such regulations shall include provisions for
9 the distribution of a dividend or credit in the event of cancellation or
10 termination by a contract holder or subscriber.

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

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

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

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

46 (a) (1) An insurer which offers a managed care product shall, upon
47 request, make available and disclose to health care professionals writ-
48 ten application procedures and minimum qualification requirements which
49 a health care professional must meet in order to be considered by the
50 insurer for participation in the in-network benefits portion of the
51 insurer's network for the managed care product. The insurer shall
52 consult with appropriately qualified health care professionals in devel-
53 oping its qualification requirements for participation in the in-network
54 benefits portion of the insurer's network for the managed care product.
55 An insurer shall complete review of the health care professional's
56 application to participate in the in-network portion of the insurer's

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

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

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

48 (G-7) "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION
49 OR DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH
50 STUDY BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL
51 RESEARCH NETWORK; OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED
52 STATES RESIDENTS PER YEAR; AND (2) FOR WHICH THERE DOES NOT EXIST A
53 STANDARD HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN
54 THAT IS MORE CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR
55 TREATMENT. A PHYSICIAN, OTHER THAN THE INSURED'S TREATING PHYSICIAN,
56 SHALL CERTIFY IN WRITING THAT THE CONDITION IS A RARE DISEASE AS

1 DEFINED IN THIS SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A
2 LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN
3 THE AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED'S RARE DISEASE.
4 THE CERTIFICATION SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE
5 DISEASE IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE
6 NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK;
7 OR (2) THAT THE INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED
8 THOUSAND UNITED STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY
9 ON MEDICAL AND SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH
10 SERVICE OR PROCEDURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A
11 STATEMENT THAT, BASED ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS
12 NO STANDARD TREATMENT THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO
13 THE INSURED THAN THE REQUESTED HEALTH SERVICE OR PROCEDURE AND THE
14 REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE INSURED
15 IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO
16 THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE.
17 THE CERTIFYING PHYSICIAN SHALL DISCLOSE ANY MATERIAL FINANCIAL OR
18 PROFESSIONAL RELATIONSHIP WITH THE PROVIDER OF THE REQUESTED HEALTH
19 SERVICE OR PROCEDURE AS PART OF THE APPLICATION FOR EXTERNAL APPEAL OF
20 DENIAL OF A RARE DISEASE TREATMENT. IF THE PROVISION OF THE REQUESTED
21 HEALTH SERVICE OR PROCEDURE AT A HEALTH CARE FACILITY REQUIRES PRIOR
22 APPROVAL OF AN INSTITUTIONAL REVIEW BOARD, AN INSURED OR INSURED'S
23 DESIGNEE SHALL ALSO SUBMIT SUCH APPROVAL AS PART OF THE EXTERNAL APPEAL
24 APPLICATION.

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

27 (c) A utilization review agent shall make a determination involving
28 continued or extended health care services, [or] additional services for
29 an insured undergoing a course of continued treatment prescribed by a
30 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-
31 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination
32 to the insured or the insured's designee, which may be satisfied by
33 notice to the insured's health care provider, by telephone and in writ-
34 ing within one business day of receipt of the necessary information
35 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT
36 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY
37 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND
38 OR HOLIDAY. Notification of continued or extended services shall
39 include the number of extended services approved, the new total of
40 approved services, the date of onset of services and the next review
41 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL
42 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR
43 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS
44 SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF
45 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME
46 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW
47 AGENT IS PENDING.

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

51 (b) A utilization review agent shall establish an expedited appeal
52 process for appeal of an adverse determination involving (1) continued
53 or extended health care services, procedures or treatments or additional
54 services for an insured undergoing a course of continued treatment
55 prescribed by a health care provider or HOME HEALTH CARE SERVICES
56 FOLLOWING DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO

1 SUBSECTION (C) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTI-
2 CLE OR (2) an adverse determination in which the health care provider
3 believes an immediate appeal is warranted except any retrospective
4 determination. Such process shall include mechanisms which facilitate
5 resolution of the appeal including but not limited to the sharing of
6 information from the insured's health care provider and the utilization
7 review agent by telephonic means or by facsimile. The utilization review
8 agent shall provide reasonable access to its clinical peer reviewer
9 within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business
10 days of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the
11 appealing party may be further appealed through the standard appeal
12 process, or through the external appeal process pursuant to section four
13 thousand nine hundred fourteen of this article as applicable.

