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2009-2010 Regular Sessions

I N S E N A T E

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Introduced by Sens. BRESLIN, ADAMS, DILAN, DUANE, HASSELL-THOMPSON, KLEIN, KRUEGER, KRUGER, MONTGOMERY, ONORATO, PARKER, SAMPSON, SAVINO, SCHNEIDERMAN, SMITH, STAVISKY -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, the public health law and the social services law, in relation to prompt payment of health care claims, dispute resolution relating to conflicts between a third party payor and a health care provider; and to amend the insurance law and the state finance law, in relation to creating the health insurance guaranty fund

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

1 Section 1. Section 2601 of the insurance law, paragraphs 4 and 5 of
2 subsection (a) as amended by chapter 547 of the laws of 1997 and para-
3 graph 6 of subsection (a) as amended by chapter 388 of the laws of 2008,
4 is amended to read as follows:
5 S 2601. Unfair claim settlement practices; penalties. (a) No insurer,
6 CORPORATION, OR ORGANIZATION LICENSED, ORGANIZED, OR CERTIFIED PURSUANT
7 TO THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND doing
8 business in this state shall engage in unfair claim settlement prac-
9 tices. Any of the following acts by [an insurer] SUCH ENTITIES, if
10 committed without just cause and performed with such frequency as to
11 indicate a general business practice, shall constitute unfair claim
12 settlement practices:
13 (1) knowingly misrepresenting to claimants pertinent facts or policy
14 provisions relating to coverages at issue;
15 (2) failing to acknowledge with reasonable promptness pertinent commu-
16 nications as to claims arising under its policies;
17 (3) failing to adopt and implement reasonable standards for the prompt
18 investigation of claims arising under its policies;

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

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(4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, except where there is a reasonable basis supported by specific information available for review by the department that the claimant has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; [or]

(6) failing to promptly disclose coverage pursuant to subsection (d) or subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter;

(7) FAILING TO COMPLY WITH SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THIS CHAPTER;

(8) FAILING TO ABIDE BY THE TERMS OF A CONTRACT WITH A HEALTH CARE PROVIDER, INCLUDING FAILURE TO MAKE PAYMENT AT THE CONTRACTED RATES, OR STATE OR FEDERAL LAWS OR REGULATIONS;

(9) REQUESTING MEDICAL RECORDS FROM HEALTH CARE PROVIDERS TO EVALUATE CLAIMS AT A RATE OR WITH SUCH FREQUENCY WHICH, UPON INVESTIGATION BY THE SUPERINTENDENT, IS FOUND NOT TO BE JUSTIFIED; OR

(10) DENYING PAYMENT TO HEALTH CARE PROVIDERS, IN WHOLE OR IN PART, WHEN, UPON INVESTIGATION BY THE SUPERINTENDENT, MORE THAN FIFTY PER CENTUM OF THE CLAIMS DENIALS ARE OVERTURNED ON APPEAL PURSUANT TO ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW, ARTICLE FORTY-NINE OF THIS CHAPTER OR SECTION TWO HUNDRED SIX OF THE PUBLIC HEALTH LAW, OR IN A JUDICIAL PROCEEDING OR ARBITRATION.

(b) Evidence as to numbers and types of complaints to the department against [an insurer] SUCH ENTITIES and as to the department's complaint experience with other [insurers] ENTITIES writing similar lines of insurance shall be admissible in evidence in any administrative or judicial proceeding under this section or article twenty-four or seventy-four of this chapter, but, EXCEPT FOR PARAGRAPHS SEVEN, EIGHT, NINE AND TEN OF SUBSECTION (A) OF THIS SECTION, no [insurer] ENTITY shall be deemed in violation of this section solely by reason of the numbers and types of such complaints.

(c) (1) If it is found, after notice and an opportunity to be heard, that an insurer has violated this section, each instance of noncompliance with subsection (a) [hereof] OF THIS SECTION may be treated as a separate violation of this section for purposes of ordering a monetary penalty pursuant to subsection (b) of section one hundred nine of this chapter. A violation of this section shall not be a misdemeanor.

(2) IF IT IS FOUND, AFTER NOTICE AND AN OPPORTUNITY TO BE HEARD, THAT 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 IS IN VIOLATION OF PARAGRAPHS SEVEN, EIGHT, NINE OR TEN OF SUBSECTION (A) OF THIS SECTION WITH RESPECT TO A PARTICULAR HEALTH CARE PROVIDER, THE SUPERINTENDENT SHALL REQUIRE THE INSURER, ORGANIZATION, OR CORPORATION TO ESTABLISH AN INTERIM PAYMENT SYSTEM THAT MAKES PAYMENT TO THE AFFECTED PROVIDER FOR HEALTH CARE SERVICES.

(A) SUCH INTERIM PAYMENT SYSTEM SHALL CONSIST OF UNIFORM PAYMENT AMOUNTS MADE ON A WEEKLY BASIS TO THE PROVIDER OF SERVICES BASED ON THE MOST RECENTLY AVAILABLE INFORMATION ON THE ACTUAL AVERAGE WEEKLY PAYMENT AMOUNTS TO THE HEALTH CARE PROVIDER, CALCULATED OVER A SIX MONTH PERIOD, INCREASED BY AN APPROPRIATE TREND FACTOR. PAYMENT AMOUNTS SHALL BE RETROACTIVELY ADJUSTED TO REFLECT ACTUAL AMOUNTS OWED PURSUANT TO A

CLAIM RECONCILIATION PROCESS. RETROSPECTIVE ADJUSTMENTS FOR OVERPAYMENT TO PROVIDERS SHALL BE MADE OVER THE SAME NUMBER OF PAYMENTS AS WERE UTILIZED IN THE RECONCILIATION CALCULATION. RETROSPECTIVE ADJUSTMENTS FOR UNDERPAYMENT TO PROVIDERS SHALL BE MADE IN THE NEXT PAYMENT.

(B) THE SUPERINTENDENT SHALL REQUIRE AN INTERIM PAYMENT SYSTEM ONLY FOR 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 OR THIRTY-ONE OF THE MENTAL HYGIENE LAW, A DISPENSER OR PROVIDER OF PHARMACEUTICAL PRODUCTS, SERVICES OR DURABLE MEDICAL EQUIPMENT OR AN INDEPENDENT PRACTICE ASSOCIATION WHICH IS AUTHORIZED TO FURNISH HEALTH CARE SERVICES UNDER A CONTRACT WITH AN INSURER, CORPORATION OR ORGANIZATION. THE INTERIM PAYMENT SYSTEM SHALL BE MAINTAINED FOR SUCH TIME AS SPECIFIED BY THE SUPERINTENDENT AND AT LEAST UNTIL SUCH TIME THAT THE INSURER, ORGANIZATION, OR CORPORATION DEMONSTRATES TO THE SATISFACTION OF THE SUPERINTENDENT THAT IT HAS IN PLACE SYSTEMS THAT WILL ENSURE THAT IT NO LONGER WILL CONSISTENTLY VIOLATE THE PROVISIONS OF THIS SECTION OR THE TERMS OF A CONTRACT WITH A HEALTH CARE PROVIDER RELATED TO PAYMENT AND MEDICAL REVIEW.

S 2. Section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

S 3224-a. Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services. In the processing of all health care claims submitted under contracts or agreements issued or entered into pursuant to articles thirty-two, forty-two and forty-three 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 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 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 days of receipt of a claim or bill for services rendered.]:

(1) FIFTEEN BUSINESS DAYS OF RECEIPT OF A CLAIM OR BILL FOR SERVICES RENDERED WHICH IS TRANSMITTED ELECTRONICALLY WITHIN THIRTY DAYS OF THE DATE THE SERVICES WERE RENDERED, OR IN THE CASE OF INPATIENT CARE, THE DATE OF DISCHARGE, IN THE CORRECT AMOUNT PROVIDED FOR UNDER THE CONTRACT, IF A CONTRACT APPLIES; OR

(2) THIRTY DAYS OF RECEIPT OF A CLAIM OR BILL FOR SERVICES RENDERED WHICH IS SUBMITTED IN WRITING OR AN ELECTRONIC TRANSMISSION WHICH DOES NOT COMPLY WITH PARAGRAPH ONE OF THIS SUBSECTION.

(b) (1) 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 corpo-

1 ration or organization for all or part of the claim, the amount of the
2 claim, the benefits covered under a contract or agreement, or the manner
3 in which services were accessed or provided, an insurer or organization
4 or corporation shall pay any undisputed portion of the claim in accord-
5 ance with this subsection and notify the policyholder, covered person
6 [or] AND health care provider in writing within thirty calendar days of
7 the receipt of the claim:

8 [(1)] (A) that it is not obligated to pay the claim or make the
9 medical payment, IN WHOLE OR IN PART, stating the specific reasons why
10 it is not liable; or

11 [(2)] (B) to request all additional information needed to determine
12 liability to pay the claim or make the health care payment, IN WHOLE OR
13 IN PART, AND

14 (C) THE AMOUNT THAT IS TO BE PAID BY THE INSURER OR ORGANIZATION OR
15 CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OF
16 THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND THE
17 AMOUNTS FOR WHICH PAYMENT IS DENIED OR IN DISPUTE, SHOWING THE CALCU-
18 LATIONS FOR PAYMENT, BY SERVICE PROVIDED, INCLUDING CO-PAYMENTS, DEDUCT-
19 IBLES, SURCHARGES AND FEE-SCHEDULES.

20 (2) Upon receipt of the information requested in [paragraph two]
21 SUBPARAGRAPH (B) OF PARAGRAPH ONE of this subsection or an appeal of a
22 claim or bill for health care services denied pursuant to SUBPARAGRAPH
23 (A) OF paragraph one of this subsection, an insurer or organization or
24 corporation licensed pursuant to article forty-three of this chapter or
25 article forty-four of the public health law shall [comply with
26 subsection (a) of this section] MAKE PAYMENT OR NOTIFY THE POLICYHOLDER,
27 COVERED PERSON AND HEALTH CARE PROVIDER OF A FINAL DETERMINATION TO DENY
28 PAYMENT STATING THE SPECIFIC REASONS WHY IT IS NOT LIABLE WITHIN FIFTEEN
29 CALENDAR DAYS OF THE RECEIPT OF THE INFORMATION REQUESTED.

