

201

Third Extraordinary Session

I N S E N A T E

June 24, 2009

Introduced by COMMITTEE ON RULES -- (at request of the Governor) -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

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 utilization review timeframes; and to amend chapter 451 of the laws of 2007 amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to the effectiveness thereof

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

1 Section 1. The insurance law is amended by adding a new section 316
2 to read as follows:
3 S 316. ELECTRONIC FILINGS. NOTWITHSTANDING SUBDIVISION ONE OF SECTION
4 THREE HUNDRED FIVE OF THE STATE TECHNOLOGY LAW, THE SUPERINTENDENT MAY
5 PROMULGATE REGULATIONS TO REQUIRE AN INSURER OR OTHER PERSON OR ENTITY
6 MAKING A FILING OR SUBMISSION WITH THE SUPERINTENDENT PURSUANT TO THIS
7 CHAPTER TO SUBMIT THE FILING OR SUBMISSION TO THE SUPERINTENDENT BY
8 ELECTRONIC MEANS. SHOULD THE SUPERINTENDENT REQUIRE THAT A FILING OR
9 SUBMISSION BE MADE BY ELECTRONIC MEANS, AN INSURER OR OTHER PERSON OR
10 ENTITY AFFECTED THEREBY MAY SUBMIT A REQUEST TO THE SUPERINTENDENT FOR
11 AN EXEMPTION FROM THE ELECTRONIC FILING REQUIREMENT UPON A DEMONSTRATION
12 OF UNDUE HARDSHIP, IMPRACTICABILITY, OR GOOD CAUSE, SUBJECT TO THE
13 APPROVAL OF THE SUPERINTENDENT.
14 S 2. Subparagraph (G) of paragraph 1 of subsection (d) of section 3216
15 of the insurance law is amended to read as follows:

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

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1 (G) PROOFS OF LOSS: Written proof of loss must be furnished to the
2 insurer at its said office in case of claim for loss for which this
3 policy provides any periodic payment contingent upon continuing loss
4 within ninety days after the termination of the period for which the
5 insurer is liable and in case of claim for any other loss within [nine-
6 ty] ONE HUNDRED TWENTY days after the date of such loss. Failure to
7 furnish such proof within the time required shall not invalidate nor
8 reduce any claim if it was not reasonably possible to give proof within
9 such time, provided such proof is furnished as soon as reasonably possi-
10 ble and in no event, except in the absence of legal capacity, later than
11 one year from the time proof is otherwise required.

12 S 3. Subsections (g) and (h) of section 3217-b of the insurance law,
13 subsection (g) as relettered by chapter 586 of the laws of 1998, are
14 relettered subsections (h) and (i) and a new subsection (g) is added to
15 read as follows:

16 (G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A
17 CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY
18 THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE
19 INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS
20 DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT
21 CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE
22 CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE
23 SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY,
24 WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE
25 INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON
26 THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE
27 PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE"
28 SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A
29 MATERIAL ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH
30 CARE PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
31 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
32 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY
33 THIS SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE
34 REQUIRED BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS
35 REQUIRED AS A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHOD-
36 OLOGY OR PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE
37 AMERICAN MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT)
38 CODES, REPORTING GUIDELINES AND CONVENTIONS; OR (B) SUCH CHANGE IS
39 EXPRESSLY PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION
40 OF OR REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHOD-
41 OLOGY OR PAYMENT POLICY INDEXING MECHANISM.

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

45 S 4. The insurance law is amended by adding a new section 3217-d to
46 read as follows:

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

54 (B) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A
55 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT
56 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 IN THIS SECTION 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.

(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 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 5. Paragraph 9 of subsection (a) of section 3221 of the insurance law is amended to read as follows:

(9) That in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within thirty days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within [ninety] ONE HUNDRED TWENTY days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible.

S 6. 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] THIRTY 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.

1 (b) In a case where the obligation of an insurer or an organization or
2 corporation licensed or certified pursuant to article forty-three OR
3 FORTY-SEVEN of this chapter or article forty-four of the public health
4 law to pay a claim or make a payment for health care services rendered
5 is not reasonably clear due to a good faith dispute regarding the eligi-
6 bility of a person for coverage, the liability of another insurer or
7 corporation or organization for all or part of the claim, the amount of
8 the claim, the benefits covered under a contract or agreement, or the
9 manner in which services were accessed or provided, an insurer or organ-
10 ization or corporation shall pay any undisputed portion of the claim in
11 accordance with this subsection and notify the policyholder, covered
12 person or health care provider in writing within thirty calendar days of
13 the receipt of the claim:

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

16 (2) to request all additional information needed to determine liabil-
17 ity to pay the claim or make the health care payment.

18 Upon receipt of the information requested in paragraph two of this
19 subsection or an appeal of a claim or bill for health care services
20 denied pursuant to paragraph one of this subsection, an insurer or
21 organization or corporation licensed OR CERTIFIED pursuant to article
22 forty-three OR FORTY-SEVEN of this chapter or article forty-four of the
23 public health law shall comply with subsection (a) of this section.

24 S 7. The insurance law is amended by adding a new section 3224-c to
25 read as follows:

26 S 3224-C. COORDINATION OF BENEFITS. AN INSURER OR ORGANIZATION OR
27 CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR
28 FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH
29 LAW SHALL NOT DENY A CLAIM, EITHER IN WHOLE OR IN PART, ON THE BASIS
30 THAT IT IS COORDINATING BENEFITS AND ANOTHER INSURER OR ORGANIZATION OR
31 CORPORATION OR OTHER ENTITY IS LIABLE FOR THE PAYMENT OF THE CLAIM,
32 UNLESS IT HAS A REASONABLE BASIS TO BELIEVE THAT THE INSURED HAS OTHER
33 HEALTH INSURANCE COVERAGE WHICH IS PRIMARY FOR THAT BENEFIT. IF AN
34 INSURER OR ORGANIZATION OR CORPORATION DOES NOT HAVE CURRENT INFORMATION
35 FROM THE INSURED REGARDING OTHER COVERAGE, AND REQUESTS SUCH INFORMATION
36 IN ACCORDANCE WITH SUBSECTION (B) OF SECTION THREE THOUSAND TWO HUNDRED
37 TWENTY-FOUR-A OF THIS ARTICLE, AND NO INFORMATION IS RECEIVED WITHIN
38 FORTY-FIVE DAYS, THE CLAIM SHALL BE ADJUDICATED PROVIDED, HOWEVER, THE
39 CLAIM SHALL NOT BE DENIED BASED ON THE INSURER, OR ORGANIZATION OR
40 CORPORATION NOT HAVING RECEIVED SUCH INFORMATION.

