

6016

2009-2010 Regular Sessions

I N   S E N A T E

June 19, 2009

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Introduced by Sen. BRESLIN -- 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:  
16    (G) PROOFS OF LOSS: Written proof of loss must be furnished to the  
17    insurer at its said office in case of claim for loss for which this  
18    policy provides any periodic payment contingent upon continuing loss  
19    within ninety days after the termination of the period for which the

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

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1 insurer is liable and in case of claim for any other loss within [nine-  
2 ty] ONE HUNDRED TWENTY days after the date of such loss. Failure to  
3 furnish such proof within the time required shall not invalidate nor  
4 reduce any claim if it was not reasonably possible to give proof within  
5 such time, provided such proof is furnished as soon as reasonably possi-  
6 ble and in no event, except in the absence of legal capacity, later than  
7 one year from the time proof is otherwise required.

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

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

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

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

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

50 (B) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES AN  
51 EXCLUSIVE NETWORK OF PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS  
52 NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION  
53 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER SHALL  
54 PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIRE-  
55 MENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR,  
56 SUBSECTION (G-6) OF SECTION FOUR THOUSAND NINE HUNDRED, SUBSECTION (A-1)

1 OF SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF  
2 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH  
3 FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF  
4 THIS CHAPTER.

5 (C) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A  
6 NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT  
7 AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE  
8 OF THIS CHAPTER AND REQUIRES THAT SPECIALTY CARE BE PROVIDED PURSUANT TO  
9 A REFERRAL FROM A PRIMARY CARE PROVIDER SHALL PROVIDE ACCESS TO SUCH  
10 SPECIALTY CARE CONSISTENT WITH THE REQUIREMENTS OF SUBSECTIONS (B), (C)  
11 AND (D) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER;  
12 PROVIDED HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED TO REQUIRE THAT  
13 AN INSURER, OR A PRIMARY CARE PROVIDER ON BEHALF OF THE INSURER, MAKE A  
14 REFERRAL TO A PROVIDER THAT IS NOT IN THE INSURER'S NETWORK.

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

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

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

35 S 6. The opening paragraph and subsections (a) and (b) of section  
36 3224-a of the insurance law, as amended by chapter 666 of the laws of  
37 1997, are amended to read as follows:

38 In the processing of all health care claims submitted under contracts  
39 or agreements issued or entered into pursuant to THIS ARTICLE AND arti-  
40 cles [thirty-two,] forty-two [and], forty-three AND FORTY-SEVEN of this  
41 chapter and article forty-four of the public health law and all bills  
42 for health care services rendered by health care providers pursuant to  
43 such contracts or agreements, any insurer or organization or corporation  
44 licensed or certified pursuant to article forty-three OR FORTY-SEVEN of  
45 this chapter or article forty-four of the public health law shall adhere  
46 to the following standards:

47 (a) Except in a case where the obligation of an insurer or an organ-  
48 ization or corporation licensed or certified pursuant to article forty-  
49 three OR FORTY-SEVEN of this chapter or article forty-four of the public  
50 health law to pay a claim submitted by a policyholder or person covered  
51 under such policy ("COVERED PERSON") or make a payment to a health care  
52 provider is not reasonably clear, or when there is a reasonable basis  
53 supported by specific information available for review by the super-  
54 intendent that such claim or bill for health care services rendered was  
55 submitted fraudulently, such insurer or organization or corporation  
56 shall pay the claim to a policyholder or covered person or make a

1 payment to a health care provider within [forty-five] THIRTY days of  
2 receipt of a claim or bill for services rendered THAT IS TRANSMITTED VIA  
3 THE INTERNET OR ELECTRONIC MAIL, OR FORTY-FIVE DAYS OF RECEIPT OF A  
4 CLAIM OR BILL FOR SERVICES RENDERED THAT IS SUBMITTED BY OTHER MEANS,  
5 SUCH AS PAPER OR FACSIMILE.