30 (c) [Each] AT LEAST ANNUALLY, THE SUPERINTENDENT SHALL COLLECT AND
31 PUBLISH THE POSTAL AND ELECTRONIC ADDRESSES TO WHICH POLICYHOLDERS,
32 COVERED PERSONS AND HEALTH CARE PROVIDERS MAY SUBMIT CLAIMS, ADDITIONAL
33 INFORMATION AND APPEALS TO EACH INSURER, CORPORATION AND ORGANIZATION.
34 THIS INFORMATION SHALL INCLUDE ADDRESSES FOR ANY ELECTRONIC TRANSACTIONS
35 VENDOR OR ANY SUBCONTRACTORS THAT PROCESS CLAIMS ON BEHALF OF THE INSUR-
36 ER, CORPORATION, OR ORGANIZATION AND INSTRUCTIONS ON WHICH CLAIMS,
37 INFORMATION OR APPEALS SHOULD BE SUBMITTED TO WHICH ADDRESS.

38 (D) (1) UNLESS OTHERWISE AGREED TO IN A CONTRACT BETWEEN AN INSURER,
39 CORPORATION OR ORGANIZATION AND A HEALTH CARE PROVIDER, AN INSURER,
40 CORPORATION OR ORGANIZATION SHALL ALLOW A HEALTH CARE PROVIDER DESIG-
41 NATED IN SUBPARAGRAPH (B) OF PARAGRAPH TWO OF SUBSECTION (C) OF SECTION
42 TWO THOUSAND SIX HUNDRED ONE OF THIS CHAPTER AT LEAST ONE HUNDRED TWENTY
43 DAYS, AND ANY OTHER HEALTH CARE PROVIDER AT LEAST SIX MONTHS, TO SUBMIT
44 A CLAIM AFTER THE PROVIDER LEARNS THAT THE INSURER, CORPORATION OR
45 ORGANIZATION HAD, AT THE TIME SERVICES WERE DELIVERED, A CONTRACT AND AN
46 OBLIGATION TO REIMBURSE THE CLAIMS FOR HEALTH SERVICES THAT WERE
47 RECEIVED BY A POLICYHOLDER OR COVERED PERSON OR AFTER THE PROVIDER HAS
48 RECEIVED A DENIAL, IN WHOLE OR IN PART, FROM ANOTHER ENTITY BELIEVED TO
49 HAVE AN OBLIGATION TO PAY CLAIMS FOR HEALTH SERVICES RECEIVED BY THE
50 POLICYHOLDER OR COVERED PERSON. AN INSURER, CORPORATION OR ORGANIZATION
51 SHALL ALLOW A POLICYHOLDER OR COVERED PERSON AT LEAST SIX MONTHS TO
52 SUBMIT A CLAIM AFTER A HEALTH CARE SERVICE WAS PROVIDED OR AFTER THE
53 POLICYHOLDER OR COVERED PERSON RECEIVED A DENIAL FROM ANOTHER ENTITY
54 THAT PROVIDES HEALTH BENEFITS TO HIM OR HER.

55 (2) AN INSURER, CORPORATION OR ORGANIZATION SHALL ALLOW POLICYHOLDERS,
56 COVERED PERSONS, AND HEALTH CARE PROVIDERS AT LEAST THIRTY CALENDAR DAYS

1 TO SUBMIT ANY ADDITIONAL INFORMATION IT REQUESTED PURSUANT TO SUBPARA-
2 GRAPH (B) OF PARAGRAPH ONE OF SUBSECTION (B) OF THIS SECTION OR THAT IT
3 REQUESTED TO RESPOND TO AN APPEAL FILED BY A POLICYHOLDER, COVERED
4 PERSON, OR HEALTH CARE PROVIDER PURSUANT TO THIS SUBSECTION.

5 (3) PURSUANT TO THIS SUBSECTION, AN INSURER, CORPORATION OR ORGANIZA-
6 TION SHALL ALLOW A POLICYHOLDER, COVERED PERSON OR HEALTH CARE PROVIDER
7 AT LEAST FORTY-FIVE DAYS TO APPEAL, AFTER RECEIPT OF A DENIAL OF A CLAIM
8 OR A BILL PURSUANT TO SUBPARAGRAPH (A) OF PARAGRAPH ONE OF SUBSECTION
9 (B) OF THIS SECTION.

10 (4) THE DATE OF RECEIPT OF A CLAIM OR ADDITIONAL INFORMATION SHALL BE,
11 WITH RESPECT TO CLAIMS OR INFORMATION DELIVERED BY THE UNITED STATES
12 POSTAL SERVICE OR OTHER DELIVERY SERVICE, THE DATE OF DELIVERY AT THE
13 SITE SPECIFIED BY THE INSURER, CORPORATION OR ORGANIZATION WITH THE
14 SUPERINTENDENT PURSUANT TO SUBSECTION (C) OF THIS SECTION; OR SHALL BE,
15 WITH RESPECT TO CLAIMS OR INFORMATION DELIVERED ELECTRONICALLY, THE DATE
16 OF ELECTRONIC ACKNOWLEDGMENT FROM THE INSURER, CORPORATION OR ORGANIZA-
17 TION OR ITS ELECTRONIC TRANSACTIONS VENDOR. AN INSURER, CORPORATION,
18 ORGANIZATION OR ANY AGENT ACTING ON BEHALF OF SUCH ENTITY WHO ACCEPTS
19 AND RECEIVES CLAIMS IN ELECTRONIC FORMAT SHALL, WITHIN FORTY-EIGHT HOURS
20 AFTER THE RECEIPT OF SUCH A CLAIM, TRANSMIT ELECTRONICALLY AN ACKNOWL-
21 EDGMENT OF THE RECEIPT OF SUCH A CLAIM TO THE HEALTH CARE PROVIDER OR
22 ENTITY WHICH SUBMITTED THE CLAIM.

23 (5) NO INSURER, CORPORATION OR ORGANIZATION SHALL SEEK TO RECOVER FROM
24 A HEALTH CARE PROVIDER, OR REDUCE PAYMENT TO A HEALTH CARE PROVIDER, ANY
25 PORTION OF A PAYMENT BEYOND THE DATE WHICH IS ONE YEAR AFTER THE DATE OF
26 PAYMENT, EXCEPT WHEN THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC
27 INFORMATION AVAILABLE FOR REVIEW BY THE SUPERINTENDENT THAT SUCH PAYMENT
28 WAS OBTAINED FRAUDULENTLY.

29 (E)(1) EXCEPT AS PROVIDED IN PARAGRAPH FOUR OF THIS SUBSECTION, EACH
30 claim or bill for health care services processed in violation of this
31 section shall constitute a separate violation. In addition to the penal-
32 ties provided in this chapter, any insurer or organization or corpo-
33 ration that fails to adhere to the standards contained in this section
34 shall be obligated to pay to the health care provider or person submit-
35 ting the claim, in full settlement of the claim or bill for health care
36 services, the amount of the claim or health care payment plus interest
37 on the amount of such claim or health care payment of the greater of the
38 rate equal to the rate set by the commissioner of taxation and finance
39 for corporate taxes pursuant to paragraph one of subsection (e) of
40 section one thousand ninety-six of the tax law or twelve percent per
41 annum, to be computed from the date the claim or health care payment was
42 required to be made. When the amount of interest due on such a claim is
43 less [then] THAN two dollars, [and] AN insurer or organization or corpo-
44 ration shall not be required to pay interest on such claim.

45 [(d)] (2) EXCEPT AS PROVIDED IN PARAGRAPH FOUR OF THIS SUBSECTION, IN
46 A CASE WHERE AN INSURER, ORGANIZATION OR CORPORATION FAILS TO PAY THE
47 INTEREST AMOUNT SPECIFIED IN THIS SUBSECTION WITH THE AMOUNT OF THE
48 CLAIM OR HEALTH CARE PAYMENT, THE SUPERINTENDENT SHALL IMPOSE THE MAXI-
49 MUM PENALTY PROVIDED IN THIS CHAPTER.

50 (3) PURSUANT TO PARAGRAPH (G) OF SUBDIVISION FOUR OF SECTION
51 TWENTY-EIGHT HUNDRED SEVEN-E OF THE PUBLIC HEALTH LAW, FOR EACH CLAIM OR
52 BILL FOR HEALTH CARE SERVICES FOR WHICH AN INSURER, ORGANIZATION OR
53 CORPORATION CANNOT ACCEPT ELECTRONIC TRANSMISSION FROM A HEALTH CARE
54 PROVIDER, THE INSURER, ORGANIZATION OR CORPORATION SHALL BE OBLIGATED TO
55 PAY AN ADDITIONAL AMOUNT OF INTEREST EQUAL TO TWO PERCENT OF THE AMOUNT
56 OF THE CLAIM.

1 (4) IF, AFTER INVESTIGATION, THE SUPERINTENDENT FINDS THAT AN INSURER,
2 ORGANIZATION, OR CORPORATION HAS PROCESSED NINETY-EIGHT PER CENTUM OF
3 CLAIMS RECEIVED IN A GIVEN TIME PERIOD IN COMPLIANCE WITH THIS SECTION,
4 THEN ANY REMAINING CLAIMS NOT PROCESSED IN COMPLIANCE WITH THIS SECTION
5 BUT WHICH WERE PAID WITHIN SIXTY DAYS OF SUBMISSION AND WITH THE APPRO-
6 PRIATE INTEREST PAYMENT FOR LATE CLAIMS SHALL NOT CONSTITUTE VIOLATIONS
7 OF THIS SECTION, SO LONG AS SUCH CLAIMS OWED TO AN INDIVIDUAL HEALTH
8 CARE PROVIDER, IN THE AGGREGATE, DO NOT EXCEED FIVE PERCENT OF THE
9 ACCOUNTS RECEIVABLE OWED BY THAT INSURER, ORGANIZATION OR CORPORATION TO
10 THAT HEALTH CARE PROVIDER FOR SUCH PERIOD.

