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

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2009-2010 Regular Sessions

I N A S S E M B L Y

May 19, 2009

Introduced by M. of A. MORELLE, BRADLEY, GOTTFRIED, HOYT, FIELDS, JAFFEE, SPANO, MILLMAN, PERRY, BARRON, ESPAILLAT, COOK, KOON, MAISEL -- Multi-Sponsored by -- M. of A. GALEF, JOHN, MAGEE, MARKEY, MAYER-SOHN, McENENY, MENG, WEISENBERG -- (at request of the Governor) -- read once and referred to the Committee on Insurance

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 provider networks; and in relation to utilization review timeframes

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

Section 1. The insurance law is amended by adding a new section 316 to read as follows:

S 316. ELECTRONIC FILINGS. NOTWITHSTANDING SUBDIVISION ONE OF SECTION THREE HUNDRED FIVE OF THE STATE TECHNOLOGY LAW, THE SUPERINTENDENT MAY PROMULGATE REGULATIONS TO REQUIRE AN INSURER OR OTHER PERSON OR ENTITY MAKING A FILING OR SUBMISSION WITH THE SUPERINTENDENT PURSUANT TO THIS CHAPTER TO SUBMIT THE FILING OR SUBMISSION TO THE SUPERINTENDENT BY ELECTRONIC MEANS. SHOULD THE SUPERINTENDENT REQUIRE THAT A FILING OR SUBMISSION BE MADE BY ELECTRONIC MEANS, AN INSURER OR OTHER PERSON OR ENTITY AFFECTED THEREBY MAY SUBMIT A REQUEST TO THE SUPERINTENDENT FOR AN EXEMPTION FROM THE ELECTRONIC FILING REQUIREMENT UPON A DEMONSTRATION OF UNDUE HARDSHIP, IMPRACTICABILITY, OR GOOD CAUSE, SUBJECT TO THE APPROVAL OF THE SUPERINTENDENT.

S 2. Subsections (g) and (h) of section 3217-b of the insurance law, subsection (g) as relettered by chapter 586 of the laws of 1998, are

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

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relettered subsections (h) and (i) and a new subsection (g) is added to read as follows:

(G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (B) SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

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

S 3. The insurance law is amended by adding a new section 3217-d to read as follows:

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

(B) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES AN EXCLUSIVE NETWORK OF PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR, SUBSECTION (G-6) OF SECTION FOUR THOUSAND NINE HUNDRED, SUBSECTION (A-1) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

(C) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C) AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER;

PROVIDED HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT AN INSURER, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE INSURER, MAKE A REFERRAL TO A PROVIDER THAT IS NOT IN THE INSURER'S NETWORK.

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

S 4. The opening paragraph and subsections (a) and (b) of section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, are amended to read as follows:

In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to THIS ARTICLE AND articles [thirty-two,] forty-two [and], forty-three AND FORTY-SEVEN of this chapter and article forty-four of the public health law and all bills for health care services rendered by health care providers pursuant to such contracts or agreements, any 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 adhere to the following standards:

(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 [forty-five] FIFTEEN days of receipt of a claim or bill for services rendered THAT IS TRANSMITTED VIA THE INTERNET OR ELECTRONIC MAIL, OR FORTY-FIVE 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: 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; OR ANY OTHER ADMINISTRATIVE OR TECHNICAL DEFECT AS THE SUPERINTENDENT MAY SPECIFY IN A REGULATION AFTER CONSULTATION WITH THE COMMISSIONER OF HEALTH. THE INSURER, ORGANIZATION OR CORPORATION AND HEALTH CARE PROVIDER MAY AGREE, PURSUANT TO A WRITTEN CONTRACT, TO MODIFIED PAYMENT TERMS FOR CLAIMS SUBMITTED WITH AN ADMINISTRATIVE OR TECHNICAL DEFECT; PROVIDED, HOWEVER, THAT THE ALTERNATE PAYMENT TERMS SHALL NOT DIFFER SUBSTANTIALLY FROM THE PAYMENT TERMS APPLICABLE TO CLAIMS SUBMITTED WITHOUT AN ADMINISTRATIVE OR TECHNICAL DEFECT. THE SUPERINTENDENT MAY APPROVE MODIFIED PAYMENT TERMS IN A CONTRACT OR AGREEMENT ISSUED OR ENTERED INTO PURSUANT TO THIS ARTICLE AND ARTICLES FORTY-THREE AND FORTY-SEVEN OF THIS CHAPTER AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW FOR CLAIMS SUBMITTED WITH AN ADMINISTRATIVE OR TECHNICAL