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

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

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

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

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

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

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

48 (c) [Each] (1) EXCEPT AS PROVIDED IN PARAGRAPH TWO OF THIS SUBSECTION,  
49 EACH claim or bill for health care services processed in violation of  
50 this section shall constitute a separate violation. In addition to the  
51 penalties provided in this chapter, any insurer or organization or  
52 corporation that fails to adhere to the standards contained in this  
53 section shall be obligated to pay to the health care provider or person  
54 submitting the claim, in full settlement of the claim or bill for health  
55 care services, the amount of the claim or health care payment plus  
56 interest on the amount of such claim or health care payment of the

1 greater of the rate equal to the rate set by the commissioner of taxa-  
2 tion and finance for corporate taxes pursuant to paragraph one of  
3 subsection (e) of section one thousand ninety-six of the tax law or  
4 twelve percent per annum, to be computed from the date the claim or  
5 health care payment was required to be made. When the amount of interest  
6 due on such a claim is less than two dollars, and insurer or organiza-  
7 tion or corporation shall not be required to pay interest on such claim.

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

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

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

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

49 (H) (1) AN INSURER OR ORGANIZATION OR CORPORATION LICENSED OR CERTI-  
50 FIED PURSUANT TO ARTICLE FORTY-THREE OR ARTICLE FORTY-SEVEN OF THIS  
51 CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL PERMIT A  
52 PARTICIPATING HEALTH CARE PROVIDER TO REQUEST RECONSIDERATION OF A CLAIM  
53 THAT IS DENIED EXCLUSIVELY BECAUSE IT WAS UNTIMELY SUBMITTED PURSUANT TO  
54 SUBSECTION (G) OF THIS SECTION. THE INSURER OR ORGANIZATION OR CORPO-  
55 RATION SHALL PAY SUCH CLAIM PURSUANT TO THE PROVISIONS OF PARAGRAPH TWO  
56 OF THIS SUBSECTION IF THE HEALTH CARE PROVIDER CAN DEMONSTRATE BOTH

1 THAT: (I) THE HEALTH CARE PROVIDER'S NON-COMPLIANCE WAS A RESULT OF AN  
2 UNUSUAL OCCURRENCE; AND (II) THE HEALTH CARE PROVIDER HAS A PATTERN OR  
3 PRACTICE OF TIMELY SUBMITTING CLAIMS IN COMPLIANCE WITH SUBDIVISION (G)  
4 OF THIS SECTION.

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

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

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

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

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

52 (4) FOR THE PURPOSES OF THIS SUBSECTION THE TERM "HEALTH CARE PROVID-  
53 ER" SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE TWEN-  
54 TY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY  
55 LICENSED PURSUANT TO ARTICLE NINETEEN, THIRTY-ONE OR THIRTY-TWO OF THE

1 MENTAL HYGIENE LAW, OR A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED  
2 OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

3 [(3)] (5) Nothing in this section shall be deemed to limit [an insurer's]  
4 A HEALTH PLAN'S right to pursue recovery of overpayments that  
5 occurred prior to the effective date of this section where the [insurer]  
6 HEALTH PLAN has provided the [physician] HEALTH CARE PROVIDER with  
7 notice of such recovery efforts prior to the effective date of this  
8 section.

9 S 11. Subparagraph (B) of paragraph 2 of subsection (e) of section  
10 3231 of the insurance law, as added by chapter 501 of the laws of 1992,  
11 is amended to read as follows:

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

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

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

1 PARTICIPATING HOSPITAL WILL BE COVERED AS OUT-OF-NETWORK SERVICES SOLELY  
2 ON THE BASIS THAT THE HEALTH CARE PROVIDER ADMITTING OR RENDERING  
3 SERVICES TO THE INSURED IS NOT A PARTICIPATING PROVIDER.

4 (B) NO MANAGED CARE HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE FOR  
5 HOSPITAL, MEDICAL OR SURGICAL CARE SHALL PROVIDE THAT SERVICES OF A  
6 PARTICIPATING HEALTH CARE PROVIDER WILL BE COVERED AS OUT-OF-NETWORK  
7 SERVICES SOLELY ON THE BASIS THAT THE SERVICES ARE RENDERED IN A  
8 NON-PARTICIPATING HOSPITAL.

