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I N   S E N A T E

April 14, 2010

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

AN ACT to amend the insurance law, in relation to standards for prompt, fair and equitable settlement of claims for health care and payments for health care services

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

1     Section 1. Subsections (a) and (b) of section 3224-a of the insurance  
2     law, as amended by chapter 237 of the laws of 2009, are amended to read  
3     as follows:  
4     (a) Except in a case where the obligation of an insurer or an organ-  
5     ization or corporation licensed or certified pursuant to article forty-  
6     three or forty-seven of this chapter or article forty-four of the public  
7     health law to pay a claim submitted by a policyholder or person covered  
8     under such policy ("covered person") or make a payment to a health care  
9     provider is not reasonably clear, or when there is a reasonable basis  
10    supported by specific information available for review by the super-  
11    intendent that such claim or bill for health care services rendered was  
12    submitted fraudulently, such insurer or organization or corporation  
13    shall pay the claim to a policyholder or covered person or make a  
14    payment to a health care provider within [thirty] FIFTEEN days of  
15    receipt of a claim or bill for services rendered that is transmitted via  
16    the internet or electronic mail, or [forty-five] THIRTY days of receipt  
17    of a claim or bill for services rendered that is submitted by other  
18    means, such as paper or facsimile. THE INSURER, ORGANIZATION OR CORPO-  
19    RATION SHALL NOT DENY PAYMENT FOR A CLAIM FOR MEDICALLY NECESSARY  
20    COVERED SERVICES ON THE BASIS OF AN ADMINISTRATIVE OR TECHNICAL DEFECT  
21    INCLUDING A FAILURE TO OBTAIN A REFERRAL; UNTIMELY FILING OF THE CLAIM;  
22    LATE NOTIFICATION OF A HOSPITAL ADMISSION OR THE PROVISION OF SERVICES  
23    THAT THE INSURER, ORGANIZATION OR CORPORATION MAY REQUIRE; A FAILURE TO  
24    PROVIDE NOTIFICATION OF A HOSPITAL ADMISSION OR PROVISION OF SERVICES  
25    THAT THE INSURER, ORGANIZATION OR CORPORATION MAY REQUIRE; A FAILURE TO  
26    PROVIDE PROPER REGISTRATION OF A HOSPITAL ADMISSION OR PROVISION OF  
27    SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY REQUIRE; A

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

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1 FAILURE TO REQUEST PROPER AUTHORIZATION OF A HOSPITAL ADMISSION OR  
2 PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY  
3 REQUIRE; OR ANY OTHER ADMINISTRATIVE OR TECHNICAL DEFECT AS THE SUPER-  
4 INTENDENT MAY SPECIFY IN A REGULATION AFTER CONSULTATION WITH THE  
5 COMMISSIONER OF HEALTH. NOTHING IN THIS SECTION SHALL PRECLUDE A HEALTH  
6 CARE PROVIDER AND A HEALTH PLAN FROM AGREEING TO PROVISIONS DIFFERENT  
7 FROM THOSE IN THIS SECTION; PROVIDED, HOWEVER, THAT ANY AGREEMENT THAT  
8 PURPORTS TO WAIVE, LIMIT, DISCLAIM, OR IN ANY WAY DIMINISH THE RIGHTS OF  
9 A HEALTH CARE PROVIDER SET FORTH IN THIS SECTION SHALL BE VOID AS  
10 CONTRARY TO PUBLIC POLICY.

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

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

28 (2) to request [all] additional information needed to determine  
29 liability to pay the claim or make the health care payment; PROVIDED,  
30 HOWEVER, IN RESPONSE TO ITS RECEIPT OF A SPECIFIC CLAIM FOR SERVICES AN  
31 INSURER, ORGANIZATION OR CORPORATION SHALL NOT GENERATE AND TRANSMIT A  
32 QUESTIONNAIRE IN ORDER TO DETERMINE WHETHER THE POLICYHOLDER OR COVERED  
33 PERSON IS COVERED FOR ALL OR PART OF THE CLAIM BY ANOTHER INSURER,  
34 CORPORATION OR ORGANIZATION. NOTHING IN THIS SECTION SHALL OTHERWISE  
35 PRECLUDE AN INSURER, ORGANIZATION OR CORPORATION FROM SENDING A COORDI-  
36 NATION OF BENEFIT QUESTIONNAIRE TO A POLICYHOLDER OR COVERED PERSON AT  
37 ANOTHER TIME PROVIDED THAT IN NO EVENT SHALL THE INSURER, ORGANIZATION  
38 OR CORPORATION DELAY OR DENY PAYMENT OF A CLAIM WHEN A POLICYHOLDER OR  
39 COVERED PERSON DOES NOT COMPLETE AND RETURN SUCH COORDINATION OF BENE-  
40 FITS QUESTIONNAIRE.