11 (F) For the purposes of this section:

12 (1) "policyholder" shall mean a person covered under such policy or a
13 representative designated by such person; and

14 (2) "health care provider" shall mean an entity licensed or certified
15 pursuant to article twenty-eight, thirty-six or forty of the public
16 health law, a facility licensed pursuant to article nineteen, FORMER
17 ARTICLE twenty-three or ARTICLE thirty-one of the mental hygiene law, a
18 health care professional licensed, registered or certified pursuant to
19 title eight of the education law, a dispenser or provider of pharmaceu-
20 tical products, services or durable medical equipment, or a represen-
21 tative designated by such entity or person.

22 [(e)] (G) IN A CASE WHERE (A) MORE THAN FIVE PERCENT OF THE ACCOUNTS
23 RECEIVABLE BALANCE DUE TO A HEALTH CARE PROVIDER FROM AN INSURER, ORGAN-
24 IZATION OR CORPORATION IS WITHHELD BECAUSE THE OBLIGATION TO PAY IS NOT
25 REASONABLY CLEAR PURSUANT TO SUBSECTION (B) OF THIS SECTION, OR (B) AN
26 INSURER, ORGANIZATION OR CORPORATION REQUESTS A PATIENT'S MEDICAL
27 RECORDS PURSUANT TO PARAGRAPH TWO OF SUBSECTION (B) OF THIS SECTION FOR
28 MORE THAN FIVE PERCENT OF CLAIMS SUBMITTED BY A HEALTH CARE PROVIDER,
29 THERE SHALL BE A PRESUMPTION THAT PAYMENT HAS NOT BEEN WITHHELD BECAUSE
30 OF A GOOD FAITH DISPUTE AND THE SUPERINTENDENT SHALL INVESTIGATE THE
31 PAYMENT PRACTICES OF THE INSURER, ORGANIZATION OR CORPORATION. IN ADDI-
32 TION, THE SUPERINTENDENT SHALL INVESTIGATE THE PAYMENT PRACTICES OF THE
33 INSURER, ORGANIZATION OR CORPORATION IN ANY INSTANCE WHERE HE OR SHE HAS
34 REASON TO BELIEVE THAT THE INSURER, ORGANIZATION OR CORPORATION HAS NOT
35 COMPLIED WITH THE PROVISIONS OF THIS SECTION. IN DETERMINING WHETHER
36 MORE THAN FIVE PERCENT OF THE ACCOUNTS RECEIVABLE BALANCE DUE TO A
37 HEALTH CARE PROVIDER FROM AN INSURER, ORGANIZATION OR CORPORATION IS
38 WITHHELD OR WHETHER MEDICAL RECORDS ARE REQUESTED FOR MORE THAN FIVE
39 PERCENT OF THE CLAIMS SUBMITTED BY A HEALTH CARE PROVIDER, THE SUPER-
40 INTENDENT SHALL DISREGARD CLAIMS FOR REIMBURSEMENT OF EMERGENCY CARE
41 RENDERED BY A HEALTH CARE PROVIDER THAT DOES NOT PARTICIPATE IN THE
42 NETWORK OF THE INSURER, ORGANIZATION OR CORPORATION RECEIVING THE CLAIM.

43 (H) Nothing in this section shall in any way be deemed to impair any
44 right available to the state to adjust the timing of its payments for
45 medical assistance pursuant to title eleven of article five of the
46 social services law, or for child health insurance plan benefits pursu-
47 ant to title [one-a] ONE-A of article twenty-five of the public health
48 law or otherwise be deemed to require adjustment of payments by the
49 state for such medical assistance or child health insurance.

50 [(f)] (I) In any action brought by the superintendent pursuant to this
51 section or article twenty-four of this chapter relating to this section
52 regarding payments for medical assistance pursuant to title eleven of
53 article five of the social services law, child health insurance plan
54 benefits pursuant to title [one-a] ONE-A of article twenty-five of the
55 public health law, benefits under the voucher insurance program pursuant
56 to section one thousand one hundred twenty-one of this chapter, and

1 benefits under the New York state small business health insurance part-
2 nership program pursuant to article nine-A of the public health law, it
3 shall be a mitigating factor that the insurer, corporation or organiza-
4 tion is owed any premium amounts, premium adjustments, stop-loss recov-
5 eries or other payments from the state or one of its fiscal interme-
6 diaries under any such program.

7 S 3. Section 206 of the public health law is amended by adding a new
8 subdivision 26 to read as follows:

9 26. (A) THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF
10 INSURANCE, SHALL ADOPT RULES AND REGULATIONS ESTABLISHING AN ALTERNATIVE
11 DISPUTE RESOLUTION SYSTEM TO MAKE DETERMINATIONS REGARDING DISAGREEMENTS
12 BETWEEN HEALTH CARE PROVIDERS AND THIRD PARTY PAYERS CONCERNING PAYMENTS
13 RELATED TO HEALTH CARE SERVICES RENDERED BY HEALTH CARE PROVIDERS, AND
14 SHALL ADOPT SUCH RULES AND REGULATIONS AS ARE NECESSARY TO PROMOTE
15 UNIFORMITY IN THE INTERPRETATION OF APPLICABLE LAWS, REGULATIONS, AND
16 CONTRACTUAL PROVISIONS.

17 (B) DEFINITIONS. A "HEALTH CARE PROVIDER" SHALL MEAN AN ENTITY
18 LICENSED OR CERTIFIED PURSUANT TO THIS ARTICLE, ARTICLE THIRTY-SIX OR
19 FORTY OF THIS CHAPTER, A FACILITY LICENSED PURSUANT TO ARTICLE NINETEEN,
20 FORMER ARTICLE TWENTY-THREE OR ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE
21 LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED
22 PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW, OR A REPRESENTATIVE DESIG-
23 NATED BY SUCH ENTITY OR PERSON. A "THIRD PARTY PAYER" SHALL INCLUDE AN
24 ENTITY DEFINED IN SUBDIVISION ONE-A OF SECTION TWENTY-EIGHT HUNDRED
25 SEVEN-J OF THIS CHAPTER, WITH THE EXCEPTION OF GOVERNMENTAL AGENCIES,
26 BUT SHALL INCLUDE THIRD PARTY PAYERS THAT ENROLL PERSONS ELIGIBLE FOR
27 MEDICAL ASSISTANCE PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THE
28 SOCIAL SERVICES LAW, OR A REPRESENTATIVE DESIGNATED BY SUCH ENTITY.

29 (C) ADMINISTRATION OF ALTERNATIVE DISPUTE RESOLUTION SYSTEM. THE
30 COMMISSIONER SHALL SELECT AND APPROVE STATEWIDE OR REGIONAL ALTERNATIVE
31 DISPUTE RESOLUTION AGENTS TO CONDUCT AND DETERMINE ALTERNATIVE DISPUTE
32 RESOLUTION REVIEWS. THE COMMISSIONER SHALL ESTABLISH CRITERIA FOR THE
33 SELECTION OF SUCH AGENTS, INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

34 I. EMPLOYMENT OR CONTROL THROUGH OTHER ARRANGEMENTS OF A SUFFICIENT
35 NUMBER OF PERSONNEL QUALIFIED TO REVIEW DISPUTES, INCLUDING SUFFICIENT
36 PHYSICIAN AND OTHER CLINICAL SPECIALISTS WHERE APPROPRIATE;

37 II. DEMONSTRATION OF AN ABILITY TO REVIEW AND RENDER DECISIONS REGARD-
38 ING DISPUTES IN A TIMELY MANNER;

39 III. ABILITY TO MAKE AVAILABLE FOR INSPECTION BY THE COMMISSIONER AND
40 SUPERINTENDENT OF INSURANCE RECORDS AND INFORMATION RELATED TO ITS
41 REVIEW ACTIVITIES;

42 IV. LACK OF CONFLICT OF INTEREST BASED ON PAYER, PROVIDER, OR PROFES-
43 SIONAL AFFILIATION, INCLUDING PROCEDURES TO ENSURE THAT CASES SUBMITTED
44 FOR REVIEW THAT HAVE BEEN PREVIOUSLY REVIEWED BY THE AGENT IN A SEPARATE
45 CAPACITY ARE IDENTIFIED FOR REASSIGNMENT TO OTHER AGENTS;

46 V. FAMILIARITY WITH BILLING, CODING, AND CLAIMS PAYMENT PRACTICES OF
47 HEALTH CARE PAYERS AND PROVIDERS IN NEW YORK STATE;

48 VI. FAMILIARITY WITH THE NATURE OF CONTRACTUAL RELATIONSHIPS BETWEEN
49 PAYERS AND PROVIDERS;

50 VII. FAMILIARITY WITH RELEVANT PROVISIONS OF THIS ARTICLE AND THE
51 INSURANCE LAW AND RELATED RULES AND REGULATIONS CONCERNING THE DELIVERY
52 AND REVIEW OF, AND BILLING AND PAYMENT FOR, HEALTH CARE SERVICES;

53 VIII. ABILITY TO ENSURE CONFIDENTIALITY OF PATIENT INFORMATION;

54 IX. ABILITY TO PROMOTE UNIFORMITY IN THE INTERPRETATION OF APPLICABLE
55 LAWS, REGULATIONS, AND CONTRACTUAL PROVISIONS AS DEFINED BY THE COMMIS-
56 SIONER AND SUPERINTENDENT OF INSURANCE; AND

1 X. ABILITY TO ESTABLISH POLICIES AND PROCEDURES AND TO CARRY OUT THE
2 PROVISIONS OF THIS SECTION.

3 (D) MINIMUM AMOUNT IN DISPUTE. I. NO DISPUTE SHALL BE ACCEPTED FOR
4 REVIEW BY THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM UNLESS THE CLAIMED
5 VALUE OF THE DISPUTED ITEM OR SERVICE IS FIVE HUNDRED DOLLARS OR MORE,
6 PROVIDED, HOWEVER, THAT A DISPUTED ITEM OR SERVICE MAY INCLUDE MULTIPLE
7 ITEMS WHOSE AGGREGATE VALUE MEETS THE MINIMUM REQUIREMENT WHEN THE
8 DISPUTE IS ALLEGED TO ARISE FROM THE SAME PATTERN OR PRACTICE APPLIED TO
9 SUCH MULTIPLE ITEMS.