DEFECT; PROVIDED, HOWEVER, THAT THE ALTERNATE PAYMENT TERMS SHALL NOT DIFFER SUBSTANTIALLY FROM THE PAYMENT TERMS APPLICABLE TO CLAIMS SUBMITTED WITHOUT AN ADMINISTRATIVE OR TECHNICAL DEFECT.

(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 OR FORTY-SEVEN 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 SUBMITTED VIA THE INTERNET OR ELECTRONIC MAIL, 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, THE INSURER, ORGANIZATION OR CORPORATION SHALL NOT SEND OUT A QUESTIONNAIRE TO DETERMINE WHETHER THE POLICYHOLDER OR COVERED PERSON IS COVERED FOR ALL OR PART OF THE CLAIM BY ANOTHER INSURER, CORPORATION OR ORGANIZATION UNLESS IT HAS NOT SENT OUT A QUESTIONNAIRE IN THE PREVIOUS TWELVE MONTHS OR IT HAS A BASIS TO BELIEVE THAT THE POLICYHOLDER OR COVERED PERSON HAS OTHER COVERAGE.

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

(b) Overpayments to [physicians] HEALTH CARE PROVIDERS. (1) Other than recovery for duplicate payments, a health plan shall provide thirty days written notice to [physicians] HEALTH CARE PROVIDERS before engaging in additional overpayment recovery efforts seeking recovery of the overpayment of claims to such [physicians] 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.

(2) A HEALTH PLAN SHALL PROVIDE A HEALTH CARE PROVIDER WITH THE OPPORTUNITY TO CHALLENGE AN OVERPAYMENT RECOVERY AND SHALL ESTABLISH WRITTEN POLICIES AND PROCEDURES FOR HEALTH CARE PROVIDERS TO FOLLOW TO CHALLENGE AN OVERPAYMENT RECOVERY. THESE WRITTEN POLICIES AND PROCEDURES SHALL INCLUDE A PROVISION STATING THAT A CHALLENGE TO AN OVERPAYMENT RECOVERY SHALL BE MADE BY A HEALTH CARE PROVIDER IN WRITING WITHIN THIRTY DAYS OF RECEIPT OF THE OVERPAYMENT RECOVERY REQUEST. 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 CHALLENGE SHALL BE RESOLVED ACCORDING TO DISPUTE RESOLUTION PROCEDURES ESTABLISHED BY THE PARTIES IN THEIR CONTRACTUAL AGREEMENT OR,

IF NO SUCH PROCEDURES ARE SET FORTH IN SUCH AGREEMENT, SHALL BE SUBMITTED TO A THIRD-PARTY ARBITRATOR FOR A DETERMINATION.

(3) A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a [physician] HEALTH CARE PROVIDER. [Provided, however, that] HOWEVER, no such time limit shall apply to overpayment recovery efforts [which] 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 by a state or federal government program. Notwithstanding the aforementioned time limitations, in the event that a [physician] 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) A HEALTH PLAN SHALL NOT OFFSET PAYMENT TO A HEALTH CARE PROVIDER PURSUANT TO AN OVERPAYMENT RECOVERY EFFORT UNLESS: THE HEALTH CARE PROVIDER AGREES TO THE REDUCTION IN WRITING; THE HEALTH CARE PROVIDER FAILS TO OBJECT TO THE HEALTH PLAN'S OVERPAYMENT RECOVERY WITHIN THIRTY DAYS OF RECEIPT OF THE REQUEST FOR RECOUPMENT; 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.

(5) 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 THREE OF THIS SUBSECTION.

(6) 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.