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

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

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

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

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

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

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

41 (C) the insured's attending physician, who must be a licensed, board-
42 certified or board-eligible physician qualified to practice in the area
43 of practice appropriate to treat the insured's life-threatening or dis-
44 abling condition or disease, must have recommended either (a) a health
45 service or procedure (including a pharmaceutical product within the
46 meaning of subparagraph (B) of paragraph two of subsection (e) of
47 section four thousand nine hundred of this article) that, based on two
48 documents from the available medical and scientific evidence, is likely
49 to be more beneficial to the insured than any covered standard health
50 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE
51 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION FOUR
52 THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE
53 INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN MAY
54 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO
55
56

1 BENEFIT THE INSURED IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND
2 THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH
3 SERVICE OR PROCEDURE; or (b) a clinical trial for which the insured is
4 eligible. Any physician certification provided under this section shall
5 include a statement of the evidence relied upon by the physician in
6 certifying his or her recommendation, and

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

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

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

31 S 28. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of
32 subsection (b) of section 4914 of the insurance law, as added by chapter
33 586 of the laws of 1998, is amended to read as follows:

34 (a) that the patient costs of the proposed health service or procedure
35 shall be covered by the health care plan either: when a majority of the
36 panel of reviewers determines, BASED upon review of the applicable
37 medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES,
38 THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION
39 FOUR THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS
40 THE INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN
41 MAY PRESENT (or upon confirmation that the recommended treatment is a
42 clinical trial), the insured's medical record, and any other pertinent
43 information, that the proposed health service or treatment (including a
44 pharmaceutical product within the meaning of subparagraph (B) of para-
45 graph two of subsection (e) of section four thousand nine hundred of
46 this article is likely to be more beneficial than any standard treatment
47 or treatments for the insured's life-threatening or disabling condition
48 or disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR
49 PROCEDURE IS LIKELY TO BENEFIT THE INSURED IN THE TREATMENT OF THE
50 INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS
51 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a
52 clinical trial, is likely to benefit the insured in the treatment of the
53 insured's condition or disease); or when a reviewing panel is evenly
54 divided as to a determination concerning coverage of the health service
55 or procedure, or

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

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

15 (2) IF AN INSURED'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL
16 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT
17 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN WHOLE, PAYMENT FOR THE
18 EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PROVIDER IN THE MANNER
19 AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH
20 ONE OF THIS SUBSECTION.

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

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

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

1 S 4917. HOLD HARMLESS. A HEALTH CARE PROVIDER REQUESTING AN EXTERNAL
2 APPEAL OF A CONCURRENT ADVERSE DETERMINATION, INCLUDING WHEN THE HEALTH
3 CARE PROVIDER REQUESTS AN EXTERNAL APPEAL AS THE INSURED'S DESIGNEE,
4 SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED FOR SERVICES DETERMINED
5 NOT MEDICALLY NECESSARY BY THE EXTERNAL APPEAL AGENT, EXCEPT TO COLLECT
6 A COPAYMENT, COINSURANCE OR DEDUCTIBLE.

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

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

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

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

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

26 5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT
27 CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE
28 PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE
29 CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH
30 WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY
31 THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF
32 THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE
33 CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE
34 HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE
35 NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR
36 HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION
37 DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS
38 SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A
39 PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A MATERIAL
40 ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH CARE
41 PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
42 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
43 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS
44 SUBDIVISION SHALL NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED
45 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS
46 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR
47 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE AMERICAN
48 MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES,
49 REPORTING GUIDELINES AND CONVENTIONS; OR (II) SUCH CHANGE IS EXPRESSLY
50 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
51 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
52 OR PAYMENT POLICY INDEXING MECHANISM.

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

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

4 1. (A) A health care plan shall, upon request, make available and
5 disclose to health care professionals written application procedures and
6 minimum qualification requirements which a health care professional must
7 meet in order to be considered by the health care plan. The plan shall
8 consult with appropriately qualified health care professionals in devel-
9 oping its qualification requirements. A health care plan shall complete
10 review of the health care professional's application to participate in
11 the in-network portion of the health care plan's network and shall,
12 within ninety days of receiving a health care professional's completed
13 application to participate in the health care plan's network, notify the
14 health care professional as to [(a)]: (I) whether he or she is creden-
15 tialed; or [(b)] (II) whether additional time is necessary to make a
16 determination in spite of the health care plan's best efforts or because
17 of a failure of a third party to provide necessary documentation, or
18 non-routine or unusual circumstances require additional time for review.
19 In such instances where additional time is necessary because of a lack
20 of necessary documentation, a health plan shall make every effort to
21 obtain such information as soon as possible.