41 S 8. Subsection (c) of section 3224-a of the insurance law, as amended
42 by chapter 666 of the laws of 1997, is amended to read as follows:

43 (c) [Each] (1) EXCEPT AS PROVIDED IN PARAGRAPH TWO OF THIS SUBSECTION,
44 EACH claim or bill for health care services processed in violation of
45 this section shall constitute a separate violation. In addition to the
46 penalties provided in this chapter, any insurer or organization or
47 corporation that fails to adhere to the standards contained in this
48 section shall be obligated to pay to the health care provider or person
49 submitting the claim, in full settlement of the claim or bill for health
50 care services, the amount of the claim or health care payment plus
51 interest on the amount of such claim or health care payment of the
52 greater of the rate equal to the rate set by the commissioner of taxa-
53 tion and finance for corporate taxes pursuant to paragraph one of
54 subsection (e) of section one thousand ninety-six of the tax law or
55 twelve percent per annum, to be computed from the date the claim or
56 health care payment was required to be made. When the amount of interest

1 due on such a claim is less than two dollars, and insurer or organiza-
2 tion or corporation shall not be required to pay interest on such claim.

3 (2) WHERE A VIOLATION OF THIS SECTION IS DETERMINED BY THE SUPERINTEN-
4 DENT AS A RESULT OF THE SUPERINTENDENT'S OWN INVESTIGATION, EXAMINATION,
5 AUDIT OR INQUIRY, AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR
6 CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER
7 OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL NOT BE SUBJECT TO A
8 CIVIL PENALTY PRESCRIBED IN PARAGRAPH ONE OF THIS SUBSECTION, IF THE
9 SUPERINTENDENT DETERMINES THAT THE INSURER OR ORGANIZATION OR CORPO-
10 RATION HAS OTHERWISE PROCESSED AT LEAST NINETY-EIGHT PERCENT OF THE
11 CLAIMS SUBMITTED IN A CALENDAR YEAR IN COMPLIANCE WITH THIS SECTION;
12 PROVIDED, HOWEVER, NOTHING IN THIS PARAGRAPH SHALL LIMIT, PRECLUDE OR
13 EXEMPT AN INSURER OR ORGANIZATION OR CORPORATION FROM PAYMENT OF A CLAIM
14 AND PAYMENT OF INTEREST PURSUANT TO THIS SECTION. THIS PARAGRAPH SHALL
15 NOT APPLY TO VIOLATIONS OF THIS SECTION DETERMINED BY THE SUPERINTENDENT
16 RESULTING FROM INDIVIDUAL COMPLAINTS SUBMITTED TO THE SUPERINTENDENT BY
17 HEALTH CARE PROVIDERS OR POLICYHOLDERS.

18 S 9. Section 3224-a of the insurance law is amended by adding two new
19 subsections (g) and (h) to read as follows:

20 (G) TIME PERIOD FOR SUBMISSION OF CLAIMS. (1) EXCEPT AS OTHERWISE
21 PROVIDED BY LAW, HEALTH CARE CLAIMS MUST BE INITIALLY SUBMITTED BY
22 HEALTH CARE PROVIDERS WITHIN ONE HUNDRED TWENTY DAYS AFTER THE DATE OF
23 SERVICE TO BE VALID AND ENFORCEABLE AGAINST AN INSURER OR ORGANIZATION
24 OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR
25 ARTICLE FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC
26 HEALTH LAW. PROVIDED, HOWEVER, THAT NOTHING IN THIS SUBSECTION SHALL
27 PRECLUDE THE PARTIES FROM AGREEING TO A TIME PERIOD OR OTHER TERMS WHICH
28 ARE MORE FAVORABLE TO THE HEALTH CARE PROVIDER. PROVIDED FURTHER THAT,
29 IN CONNECTION WITH CONTRACTS BETWEEN ORGANIZATIONS OR CORPORATIONS
30 LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER OR
31 ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND HEALTH CARE PROVIDERS
32 FOR THE PROVISION OF SERVICES PURSUANT TO SECTION THREE HUNDRED
33 SIXTY-FOUR-J OR THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW
34 OR TITLE I-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, NOTHING
35 HEREIN SHALL BE DEEMED: (I) TO PRECLUDE THE PARTIES FROM AGREEING TO A
36 DIFFERENT TIME PERIOD BUT IN NO EVENT LESS THAN NINETY DAYS; OR (II) TO
37 SUPERSEDE CONTRACT PROVISIONS IN EXISTENCE AT THE TIME THIS SUBSECTION
38 TAKES EFFECT EXCEPT TO THE EXTENT THAT SUCH CONTRACTS IMPOSE A TIME
39 PERIOD OF LESS THAN NINETY DAYS.

40 (2) THIS SUBSECTION SHALL NOT ABROGATE ANY RIGHT OR REDUCE OR LIMIT
41 ANY ADDITIONAL TIME PERIOD FOR CLAIM SUBMISSION PROVIDED BY LAW OR REGU-
42 LATION SPECIFICALLY APPLICABLE TO COORDINATION OF BENEFITS IN EFFECT
43 PRIOR TO THE EFFECTIVE DATE OF THIS SUBSECTION.

44 (H) (1) AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTI-
45 FIED PURSUANT TO ARTICLE FORTY-THREE OR ARTICLE FORTY-SEVEN OF THIS
46 CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL PERMIT A
47 PARTICIPATING HEALTH CARE PROVIDER TO REQUEST RECONSIDERATION OF A CLAIM
48 THAT IS DENIED EXCLUSIVELY BECAUSE IT WAS UNTIMELY SUBMITTED PURSUANT TO
49 SUBSECTION (G) OF THIS SECTION. THE INSURER OR ORGANIZATION OR CORPO-
50 RATION SHALL PAY SUCH CLAIM PURSUANT TO THE PROVISIONS OF PARAGRAPH TWO
51 OF THIS SUBSECTION IF THE HEALTH CARE PROVIDER CAN DEMONSTRATE BOTH
52 THAT: (I) THE HEALTH CARE PROVIDER'S NON-COMPLIANCE WAS A RESULT OF AN
53 UNUSUAL OCCURRENCE; AND (II) THE HEALTH CARE PROVIDER HAS A PATTERN OR
54 PRACTICE OF TIMELY SUBMITTING CLAIMS IN COMPLIANCE WITH SUBDIVISION (G)
55 OF THIS SECTION.

1 (2) AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED
2 PURSUANT TO ARTICLE FORTY-THREE OR ARTICLE FORTY-SEVEN OF THIS CHAPTER
3 OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW MAY REDUCE THE REIMBURSE-
4 MENT DUE TO A HEALTH CARE PROVIDER FOR AN UNTIMELY CLAIM THAT OTHERWISE
5 MEETS THE REQUIREMENTS OF PARAGRAPH ONE OF THIS SUBSECTION BY AN AMOUNT
6 NOT TO EXCEED TWENTY-FIVE PERCENT OF THE AMOUNT THAT WOULD HAVE BEEN
7 PAID HAD THE CLAIM BEEN SUBMITTED IN A TIMELY MANNER; PROVIDED, HOWEVER,
8 THAT NOTHING IN THIS SUBSECTION SHALL PRECLUDE A HEALTH CARE PROVIDER
9 AND AN INSURER OR ORGANIZATION OR CORPORATION FROM AGREEING TO A LESSER
10 REDUCTION. THE PROVISIONS OF THIS SUBSECTION SHALL NOT APPLY TO ANY
11 CLAIM SUBMITTED THREE HUNDRED SIXTY-FIVE DAYS AFTER THE DATE OF SERVICE,
12 IN WHICH CASE THE INSURER OR ORGANIZATION OR CORPORATION MAY DENY THE
13 CLAIM IN FULL.