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

S 6. Subparagraph (B) of paragraph 2 of subsection (e) of section 3231 of the insurance law, as added by chapter 501 of the laws of 1992, is amended to read as follows:

(B) Each calendar year, an insurer shall return, in the form of aggregate benefits for each policy form filed pursuant to the alternate procedure set forth in this paragraph at least seventy-five percent of the aggregate premiums collected for the policy form during that calendar year. Insurers shall annually report, no later than May first of each year, the loss ratio calculated pursuant to this paragraph for each such policy form for the previous calendar year. In each case where the loss ratio for a policy form fails to comply with the seventy-five percent loss ratio requirement, the insurer shall issue a dividend or credit against future premiums for all policy holders with that policy form in an amount sufficient to assure that the aggregate benefits paid

in the previous calendar year plus the amount of the dividends and credits shall equal seventy-five percent of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy HOLDER WHO HAD A POLICY which was in effect [as of December thirty-first of] AT ANY TIME DURING the applicable year [and remains in effect as of the date the dividend or credit is issued]. THE DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED FOR THE APPLICABLE YEAR AMONG ALL POLICY HOLDERS ELIGIBLE TO RECEIVE SUCH DIVIDEND OR CREDIT. AN INSURER SHALL MAKE A REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVIDENDS OR CREDITS TO, FORMER POLICY HOLDERS ENTITLED TO THE DIVIDEND OR CREDIT. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include an insurer's calculation of the dividends and credits, as well as an explanation of the insurer's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policy holder.

S 7. 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 THAT ISSUES A HEALTH INSURANCE CONTRACT PURSUANT TO THIS ARTICLE OR A PLAN OR CONTRACT PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER WITH A NETWORK OF HEALTH CARE PROVIDERS, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW (COLLECTIVELY "HEALTH PLAN") THAT UTILIZES A NETWORK OF PARTICIPATING PROVIDERS SHALL NOT TREAT A PROVIDER THAT PARTICIPATES WITHIN ITS NETWORK AS A NON-PARTICIPATING PROVIDER SOLELY BECAUSE ONE OR MORE OTHER PROVIDERS RENDERING SERVICES TO THE INSURED FOR THE SAME OR RELATED MEDICAL CONDITION, ILLNESS OR INJURY DOES NOT PARTICIPATE WITHIN THE HEALTH PLAN'S PROVIDER NETWORK. A HEALTH PLAN SHALL MAKE A DETERMINATION AS TO THE AMOUNT OF REIMBURSEMENT TO THE PARTICIPATING PROVIDER IN ACCORDANCE WITH THE TERMS OF THE CONTRACT BETWEEN THE PARTICIPATING PROVIDER AND THE HEALTH PLAN. THE INSURED SHALL BE RESPONSIBLE ONLY FOR THE IN-NETWORK COST SHARING PROVISIONS OF THE POLICY OR CERTIFICATE.

S 8. The insurance law is amended by adding a new section 3241 to read as follows:

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

S 9. The insurance law is amended by adding a new section 4306-c to read as follows:

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

(B) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE CONTRACT THAT UTILIZES AN EXCLUSIVE NETWORK OF PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR, SUBSECTION (G-6) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTION (A-1) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

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

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

S 10. Paragraph 2 of subsection (h) of section 4308 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(2) In each case where the loss ratio for a contract form fails to comply with the eighty-five percent minimum loss ratio requirement for individual direct payment contracts, or the seventy-five percent minimum loss ratio requirement for small group and small group remittance contracts, as set forth in paragraph one of this subsection, the corporation shall issue a dividend or credit against future premiums for all contract holders with that contract form in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year plus the amount of the dividends and credits shall equal no less than eighty-five percent for individual direct payment contracts, or seventy-five percent for small group and small group remittance contracts, of the aggregate premiums earned for the contract form in the

previous calendar year. The dividend or credit shall be issued to each contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as of December thirty-first of] AT ANY TIME DURING the applicable year [and remains in effect as of the date the dividend or credit is issued]. THE DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED FOR THE APPLICABLE YEAR AMONG ALL CONTRACT HOLDERS OR SUBSCRIBERS ELIGIBLE TO RECEIVE SUCH DIVIDEND OR CREDIT. A CORPORATION SHALL MAKE A REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVIDENDS OR CREDITS TO, FORMER CONTRACT HOLDERS OR SUBSCRIBERS ENTITLED TO THE DIVIDEND OR CREDIT. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the dividends and credits, as well as an explanation of the corporation's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a contract holder or subscriber.