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

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

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

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

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

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

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

38 S 13-a. The insurance law is amended by adding a new section 3241 to  
39 read as follows:

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

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

55 (FF) (1) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPO-  
56 RATION, HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPO-

1 RATION THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE  
2 SHALL PROVIDE THAT SERVICES OF A PARTICIPATING HOSPITAL WILL BE COVERED  
3 AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE HEALTH CARE  
4 PROVIDER ADMITTING OR RENDERING SERVICES TO THE INSURED IS NOT A PARTIC-  
5 IPATING PROVIDER.

6 (2) NO MANAGED CARE CONTRACT ISSUED BY A HEALTH SERVICE CORPORATION,  
7 HOSPITAL SERVICE CORPORATION OR MEDICAL EXPENSE INDEMNITY CORPORATION  
8 THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL CARE SHALL  
9 PROVIDE THAT SERVICES OF A PARTICIPATING HEALTH CARE PROVIDER WILL BE  
10 COVERED AS OUT-OF-NETWORK SERVICES SOLELY ON THE BASIS THAT THE SERVICES  
11 ARE RENDERED IN A NON-PARTICIPATING HOSPITAL.

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

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

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

22 (1) A HEALTH CARE CLAIM FROM A SUBSCRIBER COVERED UNDER A CONTRACT  
23 ISSUED PURSUANT TO THIS SECTION SHALL BE SUBMITTED WITHIN ONE HUNDRED  
24 TWENTY DAYS FROM THE DATE OF SERVICE; PROVIDED, HOWEVER, THAT IF IT WAS  
25 NOT REASONABLY POSSIBLE FOR THE SUBSCRIBER TO SUBMIT THE CLAIM WITHIN  
26 THAT TIMEFRAME, THEN THE CLAIM SHALL BE SUBMITTED AS SOON AS REASONABLY  
27 POSSIBLE.

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

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

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

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

45 (B) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFITS  
46 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT  
47 ISSUES A COMPREHENSIVE CONTRACT THAT UTILIZES AN EXCLUSIVE NETWORK OF  
48 PROVIDERS WITHOUT AN OUT-OF-NETWORK OPTION AND IS NOT A MANAGED CARE  
49 HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR  
50 THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO  
51 OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION

52 (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR, SUBSECTION (G-6) OF  
53 SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTION (A-1) OF  
54 SECTION FOUR THOUSAND NINE HUNDRED FOUR, PARAGRAPH THREE OF SUBSECTION  
55 (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN, AND PARAGRAPH FOUR OF

1 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS  
2 CHAPTER.