14 S 10. Subsection (b) of section 3224-b of the insurance law, as added
15 by chapter 551 of the laws of 2006, is amended to read as follows:

16 (b) Overpayments to [physicians] HEALTH CARE PROVIDERS. (1) Other
17 than recovery for duplicate payments, a health plan shall provide thirty
18 days written notice to [physicians] HEALTH CARE PROVIDERS before engag-
19 ing in additional overpayment recovery efforts seeking recovery of the
20 overpayment of claims to such [physicians] HEALTH CARE PROVIDERS. Such
21 notice shall state the patient name, service date, payment amount,
22 proposed adjustment, and a reasonably specific explanation of the
23 proposed adjustment.

24 (2) A HEALTH PLAN SHALL PROVIDE A HEALTH CARE PROVIDER WITH THE OPPOR-
25 TUNITY TO CHALLENGE AN OVERPAYMENT RECOVERY, INCLUDING THE SHARING OF
26 CLAIMS INFORMATION, AND SHALL ESTABLISH WRITTEN POLICIES AND PROCEDURES
27 FOR HEALTH CARE PROVIDERS TO FOLLOW TO CHALLENGE AN OVERPAYMENT RECOV-
28 ERY. SUCH CHALLENGE SHALL SET FORTH THE SPECIFIC GROUNDS ON WHICH THE
29 PROVIDER IS CHALLENGING THE OVERPAYMENT RECOVERY.

30 (3) A health plan shall not initiate overpayment recovery efforts more
31 than twenty-four months after the original payment was received by a
32 [physician] HEALTH CARE PROVIDER. [Provided, however, that] HOWEVER, no
33 such time limit shall apply to overpayment recovery efforts [which] THAT
34 are: (i) based on a reasonable belief of fraud or other intentional
35 misconduct, or abusive billing, (ii) required by, or initiated at the
36 request of, a self-insured plan, or (iii) required OR AUTHORIZED by a
37 state or federal government program OR COVERAGE THAT IS PROVIDED BY THIS
38 STATE OR A MUNICIPALITY THEREOF TO ITS RESPECTIVE EMPLOYEES, RETIREES OR
39 MEMBERS. Notwithstanding the aforementioned time limitations, in the
40 event that a [physician] HEALTH CARE PROVIDER asserts that a health plan
41 has underpaid a claim or claims, the health plan may defend or set off
42 such assertion of underpayment based on overpayments going back in time
43 as far as the claimed underpayment. For purposes of this paragraph,
44 "abusive billing" shall be defined as a billing practice which results
45 in the submission of claims that are not consistent with sound fiscal,
46 business, or medical practices and at such frequency and for such a
47 period of time as to reflect a consistent course of conduct.

48 (4) FOR THE PURPOSES OF THIS SUBSECTION THE TERM "HEALTH CARE PROVID-
49 ER" SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE TWEN-
50 TY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY
51 LICENSED PURSUANT TO ARTICLE NINETEEN, THIRTY-ONE OR THIRTY-TWO OF THE
52 MENTAL HYGIENE LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED
53 OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

54 [(3)] (5) Nothing in this section shall be deemed to limit [an insur-
55 er's] A HEALTH PLAN'S right to pursue recovery of overpayments that
56 occurred prior to the effective date of this section where the [insurer]

1 HEALTH PLAN has provided the [physician] HEALTH CARE PROVIDER with
2 notice of such recovery efforts prior to the effective date of this
3 section.

4 S 11. Subparagraph (B) of paragraph 2 of subsection (e) of section
5 3231 of the insurance law, as added by chapter 501 of the laws of 1992,
6 is amended to read as follows:

7 (B) Each calendar year, an insurer shall return, in the form of aggre-
8 gate benefits for each policy form filed pursuant to the alternate
9 procedure set forth in this paragraph at least seventy-five percent of
10 the aggregate premiums collected for the policy form during that calen-
11 dar year. Insurers shall annually report, no later than May first of
12 each year, the loss ratio calculated pursuant to this paragraph for each
13 such policy form for the previous calendar year. In each case where the
14 loss ratio for a policy form fails to comply with the seventy-five
15 percent loss ratio requirement, the insurer shall issue a dividend or
16 credit against future premiums for all policy holders with that policy
17 form in an amount sufficient to assure that the aggregate benefits paid
18 in the previous calendar year plus the amount of the dividends and cred-
19 its shall equal seventy-five percent of the aggregate premiums collected
20 for the policy form in the previous calendar year. The dividend or cred-
21 it shall be issued to each policy HOLDER WHO HAD A POLICY which was in
22 effect [as of December thirty-first of] AT ANY TIME DURING the applica-
23 ble year [and remains in effect as of the date the dividend or credit is
24 issued]. THE DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT
25 PREMIUMS EARNED FOR THE APPLICABLE YEAR AMONG ALL POLICY HOLDERS ELIGI-
26 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. AN INSURER SHALL MAKE A REASON-
27 ABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVIDENDS OR
28 CREDITS TO, FORMER POLICY HOLDERS ENTITLED TO THE DIVIDEND OR CREDIT.
29 AN INSURER SHALL, WITH RESPECT TO DIVIDENDS OR CREDITS TO WHICH FORMER
30 POLICY HOLDERS THAT THE INSURER IS UNABLE TO IDENTIFY AFTER A REASONABLE
31 EFFORT WOULD OTHERWISE BE ENTITLED, HAVE THE OPTION, AS DEEMED ACCEPTA-
32 BLE BY THE SUPERINTENDENT, OF PROSPECTIVELY ADJUSTING PREMIUM RATES BY
33 THE AMOUNT OF SUCH DIVIDENDS OR CREDITS, ISSUING THE AMOUNT OF SUCH
34 DIVIDENDS OR CREDITS TO EXISTING POLICY HOLDERS, DEPOSITING THE AMOUNT
35 OF SUCH DIVIDENDS OR CREDITS IN THE FUND ESTABLISHED PURSUANT TO SECTION
36 FOUR THOUSAND THREE HUNDRED TWENTY-TWO-A OF THIS CHAPTER, OR UTILIZING
37 ANY OTHER METHOD WHICH OFFSETS THE AMOUNT OF SUCH DIVIDENDS OR CREDITS.
38 All dividends and credits must be distributed by September thirtieth of
39 the year following the calendar year in which the loss ratio require-
40 ments were not satisfied. The annual report required by this paragraph
41 shall include an insurer's calculation of the dividends and credits, as
42 well as an explanation of the insurer's plan to issue dividends or cred-
43 its. The instructions and format for calculating and reporting loss
44 ratios and issuing dividends or credits shall be specified by the super-
45 intendent by regulation. Such regulations shall include provisions for
46 the distribution of a dividend or credit in the event of cancellation or
47 termination by a policy holder.

48 S 12. Subsection (i) of section 3216 of the insurance law is amended
49 by adding a new paragraph 26 to read as follows:

50 (26)(A) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE
51 FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A
52 PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY
53 ON THE BASIS THAT THE HEALTH CARE PROVIDER ADMITTING OR RENDERING
54 SERVICES TO THE INSURED IS NOT A PARTICIPATING PROVIDER.