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

(G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (B) SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

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

S 12. Subsection (a) of section 4803 of the insurance law, as amended by chapter 551 of the laws of 2006, is amended to read as follows:

(a) (1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which

a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within ninety days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to [(i)]: (A) whether he or she is credentialed; or [(ii)] (B) whether additional time is necessary to make a determination in spite of THE insurer's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible.

(2) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK, IS NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH ONE OF THIS SUBSECTION, SUCH HEALTH CARE PROFESSIONAL SHALL BE DEEMED "PROVISIONALLY CREDENTIALED" AND MAY PARTICIPATE IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK; PROVIDED, HOWEVER, THAT A PROVISIONALLY CREDENTIALED PHYSICIAN MAY NOT BE DESIGNATED AS AN INSURED'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDENTIALED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE INSURER. A HEALTH CARE PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTIFIES THE INSURER IN WRITING THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE HEALTH CARE PROFESSIONAL OR THE GROUP PRACTICE: (A) SHALL REFUND ANY PAYMENTS MADE BY THE INSURER FOR IN-NETWORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE INSURED'S CONTRACT WITH THE INSURER; AND (B) SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED, EXCEPT TO COLLECT THE COPAYMENT OR COINSURANCE THAT OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE INSURED RECEIVED SERVICES FROM A HEALTH CARE PROFESSIONAL PARTICIPATING IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK. INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THIS CHAPTER SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL WAS PROVISIONALLY CREDENTIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT AN INSURER FROM PAYING A CLAIM FROM A HEALTH CARE PROFESSIONAL WHO IS PROVISIONALLY CREDENTIALED UPON SUBMISSION OF SUCH CLAIM. AN INSURER SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

S 13. Section 4900 of the insurance law is amended by adding a new subsection (g-7) to read as follows:

(G-7) "RARE DISEASE TREATMENT" MEANS A TREATMENT OR SERVICE FOR A HEALTH CONDITION WITH A RELATIVELY LIMITED INCIDENCE, AS SPECIFIED OR DEFINED IN A REGULATION AS SHALL BE PROMULGATED BY THE SUPERINTENDENT.

S 14. Subsections (c) and (g) of section 4903 of the insurance law, subsection (c) as added by chapter 705 of the laws of 1996, and subsection (g) as added by chapter 586 of the laws of 1998, are amended to read as follows:

(c) A utilization review agent shall make a determination involving continued or extended health care services, [or] additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, OR HEALTH CARE SERVICES NECESSARY TO ENSURE A SAFE DISCHARGE FOLLOWING AN INPATIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended OR POST-HOSPITAL services shall include the number of extended OR POST-HOSPITAL services approved, the new total of approved services, the date of onset of services and the next review date.

(g) Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be [an adverse determination subject to appeal pursuant to section four thousand nine hundred four of this title] AN APPROVAL.

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

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

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

S 16. The opening paragraph of subsection (b) of section 4910 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

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

S 17. Subparagraphs (B) and (C) of paragraph 2 of subsection (b) of section 4910 of the insurance law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

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

(C) the insured's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the insured's life-threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of

section four thousand nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the insured than any covered standard health service or procedure; or (b) a clinical trial OR RARE DISEASE TREATMENT for which the insured is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

S 18. Paragraphs 2 and 3 of subsection (b) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

(2) The external appeal agent shall make a determination with regard to the appeal within thirty days of the receipt of the [insured's] request therefor, submitted in accordance with the superintendent's instructions. The external appeal agent shall have the opportunity to request additional information from the insured, the insured's health care provider and the insured's health care plan within such thirty-day period, in which case the agent shall have up to five additional business days if necessary to make such determination. The external appeal agent shall notify the insured, THE INSURED'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and the health care plan, in writing, of the appeal determination within two business days of the rendering of such determination.