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

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

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

26 (2) In each case where the loss ratio for a contract form fails to  
27 comply with the eighty-five percent minimum loss ratio requirement for  
28 individual direct payment contracts, or the seventy-five percent minimum  
29 loss ratio requirement for small group and small group remittance  
30 contracts, as set forth in paragraph one of this subsection, the corpo-  
31 ration shall issue a dividend or credit against future premiums for all  
32 contract holders with that contract form in an amount sufficient to  
33 assure that the aggregate benefits incurred in the previous calendar  
34 year plus the amount of the dividends and credits shall equal no less  
35 than eighty-five percent for individual direct payment contracts, or  
36 seventy-five percent for small group and small group remittance  
37 contracts, of the aggregate premiums earned for the contract form in the  
38 previous calendar year. The dividend or credit shall be issued to each  
39 contract HOLDER OR SUBSCRIBER WHO HAD A CONTRACT that was in effect [as  
40 of December thirty-first of] AT ANY TIME DURING the applicable year [and  
41 remains in effect as of the date the dividend or credit is issued]. THE  
42 DIVIDEND OR CREDIT SHALL BE PRORATED BASED ON THE DIRECT PREMIUMS EARNED  
43 FOR THE APPLICABLE YEAR AMONG ALL CONTRACT HOLDERS OR SUBSCRIBERS ELIGI-  
44 BLE TO RECEIVE SUCH DIVIDEND OR CREDIT. A CORPORATION SHALL MAKE A  
45 REASONABLE EFFORT TO IDENTIFY THE CURRENT ADDRESS OF, AND ISSUE DIVI-  
46 DENDS OR CREDITS TO, FORMER CONTRACT HOLDERS OR SUBSCRIBERS ENTITLED TO  
47 THE DIVIDEND OR CREDIT. A CORPORATION SHALL, WITH RESPECT TO DIVIDENDS  
48 OR CREDITS TO WHICH FORMER CONTRACT HOLDERS THAT THE CORPORATION IS  
49 UNABLE TO IDENTIFY AFTER A REASONABLE EFFORT WOULD OTHERWISE BE ENTI-  
50 TLED, HAVE THE OPTION, AS DEEMED ACCEPTABLE BY THE SUPERINTENDENT, OF  
51 PROSPECTIVELY ADJUSTING PREMIUM RATES BY THE AMOUNT OF SUCH DIVIDENDS OR  
52 CREDITS, ISSUING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS TO EXISTING  
53 CONTRACT HOLDERS, DEPOSITING THE AMOUNT OF SUCH DIVIDENDS OR CREDITS IN  
54 THE FUND ESTABLISHED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED  
55 TWENTY-TWO-A OF THIS ARTICLE, OR UTILIZING ANY OTHER METHOD WHICH  
56 OFFSETS THE AMOUNT OF SUCH DIVIDENDS OR CREDITS. All dividends and cred-

1 its must be distributed by September thirtieth of the year following the  
2 calendar year in which the loss ratio requirements were not satisfied.  
3 The annual report required by paragraph one of this subsection shall  
4 include a corporation's calculation of the dividends and credits, as  
5 well as an explanation of the corporation's plan to issue dividends or  
6 credits. The instructions and format for calculating and reporting loss  
7 ratios and issuing dividends or credits shall be specified by the super-  
8 intendent by regulation. Such regulations shall include provisions for  
9 the distribution of a dividend or credit in the event of cancellation or  
10 termination by a contract holder or subscriber.

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

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

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

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

46 (a) (1) An insurer which offers a managed care product shall, upon  
47 request, make available and disclose to health care professionals writ-  
48 ten application procedures and minimum qualification requirements which  
49 a health care professional must meet in order to be considered by the  
50 insurer for participation in the in-network benefits portion of the  
51 insurer's network for the managed care product. The insurer shall  
52 consult with appropriately qualified health care professionals in devel-  
53 oping its qualification requirements for participation in the in-network  
54 benefits portion of the insurer's network for the managed care product.  
55 An insurer shall complete review of the health care professional's  
56 application to participate in the in-network portion of the insurer's

1 network and, within ninety days of receiving a health care profes-  
2 sional's completed application to participate in the insurer's network,  
3 will notify the health care professional as to [(i)]: (A) whether he or  
4 she is credentialed; or [(ii)] (B) whether additional time is necessary  
5 to make a determination in spite of THE insurer's best efforts or  
6 because of a failure of a third party to provide necessary documenta-  
7 tion, or non-routine or unusual circumstances require additional time  
8 for review. In such instances where additional time is necessary  
9 because of a lack of necessary documentation, an insurer shall make  
10 every effort to obtain such information as soon as possible.