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

1 PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND
2 THAT THE CLAIM WAS NOT TIMELY FILED.

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

5 7-G. "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION OR
6 DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY
7 BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH
8 NETWORK OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED STATES
9 RESIDENTS PER YEAR, AND (2) FOR WHICH THERE DOES NOT EXIST A STANDARD
10 HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN THAT IS MORE
11 CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR TREATMENT. A
12 PHYSICIAN, OTHER THAN THE ENROLLEE'S TREATING PHYSICIAN, SHALL CERTIFY
13 IN WRITING THAT THE CONDITION IS A RARE DISEASE AS DEFINED IN THIS
14 SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A LICENSED, BOARD-CERTI-
15 FIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN THE AREA OF PRACTICE
16 APPROPRIATE TO TREAT THE ENROLLEE'S RARE DISEASE. THE CERTIFICATION
17 SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE DISEASE IS CURRENTLY
18 OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE NATIONAL INSTITUTES OF
19 HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK; OR (2) THAT THE
20 INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED
21 STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY ON MEDICAL AND
22 SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH SERVICE OR PROCE-
23 DURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A STATEMENT THAT, BASED
24 ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS NO STANDARD TREATMENT
25 THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO THE ENROLLEE THAN THE
26 REQUESTED HEALTH SERVICE OR PROCEDURE AND THE REQUESTED HEALTH SERVICE
27 OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE
28 ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS
29 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE. THE CERTIFYING PHYSICIAN
30 SHALL DISCLOSE ANY MATERIAL FINANCIAL OR PROFESSIONAL RELATIONSHIP WITH
31 THE PROVIDER OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AS PART OF THE
32 APPLICATION FOR EXTERNAL APPEAL OF DENIAL OF A RARE DISEASE TREATMENT.
33 IF THE PROVISION OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AT A
34 HEALTH CARE FACILITY REQUIRES PRIOR APPROVAL OF AN INSTITUTIONAL REVIEW
35 BOARD, AN ENROLLEE OR ENROLLEE'S DESIGNEE SHALL ALSO SUBMIT SUCH
36 APPROVAL AS PART OF THE EXTERNAL APPEAL APPLICATION.

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

39 3. A utilization review agent shall make a determination involving
40 continued or extended health care services, [or] additional services for
41 an enrollee undergoing a course of continued treatment prescribed by a
42 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-
43 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination
44 to the enrollee or the enrollee's designee, which may be satisfied by
45 notice to the enrollee's health care provider, by telephone and in writ-
46 ing within one business day of receipt of the necessary information
47 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT
48 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY
49 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND
50 OR HOLIDAY. Notification of continued or extended services shall
51 include the number of extended services approved, the new total of
52 approved services, the date of onset of services and the next review
53 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL
54 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR
55 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS
56 SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF

1 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME
2 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW
3 AGENT IS PENDING.

4 S 36. Subdivision 2 of section 4904 of the public health law, as added
5 by chapter 705 of the laws of 1996, paragraph (b) as amended by chapter
6 586 of the laws of 1998, is amended to read as follows:

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

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

15 (b) an adverse determination in which the health care provider
16 believes an immediate appeal is warranted except any retrospective
17 determination. Such process shall include mechanisms which facilitate
18 resolution of the appeal including but not limited to the sharing of
19 information from the enrollee's health care provider and the utilization
20 review agent by telephonic means or by facsimile. The utilization review
21 agent shall provide reasonable access to its clinical peer reviewer
22 within one business day of receiving notice of the taking of an expe-
23 dited appeal. Expedited appeals shall be determined within two business
24 days of receipt of necessary information to conduct such appeal. Expe-
25 dited appeals which do not result in a resolution satisfactory to the
26 appealing party may be further appealed through the standard appeal
27 process, or through the external appeal process pursuant to section
28 forty-nine hundred fourteen of this article as applicable.

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

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

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

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

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

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

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

1 (iii) the enrollee's attending physician, who must be a licensed,
2 board-certified or board-eligible physician qualified to practice in the
3 area of practice appropriate to treat the enrollee's life threatening or
4 disabling condition or disease, must have recommended either (a) a
5 health service or procedure (including a pharmaceutical product within
6 the meaning of subparagraph (B) of paragraph [b] (B) of subdivision five
7 of section forty-nine hundred of this article) that, based on two docu-
8 ments from the available medical and scientific evidence, is likely to
9 be more beneficial to the enrollee than any covered standard health
10 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE
11 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION
12 FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROL-
13 LEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY
14 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO
15 BENEFIT THE ENROLLEE IN THE TREATMENT OF THE ENROLLEE'S RARE DISEASE AND
16 THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS THE RISKS OF SUCH HEALTH
17 SERVICE OR PROCEDURE; or (b) a clinical trial for which the enrollee is
18 eligible. Any physician certification provided under this section shall
19 include a statement of the evidence relied upon by the physician in
20 certifying his or her recommendation, and