41 Upon receipt of the information requested in paragraph two of this  
42 subsection or an appeal of a claim or bill for health care services  
43 denied pursuant to paragraph one of this subsection, an insurer or  
44 organization or corporation licensed or certified pursuant to article  
45 forty-three or forty-seven of this chapter or article forty-four of the  
46 public health law shall comply with subsection (a) of this section.

47 S 2. Subsection (b) of section 3224-b of the insurance law, as amended  
48 by chapter 237 of the laws of 2009, is amended to read as follows:

49 (b) Overpayments to health care providers. (1) Other than recovery for  
50 duplicate payments, a health plan shall provide thirty days written  
51 notice to health care providers [before engaging in additional overpay-  
52 ment recovery efforts seeking] OF ITS INTENTION TO SEEK recovery of the  
53 overpayment of claims to such health care providers. Such notice shall  
54 state the patient name, service date, payment amount, proposed adjust-  
55 ment, and a reasonably specific explanation of the proposed adjustment.  
56 A HEALTH PLAN SHALL NOT SEEK RECOVERY FROM A HEALTH CARE PROVIDER

1 UNLESS: THE HEALTH CARE PROVIDER AGREES TO THE RECOVERY IN WRITING; THE  
2 HEALTH CARE PROVIDER FAILS TO SEND ITS WRITTEN CHALLENGE OF THE HEALTH  
3 PLAN'S OVERPAYMENT RECOVERY WITHIN NINETY DAYS OF RECEIPT OF THE PLAN'S  
4 NOTICE OF INTENT TO SEEK OVERPAYMENT RECOVERY; OR THE OVERPAYMENT RECOV-  
5 ERY HAS BEEN UPHELD ACCORDING TO PROCEDURES ESTABLISHED BY THE PARTIES  
6 IN THEIR CONTRACTUAL AGREEMENT; OR A THIRD-PARTY ARBITRATOR UPHELD THE  
7 OVERPAYMENT RECOVERY.

8 (2) A HEALTH PLAN SHALL LIMIT OVERPAYMENT RECOVERY EFFORTS TO: BILLING  
9 AND CODING ERRORS; INCORRECT RATE PAYMENTS; INELIGIBILITY OF A PERSON  
10 FOR COVERAGE; OR FRAUD. A HEALTH PLAN SHALL NOT INITIATE OVERPAYMENT  
11 RECOVERY EFFORTS FOR UTILIZATION REVIEW PURPOSES AS DEFINED IN ARTICLE  
12 FORTY-NINE OF THIS CHAPTER OR ARTICLE FORTY-NINE OF THE PUBLIC HEALTH  
13 LAW, IF THE SERVICES WERE ALREADY DEEMED MEDICALLY NECESSARY BY THE  
14 HEALTH PLAN, OR IF THE HEALTH PLAN PREVIOUSLY APPROVED THE MANNER IN  
15 WHICH SERVICES WERE ACCESSED OR PROVIDED.

16 [(2)] (3) A health plan shall provide a health care provider with the  
17 opportunity to challenge an overpayment recovery, including the sharing  
18 of claims information, and shall establish written policies and proce-  
19 dures for health care providers to follow to challenge an overpayment  
20 recovery. Such challenge shall set forth the specific grounds on which  
21 the provider is challenging the overpayment recovery. THESE WRITTEN  
22 POLICIES AND PROCEDURES SHALL INCLUDE A PROVISION STATING THAT A HEALTH  
23 CARE PROVIDER SHALL HAVE NO LESS THAN NINETY DAYS FROM RECEIPT OF THE  
24 HEALTH PLAN'S WRITTEN NOTICE OF INTENT TO SEEK RECOVERY TO PROVIDE  
25 DOCUMENTATION CHALLENGING THE ALLEGED OVERPAYMENTS. ANY CHALLENGE TO AN  
26 OVERPAYMENT RECOVERY THAT CANNOT BE RESOLVED BETWEEN THE HEALTH PLAN AND  
27 THE HEALTH CARE PROVIDER WITHIN THIRTY DAYS FROM THE HEALTH PLAN'S  
28 RECEIPT OF THE PROVIDER'S DOCUMENTATION SHALL BE RESOLVED ACCORDING TO  
29 PROCEDURES ESTABLISHED BY THE PARTIES IN THEIR CONTRACTUAL AGREEMENT OR  
30 SHALL BE SUBMITTED TO A THIRD-PARTY ARBITRATOR FOR A DETERMINATION.