11 (2) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE  
12 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO  
13 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS  
14 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF  
15 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK, IS  
16 NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO PARAGRAPH  
17 ONE OF THIS SUBSECTION, SUCH HEALTH CARE PROFESSIONAL SHALL BE DEEMED  
18 "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NETWORK  
19 PORTION OF AN INSURER'S NETWORK; PROVIDED, HOWEVER, THAT A PROVISIONALLY  
20 CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN INSURED'S PRIMARY  
21 CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS BEEN FULLY CREDEN-  
22 TIALED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY CREDENTIALLED  
23 HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING THE NINETIETH  
24 DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST UNTIL THE  
25 FINAL CREDENTIALING DETERMINATION IS MADE BY THE INSURER. A HEALTH CARE  
26 PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL CREDENTIALING IF THE  
27 GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTIFIES THE INSURER IN  
28 WRITING THAT, SHOULD THE APPLICATION ULTIMATELY BE DENIED, THE HEALTH  
29 CARE PROFESSIONAL OR THE GROUP PRACTICE: (A) SHALL REFUND ANY PAYMENTS  
30 MADE BY THE INSURER FOR IN-NETWORK SERVICES PROVIDED BY THE PROVI-  
31 SIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL THAT EXCEED ANY  
32 OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE INSURED'S CONTRACT WITH THE  
33 INSURER; AND (B) SHALL NOT PURSUE REIMBURSEMENT FROM THE INSURED, EXCEPT  
34 TO COLLECT THE COPAYMENT OR COINSURANCE THAT OTHERWISE WOULD HAVE BEEN  
35 PAYABLE HAD THE INSURED RECEIVED SERVICES FROM A HEALTH CARE PROFES-  
36 SIONAL PARTICIPATING IN THE IN-NETWORK PORTION OF AN INSURER'S NETWORK.  
37 INTEREST AND PENALTIES PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED  
38 TWENTY-FOUR-A OF THIS CHAPTER SHALL NOT BE ASSESSED BASED ON THE DENIAL  
39 OF A CLAIM SUBMITTED DURING THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL  
40 WAS PROVISIONALLY CREDENTIALLED; PROVIDED, HOWEVER, THAT NOTHING HEREIN  
41 SHALL PREVENT AN INSURER FROM PAYING A CLAIM FROM A HEALTH CARE PROFES-  
42 SIONAL WHO IS PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM.  
43 AN INSURER SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED  
44 BY A PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE  
45 GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

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

48 (G-7) "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION  
49 OR DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH  
50 STUDY BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL  
51 RESEARCH NETWORK; OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED  
52 STATES RESIDENTS PER YEAR; AND (2) FOR WHICH THERE DOES NOT EXIST A  
53 STANDARD HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN  
54 THAT IS MORE CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR  
55 TREATMENT. A PHYSICIAN, OTHER THAN THE INSURED'S TREATING PHYSICIAN,  
56 SHALL CERTIFY IN WRITING THAT THE CONDITION IS A RARE DISEASE AS

1 DEFINED IN THIS SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A  
2 LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN  
3 THE AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED'S RARE DISEASE.  
4 THE CERTIFICATION SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE  
5 DISEASE IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE  
6 NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK;  
7 OR (2) THAT THE INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED  
8 THOUSAND UNITED STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY  
9 ON MEDICAL AND SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH  
10 SERVICE OR PROCEDURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A  
11 STATEMENT THAT, BASED ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS  
12 NO STANDARD TREATMENT THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO  
13 THE INSURED THAN THE REQUESTED HEALTH SERVICE OR PROCEDURE AND THE  
14 REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO BENEFIT THE INSURED  
15 IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO  
16 THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE.  
17 THE CERTIFYING PHYSICIAN SHALL DISCLOSE ANY MATERIAL FINANCIAL OR  
18 PROFESSIONAL RELATIONSHIP WITH THE PROVIDER OF THE REQUESTED HEALTH  
19 SERVICE OR PROCEDURE AS PART OF THE APPLICATION FOR EXTERNAL APPEAL OF  
20 DENIAL OF A RARE DISEASE TREATMENT. IF THE PROVISION OF THE REQUESTED  
21 HEALTH SERVICE OR PROCEDURE AT A HEALTH CARE FACILITY REQUIRES PRIOR  
22 APPROVAL OF AN INSTITUTIONAL REVIEW BOARD, AN INSURED OR INSURED'S  
23 DESIGNEE SHALL ALSO SUBMIT SUCH APPROVAL AS PART OF THE EXTERNAL APPEAL  
24 APPLICATION.