55 (B) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR
56 HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A

1 PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS OUT-OF-NETWORK
2 SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A
3 NON-PARTICIPATING HOSPITAL.

4 (C) FOR PURPOSES OF THIS PARAGRAPH, A "HEALTH CARE PROVIDER" IS A
5 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
6 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
7 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

8 (D) FOR PURPOSES OF THIS PARAGRAPH, A "MANAGED CARE HEALTH INSURANCE
9 POLICY" IS A POLICY THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVID-
10 ER PARTICIPATING IN THE INSURER'S NETWORK IN ORDER FOR THE INSURED TO
11 RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE POLICY.

12 S 13. Subsection (k) of section 3221 of the insurance law is amended
13 by adding a new paragraph 15 to read as follows:

14 (15)(A) NO GROUP OR BLANKET MANAGED CARE HEALTH INSURANCE POLICY THAT
15 PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE
16 THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS
17 OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE PROVID-
18 ER ADMITTING OR RENDERING SERVICES TO THE INSURED IS NOT A PARTICIPATING
19 PROVIDER.

20 (B) NO GROUP OR BLANKET MANAGED CARE HEALTH INSURANCE POLICY THAT
21 PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE
22 THAT SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS
23 OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE
24 RENDERED IN A NON-PARTICIPATING HOSPITAL.

25 (C) FOR PURPOSES OF THIS PARAGRAPH, A "HEALTH CARE PROVIDER" IS A
26 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
27 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
28 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

29 (D) FOR PURPOSES OF THIS PARAGRAPH, A "MANAGED CARE HEALTH INSURANCE
30 POLICY" IS A POLICY THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVID-
31 ER PARTICIPATING IN THE INSURER'S NETWORK IN ORDER FOR THE INSURED TO
32 RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE POLICY.

33 S 14. Section 4303 of the insurance law is amended by adding a new
34 subsection (ff) to read as follows:

35 (FF) (1) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPO-
36 RATION, HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPO-
37 RATION THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE
38 SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED
39 AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE
40 PROVIDER ADMITTING OR RENDERING SERVICES TO THE INSURED IS NOT A PARTIC-
41 IPATING PROVIDER.

42 (2) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPORATION,
43 HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPORATION
44 THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL
45 PROVIDE THAT SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE
46 COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES
47 ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

48 (3) FOR PURPOSES OF THIS SUBSECTION, A "HEALTH CARE PROVIDER" IS A
49 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
50 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
51 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

52 (4) FOR PURPOSES OF THIS SUBSECTION, A "MANAGED CARE CONTRACT" IS A
53 CONTRACT THAT REQUIRES THAT SERVICES BE PROVIDED BY A PROVIDER PARTIC-
54 IPATING IN THE CORPORATION'S NETWORK IN ORDER FOR THE SUBSCRIBER TO
55 RECEIVE THE MAXIMUM LEVEL OF REIMBURSEMENT UNDER THE CONTRACT.

1 S 15. Section 4305 of the insurance law is amended by adding a new
2 subsection (1) to read as follows:

3 (1) A HEALTH CARE CLAIM FROM A SUBSCRIBER COVERED UNDER A CONTRACT
4 ISSUED PURSUANT TO THIS SECTION SHALL BE SUBMITTED WITHIN ONE HUNDRED
5 TWENTY DAYS FROM THE DATE OF SERVICE; PROVIDED, HOWEVER, THAT IF IT WAS
6 NOT REASONABLY POSSIBLE FOR THE SUBSCRIBER TO SUBMIT THE CLAIM WITHIN
7 THAT TIMEFRAME, THEN THE CLAIM SHALL BE SUBMITTED AS SOON AS REASONABLY
8 POSSIBLE.

9 S 16. Section 4306 of the insurance law is amended by adding a new
10 subsection (n) to read as follows:

11 (N) A STATEMENT THAT A HEALTH CARE CLAIM FROM A SUBSCRIBER SHALL BE
12 SUBMITTED WITHIN ONE HUNDRED TWENTY DAYS FROM THE DATE OF SERVICE;
13 PROVIDED, HOWEVER, THAT IF IT WAS NOT REASONABLY POSSIBLE FOR THE
14 SUBSCRIBER TO SUBMIT THE CLAIM WITHIN THAT TIMEFRAME, THEN THE CLAIM
15 SHALL BE SUBMITTED AS SOON AS REASONABLY POSSIBLE.

16 S 17. The insurance law is amended by adding a new section 4306-c to
17 read as follows:

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

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

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

46 S 18. Paragraph 2 of subsection (h) of section 4308 of the insurance
47 law, as added by chapter 504 of the laws of 1995, is amended to read as
48 follows:

49 (2) In each case where the loss ratio for a contract form fails to
50 comply with the eighty-five percent minimum loss ratio requirement for
51 individual direct payment contracts, or the seventy-five percent minimum
52 loss ratio requirement for small group and small group remittance
53 contracts, as set forth in paragraph one of this subsection, the corpo-
54 ration shall issue a dividend or credit against future premiums for all
55 contract holders with that contract form in an amount sufficient to
56 assure that the aggregate benefits incurred in the previous calendar

1 year plus the amount of the dividends and credits shall equal no less
2 than eighty-five percent for individual direct payment contracts, or
3 seventy-five percent for small group and small group remittance
4 contracts, of the aggregate premiums earned for the contract form in the
5 previous calendar year. The dividend or credit shall be issued to each
6 contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as
7 of December thirty-first of] AT ANY TIME DURING the applicable year [and
8 remains in effect as of the date the dividend or credit is issued]. THE
9 DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED
10 FOR THE APPLICABLE YEAR AMONG ALL CONTRACT HOLDERS OR SUBSCRIBERS ELIGI-
11 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. A CORPORATION SHALL MAKE A
12 REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVI-
13 DENDS OR CREDITS TO, FORMER CONTRACT HOLDERS OR SUBSCRIBERS ENTITLED TO
14 THE DIVIDEND OR CREDIT. A CORPORATION SHALL, WITH RESPECT TO DIVIDENDS
15 OR CREDITS TO WHICH FORMER CONTRACT HOLDERS THAT THE CORPORATION IS
16 UNABLE TO IDENTIFY AFTER A REASONABLE EFFORT WOULD OTHERWISE BE ENTI-
17 TLED, HAVE THE OPTION, AS DEEMED ACCEPTABLE BY THE SUPERINTENDENT, OF
18 PROSPECTIVELY ADJUSTING PREMIUM RATES BY THE AMOUNT OF SUCH DIVIDENDS OR
19 CREDITS, ISSUING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS TO EXISTING
20 CONTRACT HOLDERS, DEPOSITING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS IN
21 THE FUND ESTABLISHED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED
22 TWENTY-TWO-A OF THIS ARTICLE, OR UTILIZING ANY OTHER METHOD WHICH
23 OFFSETS THE AMOUNT OF SUCH DIVIDENDS OR CREDITS. All dividends and cred-
24 its must be distributed by September thirtieth of the year following the
25 calendar year in which the loss ratio requirements were not satisfied.
26 The annual report required by paragraph one of this subsection shall
27 include a corporation's calculation of the dividends and credits, as
28 well as an explanation of the corporation's plan to issue dividends or
29 credits. The instructions and format for calculating and reporting loss
30 ratios and issuing dividends or credits shall be specified by the super-
31 intendent by regulation. Such regulations shall include provisions for
32 the distribution of a dividend or credit in the event of cancellation or
33 termination by a contract holder or subscriber.