10 II. EXCEPT FOR DISPUTES WHICH MAY BE CONSIDERED AND RESOLVED UNDER
11 TITLE II OF ARTICLE FORTY-NINE OF THIS CHAPTER OR TITLE II OF ARTICLE
12 FORTY-NINE OF THE INSURANCE LAW AS IMPLEMENTED THROUGH THE SUPERINTEN-
13 DENT OF INSURANCE OR THE COMMISSIONER'S ADMINISTRATIVE PRACTICES OR
14 THROUGH REGULATION, THE DISPUTE RESOLUTION SYSTEM ESTABLISHED BY THIS
15 SUBDIVISION SHALL REVIEW DISAGREEMENTS RELATED TO THE PROVISIONS OF
16 SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW;
17 THE PROVISIONS OF STATE OR FEDERAL LAW OR REGULATION; THE PROCESS AND
18 PROCEDURES UTILIZED BY THIRD PARTY PAYERS FOR THE SUBMISSION, REVIEW,
19 AND APPEAL OF CLAIMS; CONTRACTUAL PROVISIONS RELATED TO PAYMENT AND
20 MEDICAL REVIEW; AND OTHER DISPUTES RELATED TO PAYMENT AMOUNTS AND BILL-
21 ING AND CLAIMS ADJUDICATION PRACTICES. DISPUTES SUBJECT TO REVIEW SHALL
22 INCLUDE, BUT NOT BE LIMITED TO:

23 A. DISPUTES REGARDING PAYMENT RESULTING FROM THE REVIEW OF A HEALTH
24 CARE PROCEDURE, SERVICE, OR SERVICES CONDUCTED PURSUANT TO ARTICLE
25 FORTY-NINE OF THIS CHAPTER OR ARTICLE FORTY-NINE OF THE INSURANCE LAW,
26 REGARDLESS OF WHEN THE REVIEW WAS BEGUN OR COMPLETED; PROVIDED, HOWEVER,
27 THAT IF THE PERSON RECEIVING THE HEALTH CARE PROCEDURE OR SERVICE THAT
28 GAVE RISE TO THE PAYMENT DISPUTE IS FINANCIALLY LIABLE FOR PART OR ALL
29 OF THE DISPUTED PAYMENT, SUCH PERSON HAS GIVEN HIS OR HER CONSENT IN
30 WRITING TO PERMIT THE PROVIDER OR PAYER TO PURSUE THE DISPUTE, WHICH
31 CONSENT MAY BE PROVIDED IN ADVANCE OF THE PROVISION OF THE PROCEDURE OR
32 SERVICE AND WHICH SHALL BE INCLUDED IN THE MATERIALS SUBMITTED TO THE
33 REVIEW AGENT IN SUPPORT OF THE REVIEW;

34 B. DISPUTES REGARDING PAYMENT RELATED TO THE PRIOR AUTHORIZATION OF A
35 SERVICE;

36 C. DISPUTES REGARDING PROVISIONS OF STATE OR FEDERAL LAW OR REGULATION
37 RELATED TO THE APPROPRIATENESS, BILLING, OR PAYMENT FOR HEALTH CARE
38 SERVICES BY THIRD PARTY PAYERS;

39 D. DISPUTES RELATED TO CODING OR DETERMINATION OF DIAGNOSES;

40 E. DISPUTES RELATED TO PAYMENT ASSOCIATED WITH THE APPROPRIATENESS OF
41 THE LEVEL OR SETTING FOR THE DELIVERY OF THE HEALTH CARE SERVICE; AND

42 F. DISPUTES REGARDING PAYMENT RELATED TO THE APPROPRIATENESS OF
43 SERVICES RENDERED THROUGH THE EMERGENCY DEPARTMENT.

44 (E) TIMEFRAMES. THE ALTERNATIVE DISPUTE RESOLUTION AGENT SHALL REVIEW
45 AND RENDER A DECISION ON A DISPUTE WITHIN THIRTY DAYS OF THE RECEIPT OF
46 ALL REQUESTED INFORMATION. THE DECISION WILL BE BASED UPON A REVIEW OF
47 THE MATERIALS SUBMITTED BY THE PARTIES AND APPLICABLE LAWS AND REGU-
48 LATIONS, IF ANY, AND SHALL BE IN WRITING. ANY PAYMENT DETERMINED TO BE
49 OWED BY A HEALTH CARE PROVIDER OR THIRD PARTY PAYER PURSUANT TO SUCH
50 DECISION SHALL BE MADE WITHIN THIRTY DAYS OF THE RECEIPT OF THE ALTERNA-
51 TIVE DISPUTE RESOLUTION AGENT'S DECISION.

52 (F) INTEREST. WHENEVER THE AMOUNT OF PAYMENT MADE BY A THIRD PARTY
53 PAYER TO A HEALTH CARE PROVIDER DIFFERS FROM THE AMOUNT OF PAYMENT
54 DETERMINED IN ACCORDANCE WITH THIS SECTION, INTEREST SHALL BE DUE ON ANY
55 EXCESS OWED TO THE HEALTH CARE PROVIDER OR THE THIRD PARTY PAYER AT THE
56 GREATER OF THE RATE EQUAL TO THE RATE SET BY THE COMMISSIONER OF TAXA-

1 TION AND FINANCE FOR CORPORATE TAXES PURSUANT TO PARAGRAPH ONE OF
2 SUBSECTION (E) OF SECTION ONE THOUSAND NINETY-SIX OF THE TAX LAW OR
3 TWELVE PERCENT PER ANNUM, TO BE COMPUTED FROM THE DATE THAT IS THIRTY
4 DAYS AFTER RECEIPT BY THE PROVIDER OR PAYER OF THE ALTERNATIVE DISPUTE
5 RESOLUTION AGENT'S DECISION. WHEN THE AMOUNT OF INTEREST DUE ON SUCH A
6 CLAIM IS LESS THAN TWO DOLLARS, A THIRD PARTY PAYER OR HEALTH CARE
7 PROVIDER SHALL NOT BE REQUIRED TO PAY INTEREST ON SUCH CLAIM.

8 (G) FEES. THE COMMISSIONER SHALL ESTABLISH A FEE SCHEDULE NECESSARY TO
9 SUPPORT THE OPERATION OF THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM. FEES
10 CHARGED SHALL BE BORNE BY THE PARTY THAT DOES NOT PREVAIL OR PROPOR-
11 TIONALLY DISTRIBUTED BY DOLLAR VALUE IN CASES OF A MIXED DETERMINATION.

12 (H) PROHIBITIONS. NO HEALTH CARE PROVIDER OR THIRD PARTY PAYER SHALL
13 BY CONTRACT, WRITTEN POLICY, OR WRITTEN PROCEDURE PROHIBIT OR RESTRICT
14 THE USE OF THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM ESTABLISHED HEREIN,
15 NOR SHALL USE OF THE ALTERNATIVE DISPUTE RESOLUTION SYSTEM BE A PRIOR
16 REQUIREMENT TO SEEKING ANY OTHER REMEDIES OTHERWISE PERMITTED BY LAW OR
17 CONTRACT.

18 (I) THE DECISION OF THE ALTERNATIVE DISPUTE RESOLUTION AGENT SHALL BE
19 ADMISSIBLE IN ANY COURT PROCEEDING.

20 (J) THE ALTERNATIVE DISPUTE RESOLUTION AGENT SHALL NOTIFY THE COMMIS-
21 SIONER AND THE SUPERINTENDENT OF INSURANCE WHEN IT BELIEVES THAT
22 DISPUTES ADJUDICATED BY IT MAY CONSTITUTE A VIOLATION OF APPLICABLE
23 STATE OR FEDERAL LAW OR REGULATION OR FAIR BUSINESS PRACTICES. THE
24 COMMISSIONER AND SUPERINTENDENT OF INSURANCE SHALL INVESTIGATE SUCH
25 CASES AND SEEK APPROPRIATE REMEDIES.

26 (K) A THIRD PARTY PAYER SHALL INCLUDE IN ANY QUARTERLY AND ANNUAL
27 FILINGS MADE TO THE COMMISSIONER AND THE SUPERINTENDENT OF INSURANCE
28 INFORMATION RELATED TO THE ALTERNATIVE DISPUTE RESOLUTION PROCESS,
29 INCLUDING THE NUMBER OF DISPUTES BROUGHT BY IT IN THE TIME PERIOD
30 COVERED BY THE FILING; THE NUMBER OF DISPUTES BROUGHT AGAINST IT IN THE
31 TIME PERIOD COVERED BY THE FILING; AND THE DISPOSITION OF SUCH DISPUTES
32 WITH A STATEMENT OF WHETHER IT PREVAILED OR DID NOT PREVAIL IN WHOLE OR
33 IN PART.

34 (1) FOR CLAIM PAYMENT AMOUNTS OR OTHER DISPUTES ELIGIBLE FOR DISPUTE
35 RESOLUTION PURSUANT TO THIS SECTION, NO INSURED PERSON SHALL HAVE ANY
36 FINANCIAL LIABILITY FOR ANY PORTION OF THE HEALTH CARE PROVIDER'S BILL,
37 AND NO HEALTH CARE PROVIDER SHALL BILL AN INSURED OR PURSUE COLLECTION
38 EFFORTS AGAINST SUCH INSURED FOR THE DIFFERENCE BETWEEN THE HEALTH CARE
39 PROVIDER'S BILL AND THE THIRD PARTY PAYER'S PAYMENT MADE ON SUCH BILL
40 EXCEPT FOR DEDUCTIBLES, COINSURANCE BASED ON THE UNDISPUTED PORTION OF
41 THE BILL, AND FOR UNCOVERED SERVICES; PROVIDED THAT THE DEFINITION OF
42 UNCOVERED SERVICES SHALL NOT INCLUDE ANY SERVICES OR CLAIMS WHICH ARE IN
43 DISPUTE BETWEEN THE THIRD PARTY PAYER AND THE PROVIDER. THE PROHIBITION
44 ON BILLING AND COLLECTION EFFORTS PRESCRIBED BY THIS PARAGRAPH SHALL
45 REMAIN IN EFFECT UNTIL THE DISPUTE RESOLUTION AGENT RENDERS A DECISION.