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

27 (c) A utilization review agent shall make a determination involving  
28 continued or extended health care services, [or] additional services for  
29 an insured undergoing a course of continued treatment prescribed by a  
30 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-  
31 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination  
32 to the insured or the insured's designee, which may be satisfied by  
33 notice to the insured's health care provider, by telephone and in writ-  
34 ing within one business day of receipt of the necessary information  
35 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT  
36 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY  
37 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND  
38 OR HOLIDAY. Notification of continued or extended services shall  
39 include the number of extended services approved, the new total of  
40 approved services, the date of onset of services and the next review  
41 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL  
42 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR  
43 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS  
44 SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF  
45 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME  
46 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW  
47 AGENT IS PENDING.

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

51 (b) A utilization review agent shall establish an expedited appeal  
52 process for appeal of an adverse determination involving (1) continued  
53 or extended health care services, procedures or treatments or additional  
54 services for an insured undergoing a course of continued treatment  
55 prescribed by a health care provider or HOME HEALTH CARE SERVICES  
56 FOLLOWING DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO

1 SUBSECTION (C) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTI-  
2 CLE OR (2) an adverse determination in which the health care provider  
3 believes an immediate appeal is warranted except any retrospective  
4 determination. Such process shall include mechanisms which facilitate  
5 resolution of the appeal including but not limited to the sharing of  
6 information from the insured's health care provider and the utilization  
7 review agent by telephonic means or by facsimile. The utilization review  
8 agent shall provide reasonable access to its clinical peer reviewer  
9 within one business day of receiving notice of the taking of an expe-  
10 dited appeal. Expedited appeals shall be determined within two business  
11 days of receipt of necessary information to conduct such appeal. Expe-  
12 dited appeals which do not result in a resolution satisfactory to the  
13 appealing party may be further appealed through the standard appeal  
14 process, or through the external appeal process pursuant to section four  
15 thousand nine hundred fourteen of this article as applicable.

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

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

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

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

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

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

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

43 (C) the insured's attending physician, who must be a licensed, board-  
44 certified or board-eligible physician qualified to practice in the area  
45 of practice appropriate to treat the insured's life-threatening or disa-  
46 bling condition or disease, must have recommended either (a) a health  
47 service or procedure (including a pharmaceutical product within the  
48 meaning of subparagraph (B) of paragraph two of subsection (e) of  
49 section four thousand nine hundred of this article) that, based on two  
50 documents from the available medical and scientific evidence, is likely  
51 to be more beneficial to the insured than any covered standard health  
52 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE  
53 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION FOUR  
54 THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE  
55 INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN MAY  
56 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO

1 BENEFIT THE INSURED IN THE TREATMENT OF THE INSURED'S RARE DISEASE AND  
2 THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS THE RISKS OF SUCH HEALTH  
3 SERVICE OR PROCEDURE; or (b) a clinical trial for which the insured is  
4 eligible. Any physician certification provided under this section shall  
5 include a statement of the evidence relied upon by the physician in  
6 certifying his or her recommendation, and

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

10 (2) The external appeal agent shall make a determination with regard  
11 to the appeal within thirty days of the receipt of the [insured's]  
12 request therefor, submitted in accordance with the superintendent's  
13 instructions. The external appeal agent shall have the opportunity to  
14 request additional information from the insured, the insured's health  
15 care provider and the insured's health care plan within such thirty-day  
16 period, in which case the agent shall have up to five additional busi-  
17 ness days if necessary to make such determination. The external appeal  
18 agent shall notify the insured, THE INSURED'S HEALTH CARE PROVIDER WHERE  
19 APPROPRIATE, and the health care plan, in writing, of the appeal deter-  
20 mination within two business days of the rendering of such determi-  
21 nation.