34 S 19. Subsections (g) and (h) of section 4325 of the insurance law,
35 subsection (g) as relettered by chapter 586 of the laws of 1998, are
36 relettered subsections (h) and (i) and a new subsection (g) is added to
37 read as follows:

38 (G)(1) NO INSURER SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT CHANGE TO A
39 CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE PERMITTED BY
40 THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE CHANGE, THE
41 INSURER GIVES THE HEALTH CARE PROFESSIONAL WITH WHOM THE INSURER HAS
42 DIRECTLY CONTRACTED AND WHO IS IMPACTED BY THE ADVERSE REIMBURSEMENT
43 CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF THE CHANGE. IF THE
44 CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE CHANGE THAT IS THE
45 SUBJECT OF THE NOTICE BY THE INSURER, THE HEALTH CARE PROFESSIONAL MAY,
46 WITHIN THIRTY DAYS OF THE DATE OF THE NOTICE, GIVE WRITTEN NOTICE TO THE
47 INSURER TO TERMINATE HIS OR HER CONTRACT WITH THE INSURER EFFECTIVE UPON
48 THE IMPLEMENTATION DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE
49 PURPOSES OF THIS SUBSECTION, THE TERM "ADVERSE REIMBURSEMENT CHANGE"
50 SHALL MEAN A PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A
51 MATERIAL ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH
52 CARE PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
53 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
54 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS
55 SUBSECTION SHALL NOT APPLY WHERE: (A) SUCH CHANGE IS OTHERWISE REQUIRED
56 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS

1 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR
2 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE AMERICAN
3 MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES,
4 REPORTING GUIDELINES AND CONVENTIONS; OR (B) SUCH CHANGE IS EXPRESSLY
5 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
6 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
7 OR PAYMENT POLICY INDEXING MECHANISM.

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

11 S 20. Subsection (a) of section 4803 of the insurance law, as amended
12 by chapter 551 of the laws of 2006, is amended to read as follows:

13 (a) (1) An insurer which offers a managed care product shall, upon
14 request, make available and disclose to health care professionals writ-
15 ten application procedures and minimum qualification requirements which
16 a health care professional must meet in order to be considered by the
17 insurer for participation in the in-network benefits portion of the
18 insurer's network for the managed care product. The insurer shall
19 consult with appropriately qualified health care professionals in devel-
20 oping its qualification requirements for participation in the in-network
21 benefits portion of the insurer's network for the managed care product.
22 An insurer shall complete review of the health care professional's
23 application to participate in the in-network portion of the insurer's
24 network and, within ninety days of receiving a health care profes-
25 sional's completed application to participate in the insurer's network,
26 will notify the health care professional as to [(i)]: (A) whether he or
27 she is credentialed; or [(ii)] (B) whether additional time is necessary
28 to make a determination in spite of THE insurer's best efforts or
29 because of a failure of a third party to provide necessary documenta-
30 tion, or non-routine or unusual circumstances require additional time
31 for review. In such instances where additional time is necessary
32 because of a lack of necessary documentation, an insurer shall make
33 every effort to obtain such information as soon as possible.

34 (2) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE
35 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO
36 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS
37 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF
38 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK, IS
39 NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH
40 ONE OF THIS SUBSECTION, SUCH HEALTH CARE PROFESSIONAL SHALL BE DEEMED
41 "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NETWORK
42 PORTION OF AN INSURER'S NETWORK; PROVIDED, HOWEVER, THAT A PROVISIONALLY
43 CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN INSURED'S PRIMARY
44 CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDEN-
45 TIALED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY CREDENTIALLED
46 HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH
47 DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE
48 FINAL CREDENTIALING DETERMINATION IS MADE BY THE INSURER. A HEALTH CARE
49 PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE
50 GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTIFIES THE INSURER IN
51 WRITING THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE HEALTH
52 CARE PROFESSIONAL OR THE GROUP PRACTICE: (A) SHALL REFUND ANY PAYMENTS
53 MADE BY THE INSURER FOR IN-NETWORK SERVICES PROVIDED BY THE PROVI-
54 SIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL THAT EXCEED ANY
55 OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE INSURED'S CONTRACT WITH THE
56 INSURER; AND (B) SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED, EXCEPT

1 TO COLLECT THE COPAYMENT OR COINSURANCE THAT OTHERWISE WOULD HAVE BEEN
2 PAYABLE HAD THE INSURED RECEIVED SERVICES FROM A HEALTH CARE PROFES-
3 SIONAL PARTICIPATING IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK.
4 INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED
5 TWENTY-FOUR-A OF THIS CHAPTER SHALL NOT BE ASSESSED BASED ON THE DENIAL
6 OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL
7 WAS PROVISIONALLY CREDENTIALLED; PROVIDED, HOWEVER, THAT NOTHING HEREIN
8 SHALL PREVENT AN INSURER FROM PAYING A CLAIM FROM A HEALTH CARE PROFES-
9 SIONAL WHO IS PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM.
10 AN INSURER SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED
11 BY A PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE
12 GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

13 S 21. Section 4900 of the insurance law is amended by adding a new
14 subsection (g-7) to read as follows:

15 (G-7) "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION
16 OR DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH
17 STUDY BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL
18 RESEARCH NETWORK; OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED
19 STATES RESIDENTS PER YEAR; AND (2) FOR WHICH THERE DOES NOT EXIST A
20 STANDARD HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN
21 THAT IS MORE CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR
22 TREATMENT. A PHYSICIAN, OTHER THAN THE INSURED'S TREATING PHYSICIAN,
23 SHALL CERTIFY IN WRITING THAT THE CONDITION IS A RARE DISEASE AS
24 DEFINED IN THIS SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A
25 LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN
26 THE AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED'S RARE DISEASE.
27 THE CERTIFICATION SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE
28 DISEASE IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE
29 NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK;
30 OR (2) THAT THE INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED
31 THOUSAND UNITED STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY
32 ON MEDICAL AND SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH
33 SERVICE OR PROCEDURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A
34 STATEMENT THAT, BASED ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS
35 NO STANDARD TREATMENT THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO
36 THE INSURED THAN THE REQUESTED HEALTH SERVICE OR PROCEDURE AND THE
37 REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE INSURED
38 IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO
39 THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE.
40 THE CERTIFYING PHYSICIAN SHALL DISCLOSE ANY MATERIAL FINANCIAL OR
41 PROFESSIONAL RELATIONSHIP WITH THE PROVIDER OF THE REQUESTED HEALTH
42 SERVICE OR PROCEDURE AS PART OF THE APPLICATION FOR EXTERNAL APPEAL OF
43 DENIAL OF A RARE DISEASE TREATMENT. IF THE PROVISION OF THE REQUESTED
44 HEALTH SERVICE OR PROCEDURE AT A HEALTH CARE FACILITY REQUIRES PRIOR
45 APPROVAL OF AN INSTITUTIONAL REVIEW BOARD, AN INSURED OR INSURED'S
46 DESIGNEE SHALL ALSO SUBMIT SUCH APPROVAL AS PART OF THE EXTERNAL APPEAL
47 APPLICATION.