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

S 19. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of subsection (b) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(a) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, upon review of the applicable medical and scientific evidence (or upon confirmation that the recommended treatment is a clinical trial OR RARE DISEASE TREATMENT), the insured's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subsection (e) of section four thousand nine hundred of this article is likely to be more beneficial than any standard treatment or treatments for the insured's life-threatening or disabling condition or disease (or, in the case of a clinical trial OR RARE DISEASE TREATMENT, is likely to benefit the insured in the treatment of the insured's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

S 20. Subsection (d) of section 4914 of the insurance law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(d) [Payment] (1) EXCEPT AS PROVIDED IN PARAGRAPHS TWO AND THREE OF THIS SUBSECTION, PAYMENT for an external appeal shall be the responsibility of the health care plan. The health care plan shall make payment to the external appeal agent within forty-five days, from the date the appeal determination is received by the health care plan, and the health

care plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

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

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

(4) IF AN INSURED'S HEALTH CARE PROVIDER WAS ACTING AS THE INSURED'S DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED ON A STANDARD FORM DEVELOPED BY THE SUPERINTENDENT IN CONSULTATION WITH THE COMMISSIONER OF HEALTH PURSUANT TO SUBSECTION (E) OF THIS SECTION. THE SUPERINTENDENT SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE INSURED TO CONFIRM THE DESIGNATION. THE INSURED SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE INSURED FAILS TO RESPOND TO THE SUPERINTENDENT WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT'S REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL REJECT THE APPEAL.

S 21. The insurance law is amended by adding a new section 4917 to read as follows:

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

S 22. Subdivision 5-c of section 4406-c of the public health law is relettered subdivision 5-d and a new subdivision 5-c is added to read as follows:

5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE THE EFFECT OF MATERIALLY REDUCING THE LEVEL OF PAYMENT TO A HEALTH CARE PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS SUBDIVISION SHALL NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY; OR (II) SUCH CHANGE IS EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY OR PAYMENT POLICY INDEXING MECHANISM.

(B) NOTHING IN THIS SUBDIVISION SHALL CREATE A PRIVATE RIGHT OF ACTION ON BEHALF OF A HEALTH CARE PROFESSIONAL AGAINST AN INSURER FOR VIOLATIONS OF THIS SUBDIVISION.

S 23. Subdivision 1 of section 4406-d of the public health law, as amended by chapter 551 of the laws of 2006, is amended to read as follows:

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

(B) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S NETWORK, IS NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, THE HEALTH CARE PROFESSIONAL SHALL BE

DEEMED "PROVISIONALLY CREDENTIALED" AND MAY PARTICIPATE IN THE IN-NETWORK PORTION OF THE HEALTH CARE PLAN'S NETWORK; PROVIDED, HOWEVER, THAT A PROVISIONALLY CREDENTIALED PHYSICIAN MAY NOT BE DESIGNATED AS AN ENROLLEE'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDENTIALED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE HEALTH CARE PLAN. A HEALTH CARE PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTIFIES THE HEALTH CARE PLAN IN WRITING THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE HEALTH CARE PROFESSIONAL OR THE GROUP PRACTICE: (I) SHALL REFUND ANY PAYMENTS MADE BY THE HEALTH CARE PLAN FOR IN-NETWORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE ENROLLEE'S CONTRACT WITH THE HEALTH CARE PLAN; AND (II) SHALL NOT PURSUE REIMBURSEMENT FROM THE ENROLLEE, EXCEPT TO COLLECT THE COPAYMENT THAT OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE ENROLLEE RECEIVED SERVICES FROM A HEALTH CARE PROFESSIONAL PARTICIPATING IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S NETWORK. INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL WAS PROVISIONALLY CREDENTIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT A HEALTH CARE PLAN FROM PAYING A CLAIM FROM A HEALTH CARE PROFESSIONAL WHO IS PROVISIONALLY CREDENTIALED UPON SUBMISSION OF SUCH CLAIM. A HEALTH CARE PLAN SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

S 24. Section 4900 of the public health law is amended by adding a new subdivision 7-g to read as follows:

7-G. "RARE DISEASE TREATMENT" MEANS A TREATMENT OR SERVICE FOR A HEALTH CONDITION WITH A RELATIVELY LIMITED INCIDENCE, AS SPECIFIED OR DEFINED IN A REGULATION AS SHALL BE PROMULGATED BY THE COMMISSIONER.