46 S 4. Section 2805-a of the public health law is amended by adding a
47 new subdivision 5 to read as follows:

48 5. EVERY GENERAL HOSPITAL SHALL ALSO SUBMIT A QUARTERLY REPORT ON
49 BILLING PROCEDURES FOR THIRD-PARTY PAYORS AND PAYMENTS. SUCH REPORT
50 SHALL INCLUDE BUT NOT BE LIMITED TO, A LISTING OF THE NUMBER OF DAYS
51 FROM THE DATE SERVICES WERE RENDERED UNTIL A CLAIM WAS SUBMITTED TO A
52 THIRD-PARTY PAYOR FOR SUCH SERVICES, THE NUMBER OF DAYS FROM THE DATE
53 THAT A CLAIM WAS SUBMITTED UNTIL PAYMENT WAS RECEIVED, THE NUMBER OF
54 DAYS FROM THE DATE THAT PAYMENT WAS RECEIVED UNTIL THE DATE THAT SUCH
55 PAYMENT WAS POSTED, AND SUCH OTHER INFORMATION AS THE COMMISSIONER DEEMS
56 APPROPRIATE.

1 S 5. Paragraph (g) of subdivision 4 of section 2807-e of the public
2 health law, as amended by chapter 255 of the laws of 1994, is amended to
3 read as follows:

4 (g) The commissioner, in consultation with the superintendent [and the
5 commissioner of social services] OF INSURANCE, shall establish proce-
6 dures for requiring third-party payors to accept the electronic
7 submission of claims information for inpatient or ambulatory care
8 services made pursuant to the provision of this section. A THIRD-PARTY
9 PAYOR VIOLATES THIS SUBDIVISION IN EACH INSTANCE THAT THE PAYOR FAILS TO
10 ACCEPT ELECTRONICALLY A CLAIM THAT A HEALTH CARE PROVIDER ATTEMPTS TO
11 SUBMIT ELECTRONICALLY. ANY THIRD-PARTY PAYOR VIOLATING THIS SECTION
12 AFTER JANUARY FIRST, TWO THOUSAND NINE, MUST PAY TWO PERCENT OF THE
13 FINAL CLAIM AMOUNT TO THE HEALTH CARE PROVIDER AS A PENALTY FOR EACH
14 VIOLATION. HOWEVER, THE COMMISSIONER SHALL PROMULGATE A SCHEDULE FOR
15 GRADUAL COMPLIANCE WITH THE PROVISIONS OF THIS PARAGRAPH BY THIRD-PARTY
16 PAYORS THAT CONTRACT WITH THE DEPARTMENT UNDER SECTION THREE HUNDRED
17 SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW AND ARE CONTROLLED BY, SPONSORED
18 BY, OR OTHERWISE AFFILIATED THROUGH A COMMON GOVERNANCE OR THROUGH A
19 PARENT CORPORATION WITH ONE OR MORE PRIVATE, NOT-FOR-PROFIT OR PUBLIC
20 GENERAL HOSPITALS OR DIAGNOSTIC AND TREATMENT CENTERS LICENSED PURSUANT
21 TO THIS ARTICLE. SUCH SCHEDULE SHALL BE BASED ON THE MANAGEMENT INFOR-
22 MATION SYSTEMS CAPACITY AND ENROLLMENT OF SUCH PAYORS AND SHALL REQUIRE
23 COMPLIANCE WITH THIS PARAGRAPH BY NO LATER THAN JULY FIRST, TWO THOUSAND
24 TEN.

25 S 6. Subdivision 21 of section 364-j of the social services law is
26 amended by adding a new paragraph (g) to read as follows:

27 (G) THE DEPARTMENT OF HEALTH SHALL, BY MARCH FIRST, TWO THOUSAND TEN
28 AND ANNUALLY BY DECEMBER FIRST THEREAFTER, ANNOUNCE THE PREMIUM RATES
29 EFFECTIVE FOR THE NEXT RATE YEAR. THE DEPARTMENT OF HEALTH SHALL
30 FURTHER COMMENCE PAYMENT OF THE NEW RATES ON APRIL FIRST, TWO THOUSAND
31 TEN AND ANNUALLY ON JANUARY FIRST THEREAFTER. NOTWITHSTANDING SUBDIVI-
32 SION FIVE OF SECTION ONE HUNDRED SEVENTY-NINE-P OF THE STATE FINANCE
33 LAW, IN THE EVENT THAT THE DEPARTMENT OF HEALTH FAILS TO COMMENCE
34 PAYMENT OF THE NEW RATES BY APRIL FIRST, TWO THOUSAND TEN OR BY JANUARY
35 FIRST THEREAFTER, THE DEPARTMENT OF HEALTH SHALL PAY INTEREST ON ANY
36 INCREASE IN THE RATES OVER THE PRIOR YEAR'S RATES AT THE INTEREST RATE
37 SPECIFIED IN SECTION ONE HUNDRED SEVENTY-NINE-G OF THE STATE FINANCE
38 LAW.

39 S 7. The opening paragraph of subparagraph (i) of paragraph (a) of
40 subdivision 5 of section 4900 of the public health law, as amended by
41 chapter 558 of the laws of 1999, is amended to read as follows:

42 AN INDIVIDUAL health care [procedures, treatments or services] PROCE-
43 DURE, TREATMENT OR UNIT OF SERVICE FOR WHICH A UTILIZATION REVIEW AGENT
44 CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS OF WHETHER
45 THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS PART OF A
46 COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREATMENTS OR
47 UNITS OF SERVICE

48 S 8. Subparagraph (A) of paragraph (b) of subdivision 5 of section
49 4900 of the public health law, as amended by chapter 558 of the laws of
50 1999, is amended to read as follows:

51 (A) [services] AN INDIVIDUAL HEALTH CARE PROCEDURE, TREATMENT OR UNIT
52 OF SERVICE provided within a clinical trial FOR WHICH A UTILIZATION
53 REVIEW AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS
54 OF WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS
55 PART OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREAT-
56 MENTS, OR UNITS OF SERVICE, and

1 S 9. Subparagraph (A) of paragraph 1 of subsection (e) of section 4900
2 of the insurance law, as amended by chapter 558 of the laws of 1999, is
3 amended to read as follows:

4 (A) AN INDIVIDUAL health care [procedures, treatments or services]
5 PROCEDURE, TREATMENT OR UNIT OF SERVICE FOR WHICH A UTILIZATION REVIEW
6 AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS OF
7 WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS PART
8 OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREATMENTS
9 OR UNITS OF SERVICE

10 S 10. Subparagraph (A) of paragraph 2 of subsection (e) of section
11 4900 of the insurance law, as amended by chapter 558 of the laws of
12 1999, is amended to read as follows:

13 (A) [services] AN INDIVIDUAL HEALTH CARE PROCEDURE, TREATMENT OR UNIT
14 OF SERVICE provided within a clinical trial FOR WHICH A UTILIZATION
15 REVIEW AGENT CHOOSES TO UNIQUELY DETERMINE MEDICAL NECESSITY REGARDLESS
16 OF WHETHER THE HEALTH CARE PROCEDURE, TREATMENT OR UNIT OF SERVICE IS
17 PART OF A COURSE OF TREATMENT CONSISTING OF MULTIPLE PROCEDURES, TREAT-
18 MENTS, OR UNITS OF SERVICE, and

19 S 11. Section 4900 of the public health law is amended by adding a new
20 subdivision 7-g to read as follows:

21 7-G. "RETROSPECTIVE ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMI-
22 NATION THAT AN ENROLLEE, AN ENROLLEE'S DESIGNEE, OR AN ENROLLEE'S HEALTH
23 CARE PROVIDER RECEIVES FROM A UTILIZATION REVIEW AGENT AFTER THE ENROL-
24 LEE HAS RECEIVED A HEALTH CARE SERVICE, REGARDLESS OF WHEN THE UTILIZA-
25 TION REVIEW AGENT BEGAN ITS REVIEW OF THE SERVICE.

26 S 12. Section 4900 of the insurance law is amended by adding a new
27 subsection (g-7) to read as follows:

28 (G-7) "RETROSPECTIVE ADVERSE DETERMINATION" MEANS AN ADVERSE DETERMI-
29 NATION THAT AN ENROLLEE, AN ENROLLEE'S DESIGNEE, OR AN ENROLLEE'S HEALTH
30 CARE PROVIDER RECEIVES FROM A UTILIZATION REVIEW AGENT AFTER THE ENROL-
31 LEE HAS RECEIVED A HEALTH CARE SERVICE, REGARDLESS OF WHEN THE UTILIZA-
32 TION REVIEW AGENT BEGAN ITS REVIEW OF THE SERVICE.

33 S 13. Paragraph (b) of subdivision 1 of section 4902 of the public
34 health law, as amended by chapter 586 of the laws of 1998, is amended to
35 read as follows:

36 (b) Development of written policies and procedures that govern all
37 aspects of the utilization review process and a requirement that a
38 utilization review agent shall maintain and make available to enrollees
39 and health care providers a written description of such procedures
40 including procedures to appeal an adverse determination together with a
41 description, jointly promulgated by the commissioner and the superinten-
42 dent of insurance as required pursuant to subdivision five of section
43 forty-nine hundred fourteen of this article, of the external appeal
44 process established pursuant to title two of this article and the time
45 frames for such appeals. THE UTILIZATION REVIEW AGENT SHALL NOTIFY
46 PROVIDERS AND ENROLLEES AT LEAST TWENTY BUSINESS DAYS BEFORE IT CHANGES
47 ITS POLICIES AND PROCEDURES;

48 S 14. Paragraph 2 of subsection (a) of section 4902 of the insurance
49 law, as amended by chapter 586 of the laws of 1998, is amended to read
50 as follows:

51 (2) Development of written policies and procedures that govern all
52 aspects of the utilization review process and a requirement that a
53 utilization review agent shall maintain and make available to insureds
54 and health care providers a written description of such procedures
55 including procedures to appeal an adverse determination together with a
56 description, jointly promulgated by the superintendent and the commis-

1 sioner of health as required pursuant to subsection (e) of section four
2 thousand nine hundred fourteen of this article, of the external appeal
3 process established pursuant to title two of this article and the time
4 frames for such appeals. THE UTILIZATION REVIEW AGENT SHALL NOTIFY
5 PROVIDERS AND ENROLLEES AT LEAST TWENTY BUSINESS DAYS BEFORE IT CHANGES
6 ITS POLICIES AND PROCEDURES;