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

24 (b) The external appeal agent shall make a determination with respect
25 to the appeal within thirty days of the receipt of the [enrollee's]
26 request therefor, submitted in accordance with the commissioner's
27 instructions. The external appeal agent shall have the opportunity to
28 request additional information from the enrollee, the enrollee's health
29 care provider and the enrollee's health care plan within such thirty-day
30 period, in which case the agent shall have up to five additional busi-
31 ness days if necessary to make such determination. The external appeal
32 agent shall notify the enrollee, THE ENROLLEE'S HEALTH CARE PROVIDER
33 WHERE APPROPRIATE, and the health care plan, in writing, of the appeal
34 determination within two business days of the rendering of such determi-
35 nation.

36 (c) Notwithstanding the provisions of paragraphs (a) and (b) of this
37 subdivision, if the enrollee's attending physician states that a delay
38 in providing the health care service would pose an imminent or serious
39 threat to the health of the enrollee, the external appeal shall be
40 completed within three days of the request therefor and the external
41 appeal agent shall make every reasonable attempt to immediately notify
42 the enrollee, THE ENROLLEE'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and
43 the health plan of its determination by telephone or facsimile, followed
44 immediately by written notification of such determination.

45 S 41. Item 1 of clause (ii) of subparagraph (B) of paragraph (d) of
46 subdivision 2 of section 4914 of the public health law, as added by
47 chapter 586 of the laws of 1998, is amended to read as follows:

48 (1) that the patient costs of the proposed health service or procedure
49 shall be covered by the health care plan either: when a majority of the
50 panel of reviewers determines, BASED upon review of the applicable
51 medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES,
52 THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION
53 FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROL-
54 LEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY
55 PRESENT (or upon confirmation that the recommended treatment is a clin-
56 ical trial), the enrollee's medical record, and any other pertinent

1 information, that the proposed health service or treatment (including a
2 pharmaceutical product within the meaning of subparagraph (B) of para-
3 graph (b) of subdivision five of section forty-nine hundred of this
4 article) is likely to be more beneficial than any standard treatment or
5 treatments for the enrollee's life-threatening or disabling condition or
6 disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR
7 PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE
8 ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS
9 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a
10 clinical trial, is likely to benefit the enrollee in the treatment of
11 the enrollee's condition or disease); or when a reviewing panel is even-
12 ly divided as to a determination concerning coverage of the health
13 service or procedure, or

14 S 42. Subdivision 4 of section 4914 of the public health law, as added
15 by chapter 586 of the laws of 1998, is amended to read as follows:

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

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

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

48 (D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S
49 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
50 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
51 ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH
52 THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS
53 SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON
54 RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST
55 OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT OF
56 INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO

1 CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO
2 EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTEN-
3 DENT OF INSURANCE WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF
4 INSURANCE SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
5 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
6 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
7 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE
8 REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE
9 SHALL REJECT THE APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE
10 SUPERINTENDENT'S REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE
11 IN ACCORDANCE WITH PARAGRAPHS (B) AND (C) OF THIS SUBDIVISION.

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

14 S 4917. HOLD HARMLESS. A HEALTH CARE PROVIDER REQUESTING AN EXTERNAL
15 APPEAL OF A CONCURRENT ADVERSE DETERMINATION, INCLUDING WHEN THE HEALTH
16 CARE PROVIDER REQUESTS AN EXTERNAL APPEAL AS THE ENROLLEE'S DESIGNEE,
17 SHALL NOT PURSUE REIMBURSEMENT FROM THE ENROLLEE FOR SERVICES DETERMINED
18 NOT MEDICALLY NECESSARY BY THE EXTERNAL APPEAL AGENT, EXCEPT TO COLLECT
19 A COPAYMENT.

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

24 2. sections two, three and twelve of this act shall take effect on
25 January 1, 2008; provided, however, that subparagraph (iii) of paragraph
26 (1) of subsection (a) of section 3238 of the insurance law as added in
27 section twelve of this act shall expire and be deemed repealed December
28 31, [2009] 2011;

29 S 45. Intentionally omitted.

30 S 46. Intentionally omitted.

31 S 47. Intentionally omitted.

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

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

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

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

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

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

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

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