48 S 22. Subsection (c) of section 4903 of the insurance law, as added by
49 chapter 705 of the laws of 1996, is amended to read as follows:

50 (c) A utilization review agent shall make a determination involving
51 continued or extended health care services, [or] additional services for
52 an insured undergoing a course of continued treatment prescribed by a
53 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-
54 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination
55 to the insured or the insured's designee, which may be satisfied by
56 notice to the insured's health care provider, by telephone and in writ-

1 ing within one business day of receipt of the necessary information
2 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT
3 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY
4 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND
5 OR HOLIDAY. Notification of continued or extended services shall
6 include the number of extended services approved, the new total of
7 approved services, the date of onset of services and the next review
8 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL
9 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR
10 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS
11 SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF
12 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME
13 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW
14 AGENT IS PENDING.

15 S 23. Subsection (b) of section 4904 of the insurance law, as added by
16 chapter 705 of the laws of 1996, paragraph 2 as amended by chapter 586
17 of the laws of 1998, is amended to read as follows:

18 (b) A utilization review agent shall establish an expedited appeal
19 process for appeal of an adverse determination involving (1) continued
20 or extended health care services, procedures or treatments or additional
21 services for an insured undergoing a course of continued treatment
22 prescribed by a health care provider or HOME HEALTH CARE SERVICES
23 FOLLOWING DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO
24 SUBSECTION (C) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTI-
25 CLE OR (2) an adverse determination in which the health care provider
26 believes an immediate appeal is warranted except any retrospective
27 determination. Such process shall include mechanisms which facilitate
28 resolution of the appeal including but not limited to the sharing of
29 information from the insured's health care provider and the utilization
30 review agent by telephonic means or by facsimile. The utilization review
31 agent shall provide reasonable access to its clinical peer reviewer
32 within one business day of receiving notice of the taking of an expe-
33 dited appeal. Expedited appeals shall be determined within two business
34 days of receipt of necessary information to conduct such appeal. Expe-
35 dited appeals which do not result in a resolution satisfactory to the
36 appealing party may be further appealed through the standard appeal
37 process, or through the external appeal process pursuant to section four
38 thousand nine hundred fourteen of this article as applicable.

39 S 24. Section 4906 of the insurance law, as amended by chapter 586 of
40 the laws of 1998, is amended to read as follows:

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

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

50 S 25. The opening paragraph of subsection (b) of section 4910 of the
51 insurance law, as added by chapter 586 of the laws of 1998, is amended
52 to read as follows:

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

1 S 26. Subparagraphs (B) and (C) of paragraph 2 of subsection (b) of
2 section 4910 of the insurance law, as added by chapter 586 of the laws
3 of 1998, are amended to read as follows:

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

11 (C) the insured's attending physician, who must be a licensed, board-
12 certified or board-eligible physician qualified to practice in the area
13 of practice appropriate to treat the insured's life-threatening or disa-
14 bling condition or disease, must have recommended either (a) a health
15 service or procedure (including a pharmaceutical product within the
16 meaning of subparagraph (B) of paragraph two of subsection (e) of
17 section four thousand nine hundred of this article) that, based on two
18 documents from the available medical and scientific evidence, is likely
19 to be more beneficial to the insured than any covered standard health
20 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE
21 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION FOUR
22 THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE
23 INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN MAY
24 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO
25 BENEFIT THE INSURED IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND
26 THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH
27 SERVICE OR PROCEDURE; or (b) a clinical trial for which the insured is
28 eligible. Any physician certification provided under this section shall
29 include a statement of the evidence relied upon by the physician in
30 certifying his or her recommendation, and

31 S 27. Paragraphs 2 and 3 of subsection (b) of section 4914 of the
32 insurance law, as added by chapter 586 of the laws of 1998, are amended
33 to read as follows:

34 (2) The external appeal agent shall make a determination with regard
35 to the appeal within thirty days of the receipt of the [insured's]
36 request therefor, submitted in accordance with the superintendent's
37 instructions. The external appeal agent shall have the opportunity to
38 request additional information from the insured, the insured's health
39 care provider and the insured's health care plan within such thirty-day
40 period, in which case the agent shall have up to five additional busi-
41 ness days if necessary to make such determination. The external appeal
42 agent shall notify the insured, THE INSURED'S HEALTH CARE PROVIDER WHERE
43 APPROPRIATE, and the health care plan, in writing, of the appeal deter-
44 mination within two business days of the rendering of such determi-
45 nation.

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

1 S 28. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of
2 subsection (b) of section 4914 of the insurance law, as added by chapter
3 586 of the laws of 1998, is amended to read as follows:

4 (a) that the patient costs of the proposed health service or procedure
5 shall be covered by the health care plan either: when a majority of the
6 panel of reviewers determines, BASED upon review of the applicable
7 medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES,
8 THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION
9 FOUR THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS
10 THE INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN
11 MAY PRESENT (or upon confirmation that the recommended treatment is a
12 clinical trial), the insured's medical record, and any other pertinent
13 information, that the proposed health service or treatment (including a
14 pharmaceutical product within the meaning of subparagraph (B) of para-
15 graph two of subsection (e) of section four thousand nine hundred of
16 this article is likely to be more beneficial than any standard treatment
17 or treatments for the insured's life-threatening or disabling condition
18 or disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR
19 PROCEDURE IS LIKELY TO BENEFIT THE INSURED IN THE TREATMENT OF THE
20 INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS
21 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a
22 clinical trial, is likely to benefit the insured in the treatment of the
23 insured's condition or disease); or when a reviewing panel is evenly
24 divided as to a determination concerning coverage of the health service
25 or procedure, or

26 S 29. Subsection (d) of section 4914 of the insurance law, as added by
27 chapter 586 of the laws of 1998, is amended to read as follows:

28 (d) [Payment] (1) EXCEPT AS PROVIDED IN PARAGRAPHS TWO AND THREE OF
29 THIS SUBSECTION, PAYMENT for an external appeal shall be the responsi-
30 bility of the health care plan. The health care plan shall make payment
31 to the external appeal agent within forty-five days, from the date the
32 appeal determination is received by the health care plan, and the health
33 care plan shall be obligated to pay such amount together with interest
34 thereon calculated at a rate which is the greater of the rate set by the
35 commissioner of taxation and finance for corporate taxes pursuant to
36 paragraph one of subsection (e) of section one thousand ninety-six of
37 the tax law or twelve percent per annum, to be computed from the date
38 the bill was required to be paid, in the event that payment is not made
39 within such forty-five days.