7 S 15. Paragraph (c) of subdivision 1 of section 4902 of the public
8 health law, as added by chapter 705 of the laws of 1996, is amended to
9 read as follows:

10 (c) Utilization of written clinical review criteria developed pursuant
11 to a utilization review plan CONSISTENT WITH THE REQUIREMENTS OF SECTION
12 FORTY-NINE HUNDRED TEN OF THIS ARTICLE; MADE AVAILABLE TO ENROLLEES AND
13 HEALTH CARE PROVIDERS, UPON REQUEST, IN SUFFICIENT SPECIFICITY TO
14 APPRISE THE PROVIDER OF EVERY CASE-SPECIFIC CLINICAL REVIEW CRITERION
15 AND STANDARD USED IN THE REVIEW PROCESS; WITH ADVANCE NOTICE OF AT LEAST
16 TWENTY BUSINESS DAYS TO CONTRACTED PROVIDERS OF CHANGES TO SUCH CRITERIA
17 AND STANDARDS;

18 S 16. Paragraph 3 of subsection (a) of section 4902 of the insurance
19 law, as added by chapter 705 of the laws of 1996, is amended to read as
20 follows:

21 (3) Utilization of written clinical review criteria developed pursuant
22 to a utilization review plan CONSISTENT WITH THE REQUIREMENTS OF SECTION
23 FOUR THOUSAND NINE HUNDRED TEN OF THIS ARTICLE; MADE AVAILABLE, UPON
24 REQUEST, TO ENROLLEES AND HEALTH CARE PROVIDERS IN SUFFICIENT SPECIFICI-
25 TY TO APPRISE THE PROVIDER OF EVERY CASE-SPECIFIC CLINICAL REVIEW CRITE-
26 RION AND STANDARD USED IN THE REVIEW PROCESS; WITH ADVANCE NOTICE OF AT
27 LEAST TWENTY BUSINESS DAYS TO CONTRACTED PROVIDERS OF CHANGES TO SUCH
28 CRITERIA AND STANDARDS;

29 S 17. Paragraph (h) of subdivision 1 of section 4902 of the public
30 health law, as added by chapter 705 of the laws of 1996, is amended to
31 read as follows:

32 (h) Establishment of a requirement that emergency services rendered to
33 an enrollee shall not be subject to prior authorization OR NOTICE
34 REQUIREMENTS OF FEWER THAN FIVE DAYS FOLLOWING RECEIPT OF THESE
35 SERVICES, UNLESS OTHERWISE AGREED TO BY A HEALTH CARE PLAN AND A HEALTH
36 CARE PROVIDER, nor shall reimbursement for such services be denied [on
37 retrospective review; provided, however,] FOR ANY REASON EXCEPT that
38 such services [are] WERE NOT medically necessary to stabilize or treat
39 an emergency condition.

40 S 18. Paragraph 8 of subsection (a) of section 4902 of the insurance
41 law, as added by chapter 705 of the laws of 1996, is amended to read as
42 follows:

43 (8) Establishment of a requirement that emergency services rendered to
44 an insured shall not be subject to prior authorization OR NOTICE
45 REQUIREMENTS OF FEWER THAN FIVE DAYS FOLLOWING RECEIPT OF THESE
46 SERVICES, UNLESS OTHERWISE AGREED TO BY A HEALTH CARE PLAN AND A HEALTH
47 CARE PROVIDER, nor shall reimbursement for such services be denied [on
48 retrospective review; provided, however,] FOR ANY REASON EXCEPT that
49 such services [are] WERE NOT medically necessary to stabilize or treat
50 an emergency condition.

51 S 19. Subdivision 2 of section 4903 of the public health law, as added
52 by chapter 705 of the laws of 1996, is amended to read as follows:

53 2. A UTILIZATION REVIEW AGENT SHALL NOT REQUIRE AN ENROLLEE, AN
54 ENROLLEE'S DESIGNEE OR AN ENROLLEE'S HEALTH CARE PROVIDER TO REQUEST
55 PRE-AUTHORIZATION FOR HEALTH CARE SERVICES MORE THAN SEVEN BUSINESS DAYS
56 IN ADVANCE OF THE DATE ON WHICH THE SERVICES ARE PROPOSED TO BE

1 PROVIDED. A utilization review agent shall make a utilization review
2 determination involving [health care] SUCH services [which require pre-
3 authorization] and provide notice of [a] ITS determination to the enrol-
4 lee or enrollee's designee and the enrollee's health care provider by
5 telephone and in writing within three business days of receipt of the
6 necessary information.

7 S 20. Subdivision 7 of section 4905 of the public health law, as added
8 by chapter 705 of the laws of 1996, is amended to read as follows:

9 7. When making prospective, concurrent and retrospective determi-
10 nations, utilization review agents shall collect only such information
11 as is necessary to make such determination and shall not routinely
12 require health care providers to numerically code diagnoses or proce-
13 dures to be considered for certification or routinely request copies of
14 medical records of all patients reviewed. During prospective or concu-
15 rent review, copies of medical records shall only be required when
16 necessary to verify that the health care services subject to such review
17 are medically necessary. In such cases, only the necessary or relevant
18 sections of the medical record shall be required. A utilization review
19 agent may request copies of partial or complete medical records retros-
20 pectively. [This subdivision shall not apply to health maintenance
21 organizations licensed pursuant to article forty-three of the insurance
22 law or certified pursuant to article forty-four of this chapter.]

23 S 21. Section 4905 of the public health law is amended by adding a new
24 subdivision 16 to read as follows:

25 16. A PRE-AUTHORIZATION APPROVAL GRANTED BY A UTILIZATION REVIEW AGENT
26 IS A BINDING COMMITMENT TO MAKE PAYMENT FOR SPECIFIC SERVICES PERFORMED
27 AND PRE-AUTHORIZED, EXCEPT IN CASES WHERE THE SERVICES WERE RENDERED TO
28 AN INDIVIDUAL NOT ENROLLED IN A PLAN AT THE TIME SERVICES WERE RENDERED,
29 OR WHEN THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMATION
30 AVAILABLE FOR REVIEW BY THE SUPERINTENDENT OF INSURANCE THAT SUCH
31 APPROVAL WAS OBTAINED FRAUDULENTLY. IN THE EVENT THAT MORE THAN ONE
32 PAYOR IS RESPONSIBLE FOR PAYMENT FOR HEALTH CARE SERVICES RENDERED,
33 PRE-AUTHORIZATION SHALL NOT PRECLUDE ANY CLAIM BY THE PAYOR FOR INDEMNI-
34 FICATION OR CONTRIBUTION FROM OTHER PAYORS RESPONSIBLE FOR PAYMENT.
35 SPECIFIC SERVICES MAY INCLUDE SPECIFIC PROCEDURES, SITE OF SERVICE,
36 INPATIENT ADMISSION OR A TREATMENT PLAN FOR A CHRONIC PATIENT.

37 S 22. The public health law is amended by adding a new section 4908-a
38 to read as follows:

39 S 4908-A. ENFORCEMENT. IN ADDITION TO ANY OTHER POWERS CONFERRED ON
40 THE COMMISSIONER TO ENFORCE THIS CHAPTER, THE COMMISSIONER MAY TAKE THE
41 FOLLOWING ACTIONS WHEN ENTITIES SUBJECT TO THIS TITLE FAIL TO COMPLY
42 WITH THE PROVISIONS OF THIS TITLE.

43 1. THE COMMISSIONER MAY REQUIRE AN ENTITY TO SUBMIT A CORRECTIVE
44 ACTION PLAN AND PERIODIC UPDATES UNTIL THE COMMISSIONER IS SATISFIED
45 THAT THE ENTITY IS IN COMPLIANCE AND HAS ADOPTED THE NECESSARY PROCE-
46 DURES TO ENSURE FUTURE COMPLIANCES.

47 2. THE COMMISSIONER MAY IMPOSE A FINE OF UP TO ONE THOUSAND DOLLARS
48 FOR EACH VIOLATION OF THIS TITLE.

49 3. THE COMMISSIONER MAY RENEW WITH RESTRICTIONS OR REFUSE TO RENEW THE
50 REGISTRATION OF A UTILIZATION REVIEW AGENT.

51 4. THE COMMISSIONER MAY REVOKE THE REGISTRATION OF A UTILIZATION
52 REVIEW AGENT.

53 5. THE COMMISSIONER MAY RESTRICT THE REGISTRATION OF A UTILIZATION
54 REVIEW AGENT TO PERFORM PARTICULAR TYPES OF UTILIZATION REVIEW UNTIL THE
55 AGENT COMPLIES WITH THIS TITLE.

1 S 23. Subsection (b) of section 4903 of the insurance law, as added by
2 chapter 705 of the laws of 1996, is amended to read as follows:

3 (b) A UTILIZATION REVIEW AGENT SHALL NOT REQUIRE AN ENROLLEE, AN
4 ENROLLEE'S DESIGNEE OR AN ENROLLEE'S HEALTH CARE PROVIDER TO REQUEST
5 PRE-AUTHORIZATION FOR HEALTH CARE SERVICES MORE THAN SEVEN BUSINESS DAYS
6 IN ADVANCE OF THE DATE ON WHICH THE SERVICES ARE PROPOSED TO BE
7 PROVIDED. A utilization review agent shall make a utilization review
8 determination involving [health care] SUCH services [which require pre-
9 authorization] and provide notice of [a] ITS determination to the
10 insured or insured's designee and the insured's health care provider by
11 telephone and in writing within three business days of receipt of the
12 necessary information.