31 [(3)] (4) A health plan shall not initiate overpayment recovery  
32 efforts more than twenty-four months after the original payment was  
33 received by a health care provider. However, no such time limit shall  
34 apply to overpayment recovery efforts that are: (i) based on a reason-  
35 able belief of fraud or other intentional misconduct, [or abusive bill-  
36 ing,] (ii) required by, or initiated at the request of, a self-insured  
37 plan, or (iii) required or authorized by a state or federal government  
38 program or coverage that is provided by this state or a municipality  
39 thereof to its respective employees, retirees or members. Notwithstand-  
40 ing the aforementioned time limitations, in the event that a health care  
41 provider asserts that a health plan has underpaid a claim or claims, the  
42 health plan may defend or set off such assertion of underpayment based  
43 on overpayments going back in time as far as the claimed underpayment.  
44 [For purposes of this paragraph, "abusive billing" shall be defined as a  
45 billing practice which results in the submission of claims that are not  
46 consistent with sound fiscal, business, or medical practices and at such  
47 frequency and for such a period of time as to reflect a consistent  
48 course of conduct.

49 (4)] (5) For the purposes of this subsection the term "health care  
50 provider" shall mean an entity licensed or certified pursuant to article  
51 twenty-eight, thirty-six or forty of the public health law, a facility  
52 licensed pursuant to article nineteen, thirty-one or thirty-two of the  
53 mental hygiene law, or a health care professional licensed, registered  
54 or certified pursuant to title eight of the education law.

55 [(5)] (6) Nothing in this section shall be deemed to limit a health  
56 plan's right to pursue recovery of overpayments that occurred prior to

1 the effective date of this section where the health plan has provided  
2 the health care provider with notice of such recovery efforts prior to  
3 the effective date of this section.

4 (7) A HEALTH PLAN SHALL NOT PURSUE OVERPAYMENT RECOVERY EFFORTS  
5 AGAINST AN INSURED IF THE HEALTH PLAN IS PRECLUDED FROM PURSUING OVER-  
6 PAYMENT RECOVERY EFFORTS AGAINST A HEALTH CARE PROVIDER PURSUANT TO  
7 PARAGRAPH TWO OF THIS SUBSECTION.

8 (8) A HEALTH PLAN SHALL ASSURE ADHERENCE TO THE REQUIREMENTS STATED IN  
9 THIS SECTION BY ALL CONTRACTORS, SUBCONTRACTORS, SUBVENDORS, AGENTS AND  
10 EMPLOYEES AFFILIATED BY CONTRACT OR OTHERWISE WITH SUCH LICENSED ENTITY.  
11 ALL CONTRACTORS, SUBCONTRACTORS, SUBVENDORS, AGENTS AND EMPLOYEES AFFIL-  
12 IATED BY CONTRACT OR OTHERWISE WITH ANY HEALTH PLAN SHALL ALSO ADHERE TO  
13 THE REQUIREMENTS OF THIS SECTION.

14 (9) NOTHING IN THIS SECTION SHALL PRECLUDE A HEALTH CARE PROVIDER AND  
15 A HEALTH PLAN FROM AGREEING TO PROVISIONS DIFFERENT FROM THOSE IN THIS  
16 SECTION; PROVIDED, HOWEVER, THAT ANY AGREEMENT THAT PURPORTS TO WAIVE,  
17 LIMIT, DISCLAIM, OR IN ANY WAY DIMINISH THE RIGHTS OF A HEALTH CARE  
18 PROVIDER SET FORTH IN THIS SECTION SHALL BE VOID AS CONTRARY TO PUBLIC  
19 POLICY.

20 (10) HEALTH CARE PROVIDER SHALL MEAN AN ENTITY LICENSED OR CERTIFIED  
21 PURSUANT TO ARTICLE TWENTY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC  
22 HEALTH LAW, A FACILITY LICENSED PURSUANT TO ARTICLE NINETEEN, FORMER  
23 TWENTY-THREE OR THIRTY-ONE OF THE MENTAL HYGIENE LAW, AND A HEALTH CARE  
24 PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT  
25 OF THE EDUCATION LAW.

