S T A T E  O F  N E W  Y O R K

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I N  S E N A T E

April 14, 2010

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:

Section 1. Subsections (a) and (b) of section 3224-a of the insurance law, as amended by chapter 237 of the laws of 2009, are amended to read as follows:

(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within [thirty] FIFTEEN days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or [forty-five] THIRTY days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile. THE INSURER, ORGANIZATION OR CORPORATION SHALL NOT DENY PAYMENT FOR A CLAIM FOR MEDICALLY NECESSARY COVERED SERVICES ON THE BASIS OF AN ADMINISTRATIVE OR TECHNICAL DEFECT INCLUDING A FAILURE TO OBTAIN A REFERRAL; UNTIMELY FILING OF THE CLAIM; LATE NOTIFICATION OF A HOSPITAL ADMISSION OR THE PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY REQUIRE; A FAILURE TO PROVIDE NOTIFICATION OF A HOSPITAL ADMISSION OR PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY REQUIRE; A FAILURE TO PROVIDE PROPER REGISTRATION OF A HOSPITAL ADMISSION OR PROVISION OF 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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FAILURE TO REQUEST PROPER AUTHORIZATION OF A HOSPITAL ADMISSION OR PROVISION OF SERVICES THAT THE INSURER, ORGANIZATION OR CORPORATION MAY REQUIRE; OR ANY OTHER ADMINISTRATIVE OR TECHNICAL DEFECT AS THE SUPERINTENDENT MAY SPECIFY IN A REGULATION AFTER CONSULTATION WITH THE COMMISSIONER OF HEALTH. NOTHING IN THIS SECTION SHALL PRECLUDE A HEALTH CARE PROVIDER AND A HEALTH PLAN FROM AGREEING TO PROVISIONS DIFFERENT FROM THOSE IN THIS SECTION; PROVIDED, HOWEVER, THAT ANY AGREEMENT THAT PURPORTS TO WAIVE, LIMIT, DISCLAIM, OR IN ANY WAY DIMINISH THE RIGHTS OF A HEALTH CARE PROVIDER SET FORTH IN THIS SECTION SHALL BE VOID AS CONTRARY TO PUBLIC POLICY.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) IN DETERMINING THE AMOUNT OF A FINE TO BE LEVIED WITHIN THE SPECIFIED LIMITS, THE SUPERINTENDENT SHALL CONSIDER THE FOLLOWING FACTORS:

(A) THE EXTENT AND FREQUENCY OF THE VIOLATIONS;

(B) WHETHER THE VIOLATIONS WERE DUE TO CIRCUMSTANCES BEYOND THE INSURER, ORGANIZATION OR CORPORATION'S CONTROL;

(C) ANY REMEDIAL ACTIONS TAKEN BY THE INSURER, ORGANIZATION OR CORPORATION TO PREVENT FUTURE VIOLATIONS;

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

(E) IF THE INSURER, ORGANIZATION OR CORPORATION KNOWINGLY AND WILLINGLY COMMITTED THE VIOLATIONS;

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

(G) ANY OTHER FACTORS THE SUPERINTENDENT CONSIDERS APPROPRIATE.

S 5. This act shall take effect immediately.