13 S 24. Section 4905 of the insurance law is amended by adding a new
14 subsection (p) to read as follows:

15 (P) A PRE-AUTHORIZATION APPROVAL GRANTED BY A UTILIZATION REVIEW AGENT
16 IS A BINDING COMMITMENT TO MAKE PAYMENT FOR SPECIFIC SERVICES PERFORMED
17 AND PRE-AUTHORIZED, EXCEPT IN CASES WHERE THE SERVICES WERE RENDERED TO
18 AN INDIVIDUAL NOT ENROLLED IN A PLAN AT THE TIME SERVICES WERE DELIV-
19 ERED, OR WHEN THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMA-
20 TION AVAILABLE FOR REVIEW BY THE SUPERINTENDENT THAT SUCH APPROVAL WAS
21 OBTAINED FRAUDULENTLY. IN THE EVENT THAT MORE THAN ONE PAYOR IS RESPON-
22 SIBLE FOR PAYMENT FOR HEALTH CARE SERVICES RENDERED, PRE-AUTHORIZATION
23 SHALL NOT PRECLUDE ANY CLAIM BY THE PAYOR FOR INDEMNIFICATION OR
24 CONTRIBUTION FROM OTHER PAYORS RESPONSIBLE FOR PAYMENT. SPECIFIC
25 SERVICES MAY INCLUDE SPECIFIC PROCEDURES, SITE OF SERVICE, INPATIENT
26 ADMISSION OR A TREATMENT PLAN FOR A CHRONIC PATIENT.

27 S 25. The insurance law is amended by adding a new section 4908-a to
28 read as follows:

29 S 4908-A. ENFORCEMENT. IN ADDITION TO ANY OTHER POWERS CONFERRED ON
30 THE SUPERINTENDENT TO ENFORCE THIS CHAPTER, THE SUPERINTENDENT MAY TAKE
31 THE FOLLOWING ACTIONS WHEN ENTITIES SUBJECT TO THIS TITLE FAIL TO COMPLY
32 WITH THE PROVISIONS OF THIS TITLE.

33 (A) THE SUPERINTENDENT MAY REQUIRE AN ENTITY TO SUBMIT A CORRECTIVE
34 ACTION PLAN AND PERIODIC UPDATES UNTIL THE SUPERINTENDENT IS SATISFIED
35 THAT THE ENTITY COMPLIES.

36 (B) THE SUPERINTENDENT MAY IMPOSE A FINE OF UP TO ONE THOUSAND DOLLARS
37 FOR EACH VIOLATION OF THIS TITLE.

38 (C) THE SUPERINTENDENT MAY RENEW WITH RESTRICTIONS OR REFUSE TO RENEW
39 THE REGISTRATION OF A UTILIZATION REVIEW AGENT.

40 (D) THE SUPERINTENDENT MAY REVOKE THE REGISTRATION OF A UTILIZATION
41 REVIEW AGENT.

42 (E) THE SUPERINTENDENT MAY RESTRICT THE REGISTRATION OF A UTILIZATION
43 REVIEW AGENT TO PERFORM PARTICULAR TYPES OF UTILIZATION REVIEW UNTIL THE
44 AGENT COMPLIES WITH THIS TITLE.

45 S 26. Subsection (e) of section 7402 of the insurance law is amended
46 to read as follows:

47 (e) Is found, after examination, to be in such condition that its
48 further transaction of business will be hazardous to its policyholders,
49 creditors, or the public. THIS SHALL INCLUDE A HEALTH INSURER, AS
50 DEFINED IN ARTICLE EIGHTY OF THIS CHAPTER, THAT IS CONSISTENTLY UNABLE
51 TO MEET THE REQUIREMENTS OF SECTION THREE THOUSAND TWO HUNDRED
52 TWENTY-FOUR-A OF THIS CHAPTER.

53 S 27. Section 7403 of the insurance law is amended by adding a new
54 subsection (e) to read as follows:

55 (E)(1) UPON A DETERMINATION BY THE SUPERINTENDENT AND THE REHABILITA-
56 TOR THAT FUNDS FROM THE NEW YORK HEALTH INSURANCE GUARANTY FUND ARE

NECESSARY TO MEET THE REQUIREMENTS OF ARTICLE EIGHTY OF THIS CHAPTER, THE SUPERINTENDENT SHALL MAKE AVAILABLE SUCH FUNDS AS ARE NECESSARY, PURSUANT TO THE REQUIREMENTS OF SUCH ARTICLE.

(2) THE SUPERINTENDENT SHALL ADVANCE SUCH FUNDS AS MAY BE NECESSARY PURSUANT TO SUBSECTION (D) OF SECTION EIGHT THOUSAND FOUR OF THIS CHAPTER. THE REHABILITATOR AND THE SUPERINTENDENT SHALL ESTABLISH A PLAN, IF POSSIBLE, FOR REPAYMENT OF THE ADVANCE, AT A RATE OF INTEREST DETERMINED BY THE SUPERINTENDENT.

(3) ADVANCES, PURSUANT TO PARAGRAPH TWO OF THIS SUBSECTION, SHALL, IN ALL RESPECTS EXCEPT TO RATE OF INTEREST, BE SUBJECT TO THE PROVISIONS OF SECTION ONE THOUSAND THREE HUNDRED SEVEN OF THIS CHAPTER, PROVIDED THAT IN THE EVENT THAT AN INSURER WHICH HAS RECEIVED AN ADVANCE PURSUANT TO THIS SUBSECTION IS SUBSEQUENTLY THE SUBJECT OF AN ORDER OF LIQUIDATION, THE CLAIM OF THE FUND FOR THE ADVANCE AND ANY ACCRUED INTEREST SHALL HAVE PRIORITY ABOVE CLAIMS OF ALL NONSECURED CREDITORS, PROVIDED THE REQUIREMENTS OF ARTICLE EIGHTY OF THIS CHAPTER HAVE BEEN MET, AND SHALL BE PAID IMMEDIATELY TO THE FUND OR AS SOON AS ASSETS ARE AVAILABLE THEREFOR.

S 28. Paragraph 1 of subsection (f) of section 7405 of the insurance law, as amended by chapter 33 of the laws of 2005, is amended to read as follows:

(1) No later than one hundred eighty days after a final order of liquidation with an adjudication of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator may in his sole discretion make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to any fund established by article seventy-six of this chapter, article six-A of the workers' compensation law and any foreign entity performing a similar function, AND ANY FUND ESTABLISHED PURSUANT TO ARTICLE EIGHTY OF THIS CHAPTER, PROVIDED THAT THE REQUIREMENTS OF SUBSECTION (A) OF SECTION EIGHT THOUSAND THREE OF THIS CHAPTER HAVE BEEN MET, having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application authorized by this subsection shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

S 29. The insurance law is amended by adding a new article 80 to read as follows:

ARTICLE 80

HEALTH INSURANCE GUARANTY FUND

SECTION 8001. PURPOSE.

8002. DEFINITIONS.

8003. NEW YORK HEALTH INSURANCE CONSUMER PROTECTION SECURITY FUND.

8004. POWERS OF THE SUPERINTENDENT.

S 8001. PURPOSE. THE PURPOSE OF THIS ARTICLE IS TO PROTECT COVERED INDIVIDUALS AGAINST THE FAILURE OR INABILITY OF A HEALTH INSURER TO PERFORM ITS CONTRACTUAL OBLIGATIONS DUE TO FINANCIAL IMPAIRMENT OR INSOLVENCY. TO PROVIDE THIS PROTECTION, THE LEGISLATURE HEREBY CREATES A NEW YORK HEALTH INSURANCE GUARANTY FUND TO SERVE AS A GUARANTY FUND MECHANISM CAPABLE OF INSURING THAT THE FINANCIAL OBLIGATIONS OF HEALTH INSURERS TO THEIR ENROLLEES AND HEALTH CARE PROVIDERS ARE SATISFIED.

S 8002. DEFINITIONS. AS USED IN THIS ARTICLE:

(A) "FUND" MEANS THE NEW YORK HEALTH INSURANCE CONSUMER PROTECTION SECURITY FUND CREATED BY THIS ARTICLE.

1 (B) "HEALTH INSURER" MEANS ANY ORGANIZATION OR ENTITY PROVIDING
2 REIMBURSEMENT FOR A COVERED EXPENSE UNDER ANY INDIVIDUAL, GROUP OR BLAN-
3 KET POLICY OR CONTRACT COVERING THE KINDS OF INSURANCE DESCRIBED IN ITEM
4 (I) OF PARAGRAPH THREE OF SUBSECTION (A) OF SECTION ONE THOUSAND ONE
5 HUNDRED THIRTEEN OF THIS CHAPTER AND LICENSED UNDER ARTICLE THIRTY-TWO
6 OR FORTY-TWO OF THIS CHAPTER, WHICH IS NOT A MEMBER OF, OR PARTICIPANT
7 IN, OR A SUBSIDIARY OF A MEMBER OF OR PARTICIPANT IN, THE FUNDS CREATED
8 PURSUANT TO ARTICLES SEVENTY-FIVE, SEVENTY-SIX AND SEVENTY-SEVEN OF THIS
9 CHAPTER; A CORPORATION ORGANIZED UNDER ARTICLE FORTY-THREE OF THIS CHAP-
10 TER; OR AN ORGANIZATION CERTIFIED UNDER ARTICLE FORTY-FOUR OF THE PUBLIC
11 HEALTH LAW.

12 (C) "CONTRACTUAL OBLIGATION" MEANS ANY PAYMENT OR REIMBURSEMENT OWED
13 BY A HEALTH INSURER FOR A COVERED BENEFIT UNDER A POLICY, CONTRACT, OR
14 COMPREHENSIVE HEALTH BENEFITS PLAN.

15 (D) "IMPAIRED HEALTH INSURER" MEANS A HEALTH INSURER FOR WHOM THE
16 SUPERINTENDENT HAS INITIATED A PROCEEDING UNDER THE PROVISIONS OF ARTI-
17 CLE SEVENTY-FOUR OF THIS CHAPTER.

18 (E) "COMMISSIONER" MEANS THE COMMISSIONER OF TAXATION AND FINANCE.

19 S 8003. NEW YORK HEALTH INSURANCE CONSUMER PROTECTION SECURITY FUND.

20 (A) CONSISTENT WITH THE PROVISIONS OF SUBDIVISION ONE OF SECTION NINE-
21 TY-TWO-FF OF THE STATE FINANCE LAW, THERE IS HEREBY ESTABLISHED A NEW
22 YORK HEALTH INSURANCE GUARANTY FUND. SUCH FUND SHALL BE USED IN THE
23 PAYMENT OF UNPAID CONTRACTUAL OBLIGATIONS, IN WHOLE OR IN PART, BY AN
24 IMPAIRED HEALTH INSURER, AFTER APPLICATION OF ANY FUNDS AVAILABLE FROM A
25 PROCEEDING IMPLEMENTED PURSUANT TO ARTICLE SEVENTY-FOUR OF THIS CHAPTER.