26 S 3. The insurance law is amended by adding a new section 3240 to read  
27 as follows:

28 S 3240. COVERAGE OF SERVICES OF PARTICIPATING PROVIDERS. AN INSURER  
29 LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE, A CORPORATION ORGANIZED  
30 PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, HEALTH MAINTENANCE  
31 ORGANIZATIONS AND OTHER ORGANIZATIONS CERTIFIED PURSUANT TO ARTICLE  
32 FORTY-FOUR OF THE PUBLIC HEALTH LAW OR A MUNICIPAL COOPERATIVE HEALTH  
33 BENEFITS PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER  
34 (COLLECTIVELY A "HEALTH PLAN") THAT UTILIZES A NETWORK OF PARTICIPATING  
35 PROVIDERS IN THE DELIVERY AND PROVISION OF HEALTH INSURANCE BENEFITS  
36 SHALL NOT DEEM A HEALTH CARE PROVIDER WHO IS PARTICIPATING IN THE HEALTH  
37 PLAN'S PROVIDER NETWORK AND RENDERING MEDICAL SERVICES TO AN INSURED,  
38 SUBSCRIBER OR ENROLLEE TO BE OUT-OF-NETWORK BECAUSE ONE OR MORE OTHER  
39 HEALTH PROVIDERS RENDERING SERVICES TO THE INSURED, SUBSCRIBER OR ENROL-  
40 LEE FOR THE SAME OR RELATED MEDICAL CONDITION, ILLNESS OR INJURY DOES  
41 NOT PARTICIPATE IN THE HEALTH PLAN'S PROVIDER NETWORK. THE INSURED,  
42 SUBSCRIBER OR ENROLLEE SHALL ONLY BE SUBJECT TO THE IN-NETWORK COST  
43 SHARING PROVISIONS OF THE POLICY OR CERTIFICATE FOR THE SERVICES OF SUCH  
44 PARTICIPATING PROVIDER OR PROVIDERS. FURTHER, THE HEALTH PLAN SHALL PAY  
45 A PARTICIPATING HEALTH CARE PROVIDER OR PROVIDERS THE CONTRACTED RATE  
46 FOR SERVICES PROVIDED BY SUCH PARTICIPATING PROVIDER OR PROVIDERS  
47 REGARDLESS OF THE NETWORK STATUS OF THE OTHER PROVIDERS. HEALTH CARE  
48 PROVIDER SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE  
49 TWENTY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY  
50 LICENSED PURSUANT TO ARTICLE NINETEEN, FORMER TWENTY-THREE OR THIRTY-ONE  
51 OF THE MENTAL HYGIENE LAW, AND A HEALTH CARE PROFESSIONAL LICENSED,  
52 REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

53 S 4. Section 2406 of the insurance law is amended by adding a new  
54 subsection (a-1) to read as follows:

55 (A-1) (1) IF, AFTER COMPLETION OF AN INVESTIGATION INVOLVING INFORMA-  
56 TION COLLECTED FROM A SIX MONTH PERIOD, NOTICE AND HEARING, THE SUPER-

1 INTENDENT FINDS THAT THE PERSON COMPLAINED OF HAS ENGAGED IN A SERIES OF  
2 ACTS PROHIBITED BY SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF  
3 THIS CHAPTER THAT, TAKEN TOGETHER, CONSTITUTE A CONSISTENT PATTERN OR  
4 PRACTICE, THE SUPERINTENDENT IS AUTHORIZED TO LEVY A CIVIL PENALTY  
5 AGAINST SUCH PERSON IN THE FOLLOWING MANNER:

6 (A) FOR THE FIRST FINDING OF A CONSISTENT PATTERN OR PRACTICE, THE  
7 SUPERINTENDENT MAY LEVY A FINE OF NOT MORE THAN ONE HUNDRED THOUSAND  
8 DOLLARS.

9 (B) FOR A SECOND FINDING OF A CONSISTENT PATTERN OR PRACTICE THAT  
10 OCCURS ON OR EARLIER THAN TWO YEARS FROM THE FIRST OFFENSE THE SUPER-  
11 INTENDENT MAY LEVY A FINE OF NOT MORE THAN THREE HUNDRED THOUSAND  
12 DOLLARS.

13 (C) FOR A THIRD FINDING OF A CONSISTENT PATTERN OR PRACTICE THAT  
14 OCCURS ON OR EARLIER THAN FIVE YEARS AFTER A FIRST OFFENSE, THE SUPER-  
15 INTENDENT MAY LEVY A FINE OF NOT MORE THAN ONE MILLION DOLLARS.

16 (2) IN DETERMINING THE AMOUNT OF A FINE TO BE LEVIED WITHIN THE SPECI-  
17 FIED LIMITS, THE SUPERINTENDENT SHALL CONSIDER THE FOLLOWING FACTORS:

18 (A) THE EXTENT AND FREQUENCY OF THE VIOLATIONS;

19 (B) WHETHER THE VIOLATIONS WERE DUE TO CIRCUMSTANCES BEYOND THE INSUR-  
20 ER, ORGANIZATION OR CORPORATION'S CONTROL;

21 (C) ANY REMEDIAL ACTIONS TAKEN BY THE INSURER, ORGANIZATION OR CORPO-  
22 RATION TO PREVENT FUTURE VIOLATIONS;

23 (D) THE ACTUAL OR POTENTIAL HARM TO OTHERS RESULTING FROM THE  
24 VIOLATIONS;

25 (E) IF THE INSURER, ORGANIZATION OR CORPORATION KNOWINGLY AND WILLING-  
26 LY COMMITTED THE VIOLATIONS;

27 (F) THE INSURER, ORGANIZATION OR CORPORATION'S FINANCIAL CONDITION;  
28 AND

29 (G) ANY OTHER FACTORS THE SUPERINTENDENT CONSIDERS APPROPRIATE.

30 S 5. This act shall take effect immediately.