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

46 (3) IF AN INSURED'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL
47 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT
48 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE
49 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND
50 THE INSURED'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL AND
51 SHALL BE MADE BY THE HEALTH CARE PLAN AND THE INSURED'S HEALTH CARE
52 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS
53 SET FORTH IN PARAGRAPH ONE OF THIS SUBSECTION; PROVIDED, HOWEVER, THAT
54 THE SUPERINTENDENT MAY, UPON A DETERMINATION THAT HEALTH CARE PLANS OR
55 HEALTH CARE PROVIDERS ARE EXPERIENCING A SUBSTANTIAL HARDSHIP AS A
56 RESULT OF PAYMENT FOR THE EXTERNAL APPEAL WHEN THE EXTERNAL APPEAL AGENT

1 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, IN CONSULTATION
2 WITH THE COMMISSIONER OF HEALTH, PROMULGATE REGULATIONS TO LIMIT SUCH
3 HARDSHIP.

4 (4) IF AN INSURED'S HEALTH CARE PROVIDER WAS ACTING AS THE INSURED'S
5 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
6 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
7 ON A STANDARD FORM DEVELOPED BY THE SUPERINTENDENT IN CONSULTATION WITH
8 THE COMMISSIONER OF HEALTH PURSUANT TO SUBSECTION (E) OF THIS SECTION.
9 THE SUPERINTENDENT SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL
10 APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECES-
11 SARY, IN WHICH CASE THE SUPERINTENDENT SHALL MAKE AT LEAST TWO WRITTEN
12 REQUESTS TO THE INSURED TO CONFIRM THE DESIGNATION. THE INSURED SHALL
13 HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE INSURED FAILS TO
14 RESPOND TO THE SUPERINTENDENT WITHIN THE SPECIFIED TIMEFRAME, THE SUPER-
15 INTENDENT SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
16 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
17 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
18 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT'S REQUESTS
19 WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL REJECT THE
20 APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE SUPERINTENDENT'S
21 REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE IN ACCORDANCE
22 WITH PARAGRAPHS TWO AND THREE OF THIS SUBSECTION.

23 S 30. The insurance law is amended by adding a new section 4917 to
24 read as follows:

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

31 S 31. Subdivisions 3 and 4 of section 4406 of the public health law,
32 subdivision 3 as renumbered by chapter 538 of the laws of 1993, are
33 renumbered subdivisions 4 and 5 and a new subdivision 3 is added to read
34 as follows:

35 3. (A) NO CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL PROVIDE THAT
36 SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK
37 SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE PROVIDER ADMITTING OR
38 RENDERING SERVICES TO THE ENROLLEE IS NOT A PARTICIPATING PROVIDER.

39 (B) NO CONTRACT ISSUED PURSUANT TO THIS SECTION SHALL PROVIDE THAT
40 SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS
41 OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE
42 RENDERED IN A NON-PARTICIPATING HOSPITAL.

43 (C) FOR PURPOSES OF THIS SUBDIVISION, A "HEALTH CARE PROVIDER" IS A
44 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
45 TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPAR-
46 ABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

47 S 32. Subdivision 5-c of section 4406-c of the public health law is
48 relettered subdivision 5-d and a new subdivision 5-c is added to read as
49 follows:

50 5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT
51 CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE
52 PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE
53 CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH
54 WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY
55 THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF
56 THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE

1 CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE
2 HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE
3 NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR
4 HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION
5 DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS
6 SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A
7 PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A MATERIAL
8 ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH CARE
9 PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A
10 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO
11 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS
12 SUBDIVISION SHALL NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED
13 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS
14 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR
15 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE AMERICAN
16 MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES,
17 REPORTING GUIDELINES AND CONVENTIONS; OR (II) SUCH CHANGE IS EXPRESSLY
18 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR
19 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY
20 OR PAYMENT POLICY INDEXING MECHANISM.

21 (B) NOTHING IN THIS SUBDIVISION SHALL CREATE A PRIVATE RIGHT OF ACTION
22 ON BEHALF OF A HEALTH CARE PROFESSIONAL AGAINST A HEALTH CARE PLAN FOR
23 VIOLATIONS OF THIS SUBDIVISION.

24 S 33. Subdivision 1 of section 4406-d of the public health law, as
25 amended by chapter 551 of the laws of 2006, is amended to read as
26 follows:

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

45 (B) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE
46 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO
47 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS
48 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF
49 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S
50 NETWORK, IS NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO
51 PARAGRAPH (A) OF THIS SUBDIVISION, THE HEALTH CARE PROFESSIONAL SHALL BE
52 DEEMED "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NET-
53 WORK PORTION OF THE HEALTH CARE PLAN'S NETWORK; PROVIDED, HOWEVER, THAT
54 A PROVISIONALLY CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN
55 ENROLLEE'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS
56 BEEN FULLY CREDENTIALLED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY

1 CREDENTIALLED HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING
2 THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST
3 UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE HEALTH CARE
4 PLAN. A HEALTH CARE PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL
5 CREDENTIALING IF THE GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTI-
6 FIES THE HEALTH CARE PLAN IN WRITING THAT, SHOULD THE APPLICATION ULTI-
7 MATELY BE DENIED, THE HEALTH CARE PROFESSIONAL OR THE GROUP PRACTICE:
8 (I) SHALL REFUND ANY PAYMENTS MADE BY THE HEALTH CARE PLAN FOR IN-NET-
9 WORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALLED HEALTH CARE
10 PROFESSIONAL THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE
11 ENROLLEE'S CONTRACT WITH THE HEALTH CARE PLAN; AND (II) SHALL NOT PURSUE
12 REIMBURSEMENT FROM THE ENROLLEE, EXCEPT TO COLLECT THE COPAYMENT THAT
13 OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE ENROLLEE RECEIVED SERVICES
14 FROM A HEALTH CARE PROFESSIONAL PARTICIPATING IN THE IN-NETWORK PORTION
15 OF A HEALTH CARE PLAN'S NETWORK. INTEREST AND PENALTIES PURSUANT TO
16 SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW
17 SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING
18 THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL WAS PROVISIONALLY CREDEN-
19 TIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT A HEALTH
20 CARE PLAN FROM PAYING A CLAIM FROM A HEALTH CARE PROFESSIONAL WHO IS
21 PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM. A HEALTH CARE
22 PLAN SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A
23 PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND
24 THAT THE CLAIM WAS NOT TIMELY FILED.