26 (B)(1) PAYMENT INTO THE FUND BY HEALTH INSURERS SHALL BE MADE THROUGH
27 AN ASSESSMENT BASED ON THE PREMIUMS RECEIVED BY A HEALTH INSURER FOR
28 BUSINESS IN THIS STATE FOR THE MOST RECENT CALENDAR YEAR FOR WHICH
29 PREMIUM INFORMATION IS AVAILABLE. THE SUPERINTENDENT SHALL ESTABLISH
30 ASSESSMENT LEVELS SUFFICIENT TO FULLY PAY ALL UNPAID CLAIMS OF AN
31 IMPAIRED HEALTH INSURER, PURSUANT TO SUBSECTIONS (B), (C) AND (D) OF
32 SECTION EIGHT THOUSAND FOUR OF THIS ARTICLE, AND TO REPAY ANY TRANSFERS
33 MADE PURSUANT TO SUBDIVISION FIVE OF SECTION SEVENTY-TWO OF THE STATE
34 FINANCE LAW.

35 (2) THE SUPERINTENDENT MAY EXEMPT, ABATE OR DEFER, IN WHOLE OR IN
36 PART, THE ASSESSMENT OF A HEALTH INSURER IF THE SUPERINTENDENT DETER-
37 MINES THAT PAYMENT OF THE ASSESSMENT WOULD ENDANGER THE ABILITY OF THE
38 HEALTH INSURER TO FULFILL ITS CONTRACTUAL OBLIGATIONS OR PLACE THE
39 HEALTH INSURER IN AN UNSAFE OR UNSOUND FINANCIAL CONDITION. IN THE
40 EVENT THAT HEALTH INSURERS PARTICIPATING IN THE FUND DUE TO BENEFITS
41 PROVIDED PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES
42 LAW, TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW OR
43 SECTION THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW DO NOT
44 RECEIVE PAYMENTS FROM THE GOVERNMENT AGENCY RESPONSIBLE FOR ADMINISTER-
45 ING SUCH PROGRAMS, IN ADDITION TO REGULAR PREMIUM PAYMENTS, WHICH ARE
46 EQUAL TO THE AMOUNT OF ANY ASSESSMENT PRIOR TO THE DATE THAT PAYMENT OF
47 ANY SUCH ASSESSMENT IS DUE, THEN THE SUPERINTENDENT SHALL EXEMPT SUCH
48 HEALTH INSURERS FROM SUCH ASSESSMENT.

49 (3) IN THE EVENT AN ASSESSMENT AGAINST A HEALTH INSURER IS EXEMPTED,
50 ABATED OR DEFERRED, IN WHOLE OR IN PART, THE AMOUNT BY WHICH THAT
51 ASSESSMENT IS EXEMPTED, ABATED OR DEFERRED SHALL BE ASSESSED AGAINST
52 OTHER HEALTH INSURERS IN A MANNER CONSISTENT WITH THIS SECTION.

53 (C) REPAYMENT OF HEALTH INSURERS WHEN FUNDS BECOME AVAILABLE FROM A
54 PROCEEDING PURSUANT TO ARTICLE SEVENTY-FOUR OF THIS CHAPTER SHALL BE
55 PROPORTIONATE TO THE CONTRIBUTION FROM EACH HEALTH INSURER.

1 S 8004. POWERS OF THE SUPERINTENDENT. (A) FOR ANY IMPAIRED HEALTH
2 INSURER, THE SUPERINTENDENT SHALL DIRECT THE COMMISSIONER TO MAKE
3 PAYMENTS FROM THE NEW YORK HEALTH INSURANCE GUARANTY FUND TO ENSURE THAT
4 PAYMENTS TO HEALTH CARE PROVIDERS, OR INDEMNITY PAYMENTS TO COVERED
5 INDIVIDUALS, ARE MADE IN FULL FOR SERVICES PROVIDED THAT WOULD NOT
6 OTHERWISE BE FULLY REIMBURSED DESPITE THE PROCEEDINGS IMPLEMENTED PURSU-
7 ANT TO ARTICLE SEVENTY-FOUR OF THIS CHAPTER. SERVICES PROVIDED EITHER
8 PRIOR TO THE IMPLEMENTATION OF A PROCEEDING UNDER ARTICLE SEVENTY-FOUR
9 OF THIS CHAPTER OR AFTER IMPLEMENTATION OF SUCH PROCEEDING SHALL BE
10 ELIGIBLE FOR REIMBURSEMENT, IN PART OR IN WHOLE, FROM THE FUND. PAYMENT
11 IN FULL SHALL BE DETERMINED BY THE TERMS OF THE HEALTH INSURANCE
12 CONTRACT, ANY CONTRACT BETWEEN A HEALTH CARE PROVIDER AND THE IMPAIRED
13 HEALTH INSURER AND ANY APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

14 (B) THE SUPERINTENDENT SHALL DIRECT THE COMMISSIONER TO MAKE PAYMENTS
15 TO ENSURE THAT PAYMENT IN FULL IS MADE TO HEALTH CARE PROVIDERS, OR
16 INDEMNITY PAYMENTS TO COVERED INDIVIDUALS, FOR SERVICES PROVIDED BEFORE
17 THE IMPLEMENTATION OF PROCEEDINGS PURSUANT TO ARTICLE SEVENTY-FOUR OF
18 THIS CHAPTER WITHIN THIRTY DAYS OF THE IMPLEMENTATION OF SUCH PROCEED-
19 ING.

20 (C) THE SUPERINTENDENT SHALL DIRECT THE COMMISSIONER TO ENSURE THAT
21 PAYMENT IN FULL IS MADE TO HEALTH CARE PROVIDERS, OR INDEMNITY PAYMENTS
22 TO COVERED INDIVIDUALS, FOR SERVICES PROVIDED AFTER THE IMPLEMENTATION
23 OF PROCEEDINGS PURSUANT TO ARTICLE SEVENTY-FOUR OF THIS CHAPTER WITHIN
24 THIRTY DAYS OF RECEIPT OF A CLAIM.

25 (D) IF NECESSARY, THE SUPERINTENDENT SHALL DIRECT THE COMMISSIONER TO
26 ADVANCE MONIES FROM THE FUND TO COMPLY WITH THE PROVISIONS OF
27 SUBSECTIONS (B) AND (C) OF THIS SECTION.

28 (E) THE SUPERINTENDENT SHALL NOTIFY THE DIRECTOR OF THE BUDGET OF THE
29 NEED FOR MONIES TO BE TRANSFERRED PURSUANT TO SUBDIVISION FIVE OF
30 SECTION SEVENTY-TWO OF THE STATE FINANCE LAW TO MEET THE REQUIREMENTS OF
31 SUBSECTIONS (B), (C) AND (D) OF THIS SECTION.

32 (F) THE SUPERINTENDENT SHALL DIRECT THE COMMISSIONER TO USE THE MONIES
33 OF THE FUND TO REPAY ANY TRANSFERS MADE PURSUANT TO SUBDIVISION FIVE OF
34 SECTION SEVENTY-TWO OF THE STATE FINANCE LAW, WHEN SUCH FUNDS ARE PAID
35 PURSUANT TO SUBSECTION (B) OF SECTION EIGHT THOUSAND THREE OF THIS ARTI-
36 CLE.

37 S 30. Section 72 of the state finance law is amended by adding a new
38 subdivision 5 to read as follows:

39 5. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, UPON NOTIFI-
40 CATION FROM THE SUPERINTENDENT OF INSURANCE OF THE NEED FOR MONIES TO
41 MEET THE REQUIREMENTS OF SUBSECTIONS (B), (C) AND (D) OF SECTION EIGHT
42 THOUSAND FOUR OF THE INSURANCE LAW, THE DIRECTOR OF THE BUDGET SHALL
43 TRANSFER SUCH FUNDS AS ARE NECESSARY.

44 S 31. The state finance law is amended by adding a new section 92-ff
45 to read as follows:

46 S 92-FF. NEW YORK HEALTH INSURANCE GUARANTY FUND. 1. THERE IS HEREBY
47 ESTABLISHED IN THE CUSTODY OF THE COMMISSIONER OF THE DEPARTMENT OF
48 TAXATION AND FINANCE AN ACCOUNT OF THE MISCELLANEOUS SPECIAL REVENUE
49 FUND TO BE KNOWN AS THE NEW YORK HEALTH INSURANCE CONSUMER PROTECTION
50 SECURITY FUND ACCOUNT.

51 2. NOTWITHSTANDING ANY OTHER LAW, RULE OR REGULATION TO THE CONTRARY,
52 THE COMMISSIONER OF TAXATION AND FINANCE IS HEREBY AUTHORIZED AND
53 DIRECTED TO RECEIVE FOR DEPOSIT TO THE CREDIT OF THE NEW YORK HEALTH
54 INSURANCE GUARANTY FUND ACCOUNT, ASSESSMENTS IMPOSED PURSUANT TO ARTICLE
55 EIGHTY OF THE INSURANCE LAW AND TRANSFERS FROM THE GENERAL FUND PURSUANT
56 TO SUBDIVISION FIVE OF SECTION SEVENTY-TWO OF THIS ARTICLE.

1 3. THE COMMISSIONER OF TAXATION AND FINANCE SHALL MAKE PAYMENTS FROM
2 THE MONIES ON DEPOSIT IN THE NEW YORK HEALTH INSURANCE GUARANTY FUND
3 ACCOUNT IN THE AMOUNTS AND AT THE TIMES DETERMINED BY THE SUPERINTENDENT
4 OF INSURANCE.

5 S 32. This act shall take effect immediately, except that sections one
6 through twelve and sections seventeen through thirty-one of this act
7 shall take effect January 1, 2010 and sections thirteen, fourteen,
8 fifteen and sixteen of this act shall take effect on the sixtieth day
9 after it shall have become a law; provided, however, that the amendments
10 to section 364-j of the social services law made by section six of this
11 act shall not affect the repeal of such section and shall be deemed
12 repealed therewith; and provided further, however, that effective imme-
13 diately, the addition, amendment and/or repeal of any rule or regulation
14 or other administrative action necessary for the implementation of this
15 act on its effective date are authorized and directed to be made and
16 completed on or before such effective date.