S 25. Subdivisions 3 and 7 of section 4903 of the public health law, subdivision 3 as added by chapter 705 of the laws of 1996 and subdivision 7 as added by chapter 586 of the laws of 1998, are amended to read as follows:

3. A utilization review agent shall make a determination involving continued or extended health care services, [or] additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, OR HEALTH CARE SERVICES NECESSARY TO ENSURE A SAFE DISCHARGE FOLLOWING AN INPATIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information. Notification of continued or extended OR POST-HOSPITAL services shall include the number of extended OR POST-HOSPITAL services approved, the new total of approved services, the date of onset of services and the next review date.

7. Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be [an adverse determination subject to appeal pursuant to section forty nine hundred four of this title] AN APPROVAL.

S 26. Section 4906 of the public health law, as amended by chapter 586 of the laws of 1998, is amended to read as follows:

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

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

S 27. The opening paragraph of subdivision 2 of section 4910 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

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

S 28. Subparagraphs (ii) and (iii) of paragraph (b) of subdivision 2 of section 4910 of the public health law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

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

(iii) the enrollee's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life threatening or disabling condition or disease, must have recommended either (a) a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph [b] (B) of subdivision five of section forty-nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered standard health service or procedure; or (b) a clinical trial OR RARE DISEASE TREATMENT for which the enrollee is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and

S 29. Paragraphs (b) and (c) of subdivision 2 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, are amended to read as follows:

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

(c) Notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, if the enrollee's attending physician states that a delay

in providing the health care service would pose an imminent or serious threat to the health of the enrollee, the external appeal shall be completed within three days of the request therefor and the external appeal agent shall make every reasonable attempt to immediately notify the enrollee, THE ENROLLEE'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

S 30. Item 1 of clause (ii) of subparagraph (B) of paragraph (d) of subdivision 2 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

(1) that the patient costs of the proposed health service or procedure shall be covered by the health care plan either: when a majority of the panel of reviewers determines, upon review of the applicable medical and scientific evidence (or upon confirmation that the recommended treatment is a clinical trial OR RARE DISEASE TREATMENT), the enrollee's medical record, and any other pertinent information, that the proposed health service or treatment (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph (b) of subdivision five of section forty-nine hundred of this article) is likely to be more beneficial than any standard treatment or treatments for the enrollee's life-threatening or disabling condition or disease (or, in the case of a clinical trial OR RARE DISEASE TREATMENT, is likely to benefit the enrollee in the treatment of the enrollee's condition or disease); or when a reviewing panel is evenly divided as to a determination concerning coverage of the health service or procedure, or

S 31. Subdivision 4 of section 4914 of the public health law, as added by chapter 586 of the laws of 1998, is amended to read as follows:

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

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

(C) IF AN ENROLLEE'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION; PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY, UPON A DETERMINATION BY THE SUPERINTENDENT OF INSURANCE THAT HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENCING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL

APPEAL WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, IN CONSULTATION WITH THE SUPERINTENDENT, PROMULGATE REGULATIONS TO LIMIT SUCH HARDSHIP.

(D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT OF INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTENDENT OF INSURANCE WITHIN THE SPECIFIED TIME FRAME, THE SUPERINTENDENT OF INSURANCE SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE SHALL REJECT THE APPEAL.

S 32. The public health law is amended by adding a new section 4917 to read as follows:

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

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

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

2. provided, further, that the amendments to subsection (i) of section 3217-b of the insurance law made by section two of this act shall not affect the repeal of such subsection and shall be deemed repealed therewith;

3. provided, further, that the amendments to subsection (i) of section 4325 of the insurance law made by section eleven of this act shall not affect the repeal of such subsection and shall be deemed repealed therewith; and

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