25 S 34. Section 4900 of the public health law is amended by adding a new
26 subdivision 7-g to read as follows:

27 7-G. "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION OR
28 DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY
29 BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH
30 NETWORK OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED STATES
31 RESIDENTS PER YEAR, AND (2) FOR WHICH THERE DOES NOT EXIST A STANDARD
32 HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN THAT IS MORE
33 CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR TREATMENT. A
34 PHYSICIAN, OTHER THAN THE ENROLLEE'S TREATING PHYSICIAN, SHALL CERTIFY
35 IN WRITING THAT THE CONDITION IS A RARE DISEASE AS DEFINED IN THIS
36 SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A LICENSED, BOARD-CERTI-
37 FIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN THE AREA OF PRACTICE
38 APPROPRIATE TO TREAT THE ENROLLEE'S RARE DISEASE. THE CERTIFICATION
39 SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE DISEASE IS CURRENTLY
40 OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE NATIONAL INSTITUTES OF
41 HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK; OR (2) THAT THE
42 INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED
43 STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY ON MEDICAL AND
44 SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH SERVICE OR PROCE-
45 DURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A STATEMENT THAT, BASED
46 ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS NO STANDARD TREATMENT
47 THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO THE ENROLLEE THAN THE
48 REQUESTED HEALTH SERVICE OR PROCEDURE AND THE REQUESTED HEALTH SERVICE
49 OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE
50 ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS
51 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE. THE CERTIFYING PHYSICIAN
52 SHALL DISCLOSE ANY MATERIAL FINANCIAL OR PROFESSIONAL RELATIONSHIP WITH
53 THE PROVIDER OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AS PART OF THE
54 APPLICATION FOR EXTERNAL APPEAL OF DENIAL OF A RARE DISEASE TREATMENT.
55 IF THE PROVISION OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AT A
56 HEALTH CARE FACILITY REQUIRES PRIOR APPROVAL OF AN INSTITUTIONAL REVIEW

1 BOARD, AN ENROLLEE OR ENROLLEE'S DESIGNEE SHALL ALSO SUBMIT SUCH
2 APPROVAL AS PART OF THE EXTERNAL APPEAL APPLICATION.

3 S 35. Subdivision 3 of section 4903 of the public health law, as added
4 by chapter 705 of the laws of 1996, is amended to read as follows:

5 3. A utilization review agent shall make a determination involving
6 continued or extended health care services, [or] additional services for
7 an enrollee undergoing a course of continued treatment prescribed by a
8 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-
9 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination
10 to the enrollee or the enrollee's designee, which may be satisfied by
11 notice to the enrollee's health care provider, by telephone and in writ-
12 ing within one business day of receipt of the necessary information
13 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT
14 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY
15 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND
16 OR HOLIDAY. Notification of continued or extended services shall
17 include the number of extended services approved, the new total of
18 approved services, the date of onset of services and the next review
19 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL
20 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR
21 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS
22 SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF
23 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME
24 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW
25 AGENT IS PENDING.

26 S 36. Subdivision 2 of section 4904 of the public health law, as added
27 by chapter 705 of the laws of 1996, paragraph (b) as amended by chapter
28 586 of the laws of 1998, is amended to read as follows:

29 2. A utilization review agent shall establish an expedited appeal
30 process for appeal of an adverse determination involving:

31 (a) continued or extended health care services, procedures or treat-
32 ments or additional services for an enrollee undergoing a course of
33 continued treatment prescribed by a health care provider HOME HEALTH
34 CARE SERVICES FOLLOWING DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION
35 PURSUANT TO SUBDIVISION THREE OF SECTION FORTY-NINE HUNDRED THREE OF
36 THIS ARTICLE; or

37 (b) an adverse determination in which the health care provider
38 believes an immediate appeal is warranted except any retrospective
39 determination. Such process shall include mechanisms which facilitate
40 resolution of the appeal including but not limited to the sharing of
41 information from the enrollee's health care provider and the utilization
42 review agent by telephonic means or by facsimile. The utilization review
43 agent shall provide reasonable access to its clinical peer reviewer
44 within one business day of receiving notice of the taking of an expe-
45 dited appeal. Expedited appeals shall be determined within two business
46 days of receipt of necessary information to conduct such appeal. Expe-
47 dited appeals which do not result in a resolution satisfactory to the
48 appealing party may be further appealed through the standard appeal
49 process, or through the external appeal process pursuant to section
50 forty-nine hundred fourteen of this article as applicable.

51 S 37. Section 4906 of the public health law, as amended by chapter 586
52 of the laws of 1998, is amended to read as follows:

53 S 4906. Waiver. 1. Any agreement which purports to waive, limit,
54 disclaim, or in any way diminish the rights set forth in this article,
55 except as provided pursuant to section four thousand nine hundred ten of
56 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 38. 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 39. 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, IN THE CASE OF A RARE DISEASE, BASED ON THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROLLEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE; or (b) a clinical trial 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 40. 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 41. 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, BASED upon review of the applicable medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES, THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROLLEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY PRESENT (or upon confirmation that the recommended treatment is a clinical trial), 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, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a clinical trial, 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 42. 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

1 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE
2 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND
3 THE ENROLLEE'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL
4 AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE
5 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS
6 SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION; PROVIDED, HOWEVER, THAT
7 THE COMMISSIONER MAY, UPON A DETERMINATION BY THE SUPERINTENDENT OF
8 INSURANCE THAT HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENC-
9 ING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL
10 APPEAL WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S
11 DETERMINATION IN PART, IN CONSULTATION WITH THE SUPERINTENDENT, PROMUL-
12 GATE REGULATIONS TO LIMIT SUCH HARDSHIP.

13 (D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S
14 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH
15 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED
16 ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH
17 THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS
18 SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON
19 RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST
20 OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT OF
21 INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO
22 CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO
23 EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTEN-
24 DENT OF INSURANCE WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF
25 INSURANCE SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO
26 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE
27 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE
28 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE
29 REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE
30 SHALL REJECT THE APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE
31 SUPERINTENDENT'S REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE
32 IN ACCORDANCE WITH PARAGRAPHS (B) AND (C) OF THIS SUBDIVISION.

33 S 43. The public health law is amended by adding a new section 4917 to
34 read as follows:

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

41 S 44. Subdivision 2 of section 20 of chapter 451 of the laws of 2007,
42 amending the public health law, the social services law and the insur-
43 ance law relating to providing enhanced consumer and provider
44 protections, is amended to read as follows:

45 2. sections two, three and twelve of this act shall take effect on
46 January 1, 2008; provided, however, that subparagraph (iii) of paragraph
47 (1) of subsection (a) of section 3238 of the insurance law as added in
48 section twelve of this act shall expire and be deemed repealed December
49 31, [2009] 2011;

50 S 45. Intentionally omitted.

51 S 46. Intentionally omitted.

52 S 47. Intentionally omitted.

53 S 48. This act shall take effect January 1, 2010; provided, however,
54 that:

55 1. sections twenty and thirty-three of this act shall take effect
56 October 1, 2009, and shall apply to applications submitted after that

1 date, and shall not apply to applications submitted prior to such date
2 if such application is resubmitted in substantially similar form on or
3 after October 1, 2009;
4 2. provided, further, that the amendments to subsection (i) of section
5 3217-b of the insurance law made by section three of this act shall not
6 affect the repeal of such subsection and shall be deemed repealed there-
7 with;
8 3. provided, further, that the amendments to subsection (i) of section
9 4325 of the insurance law made by section nineteen of this act shall not
10 affect the repeal of such subsection and shall be deemed repealed there-
11 with;
12 4. provided, further, that the amendments to subdivision 5-d of
13 section 4406-c of the public health law made by section thirty-two of
14 this act shall not affect the repeal of such subdivision and shall be
15 deemed repealed therewith;
16 5. provided further that sections eight and forty-four of this act
17 shall take effect immediately;
18 6. provided further that section nine of this act shall apply to dates
19 of service on or after April 1, 2010; and
20 7. provided further that sections two, four, five, fifteen, sixteen
21 and seventeen of this act shall take effect January 1, 2011.