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

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I N A S S E M B L Y

(PREFILED)

January 7, 2009

Introduced by M. of A. MAGNARELLI, GALEF, JOHN, LUPARDO, MARKEY, ROBINSON -- Multi-Sponsored by -- M. of A. ALESSI, CHRISTENSEN, ESPAILLAT, HOOPER, McENENY, PHEFFER, WEISENBERG -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to prompt 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), (b) and (c) of section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, 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 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 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 [forty-five] *THIRTY* days of receipt of a claim or bill for services rendered.

(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three 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

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

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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 [thirty] FIFTEEN calendar days of the receipt of the claim:

(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 AND TO RECEIVE SUCH INFORMATION IN SUCH A MANNER THAT WILL ACCOMMODATE THE ELECTRONIC SUBMISSION AND TRACKING OF SUCH REQUESTED ADDITIONAL INFORMATION.

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 pursuant to article forty-three of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section OR IF THE CLAIM IS DENIED, THE PROVIDER SHALL COMPLY WITH PARAGRAPH THREE OF THIS SUBSECTION.

(3) IN CASES WHERE A PROVIDER HAS SUBMITTED ADDITIONAL INFORMATION AND THE INSURER, AFTER RECEIVING SUCH ADDITIONAL INFORMATION, DETERMINES THAT IT WILL DENY THE CLAIM, THE PROVIDER SHALL BE NOTIFIED OF SUCH DENIAL IN WRITING WITHIN FIFTEEN CALENDAR DAYS OF SUCH DENIAL.

(c) Each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided IN ARTICLE TWENTY-FOUR OF THIS CHAPTER AND ELSEWHERE in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less [then] THAN two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.

S 2. Section 3224-a of the insurance law is amended by adding two new subsections (g) and (h) to read as follows:

(G) IN ADDITION TO THE PROVISIONS OF SUBSECTION (C) OF THIS SECTION, ANY POLICYHOLDER OR HEALTH CARE PROVIDER MAY COMMENCE AN ACTION IN A COURT OF COMPETENT JURISDICTION ON HIS OR HER OWN BEHALF AGAINST AN INSURER FOR FAILURE TO COMPLY WITH ANY OF THE PROVISIONS OF THIS SUBSECTION. SUCH ACTION SHALL BE BROUGHT IN THE COUNTY IN WHICH THE ALLEGED VIOLATION OCCURRED OR WHERE THE COMPLAINANT RESIDES. THE COURT MAY IMPOSE THE CIVIL PENALTY PROVIDED FOR IN SUBSECTION (C) OF THIS SECTION AND/OR THE PENALTY PROVIDED FOR IN SUBSECTION (A) OF SECTION TWO THOUSAND FOUR HUNDRED SIX OF THIS CHAPTER. ANY FINAL ORDER ISSUED PURSUANT TO THIS SUBSECTION MAY AWARD COSTS OF LITIGATION, INCLUDING REASONABLE ATTORNEYS' FEES, TO THE PREVAILING PARTY WHENEVER THE COURT DEEMS SUCH AWARD IS APPROPRIATE. IN ANY ACTION BROUGHT PURSUANT TO THIS SUBSECTION, THE SUPERINTENDENT MAY INTERVENE AS A MATTER OF RIGHT.

(H) EVERY SIX MONTHS, INSURERS SHALL PREPARE A LIST OF CLAIMS FOR WHICH THEY WILL ALWAYS REQUEST OPERATIVE NOTES AND/OR DOCUMENTATION OF

MEDICAL NECESSITY AND SHALL MAKE SUCH LIST AVAILABLE TO ALL PARTICIPATING PROVIDERS. INSURERS SHALL ACCOMMODATE THE ELECTRONIC SUBMISSION AND TRACKING OF SUCH OPERATIVE NOTES AND/OR DOCUMENTATION OF MEDICAL NECESSITY AT THE TIME OF SUBMISSION OF THE INITIAL CLAIM.

S 3. Subsection (a) of section 2406 of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

(a) If the hearing was on a charge of a defined violation the superintendent shall make an order on his report and serve a copy of the findings and order upon the person charged with the violation and any intervenor. If the superintendent finds that the person complained of has engaged in a defined violation, the order shall require the person to cease and desist from engaging in such defined violation. Furthermore, if the superintendent finds, after notice and hearing, that the person complained of has engaged in an act prohibited by section three thousand two hundred twenty-four-a of this chapter, the superintendent is authorized to levy a civil penalty against such person in an amount up to five hundred dollars per day for each day beyond the date that a bill or claim was to be processed in accordance with section three thousand two hundred twenty-four-a of this chapter, but in no event shall such penalty exceed five thousand dollars; AND FURTHERMORE, THE SUPERINTENDENT MAY REVOKE ANY LICENSE ISSUED TO AN INSURER LICENSED PURSUANT TO THIS CHAPTER IF, AFTER NOTICE AND HEARING, HE OR SHE FINDS THAT SUCH INSURER HAS FAILED TO COMPLY WITH ANY REQUIREMENT IMPOSED UPON IT BY THE PROVISIONS OF THIS SECTION MORE THAN SIX TIMES WITHIN A CALENDAR YEAR AND IF IN HIS OR HER JUDGMENT SUCH REVOCATION IS REASONABLY NECESSARY TO PROTECT THE INTERESTS OF THE PEOPLE OF THIS STATE. THE SUPERINTENDENT MAY IN HIS OR HER DISCRETION REINSTATE ANY SUCH LICENSE IF HE OR SHE FINDS THAT A GROUND FOR SUCH REVOCATION NO LONGER EXISTS.

S 4. Section 3217-a of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, ANY EMPLOYER IN THIS STATE PROVIDING A SELF-INSURED EMPLOYEE WELFARE BENEFIT PLAN, AS DEFINED IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED, SHALL PROVIDE INSUREDS WITH IDENTIFICATION CARDS INDICATING THAT SUCH INSURED'S PLAN IS A SELF-INSURED PLAN AND SHALL INFORM PROVIDERS ON REQUEST THAT SUCH INSURED'S PLAN IS A SELF-INSURED PLAN.

S 5. This act shall take effect on the one hundred eightieth day after it shall have become a law; provided, however, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.