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

31 S 28. Clause (a) of item (ii) of subparagraph (B) of paragraph 4 of  
32 subsection (b) of section 4914 of the insurance law, as added by chapter  
33 586 of the laws of 1998, is amended to read as follows:

34 (a) that the patient costs of the proposed health service or procedure  
35 shall be covered by the health care plan either: when a majority of the  
36 panel of reviewers determines, BASED upon review of the applicable  
37 medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES,  
38 THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBSECTION (G-7) OF SECTION  
39 FOUR THOUSAND NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS  
40 THE INSURED, THE INSURED'S DESIGNEE OR THE INSURED'S ATTENDING PHYSICIAN  
41 MAY PRESENT (or upon confirmation that the recommended treatment is a  
42 clinical trial), the insured's medical record, and any other pertinent  
43 information, that the proposed health service or treatment (including a  
44 pharmaceutical product within the meaning of subparagraph (B) of para-  
45 graph two of subsection (e) of section four thousand nine hundred of  
46 this article is likely to be more beneficial than any standard treatment  
47 or treatments for the insured's life-threatening or disabling condition  
48 or disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR  
49 PROCEDURE IS LIKELY TO BENEFIT THE INSURED IN THE TREATMENT OF THE  
50 INSURED'S RARE DISEASE AND THAT SUCH BENEFIT TO THE INSURED OUTWEIGHS  
51 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a  
52 clinical trial, is likely to benefit the insured in the treatment of the  
53 insured's condition or disease); or when a reviewing panel is evenly  
54 divided as to a determination concerning coverage of the health service  
55 or procedure, or

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

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

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

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

35 (4) IF AN INSURED'S HEALTH CARE PROVIDER WAS ACTING AS THE INSURED'S  
36 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH  
37 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED  
38 ON A STANDARD FORM DEVELOPED BY THE SUPERINTENDENT IN CONSULTATION WITH  
39 THE COMMISSIONER OF HEALTH PURSUANT TO SUBSECTION (E) OF THIS SECTION.  
40 THE SUPERINTENDENT SHALL HAVE THE AUTHORITY UPON RECEIPT OF AN EXTERNAL  
41 APPEAL TO CONFIRM THE DESIGNATION OR REQUEST OTHER INFORMATION AS NECES-  
42 SARY, IN WHICH CASE THE SUPERINTENDENT SHALL MAKE AT LEAST TWO WRITTEN  
43 REQUESTS TO THE INSURED TO CONFIRM THE DESIGNATION. THE INSURED SHALL  
44 HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE INSURED FAILS TO  
45 RESPOND TO THE SUPERINTENDENT WITHIN THE SPECIFIED TIMEFRAME, THE SUPER-  
46 INTENDENT SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO  
47 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE  
48 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE  
49 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT'S REQUESTS  
50 WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT SHALL REJECT THE  
51 APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE SUPERINTENDENT'S  
52 REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE IN ACCORDANCE  
53 WITH PARAGRAPHS TWO AND THREE OF THIS SUBSECTION.

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

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

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

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

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

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

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

26 5-C. (A) NO HEALTH CARE PLAN SHALL IMPLEMENT AN ADVERSE REIMBURSEMENT  
27 CHANGE TO A CONTRACT WITH A HEALTH CARE PROFESSIONAL THAT IS OTHERWISE  
28 PERMITTED BY THE CONTRACT, UNLESS, PRIOR TO THE EFFECTIVE DATE OF THE  
29 CHANGE, THE HEALTH CARE PLAN GIVES THE HEALTH CARE PROFESSIONAL WITH  
30 WHOM THE HEALTH CARE PLAN HAS DIRECTLY CONTRACTED AND WHO IS IMPACTED BY  
31 THE ADVERSE REIMBURSEMENT CHANGE, AT LEAST NINETY DAYS WRITTEN NOTICE OF  
32 THE CHANGE. IF THE CONTRACTING HEALTH CARE PROFESSIONAL OBJECTS TO THE  
33 CHANGE THAT IS THE SUBJECT OF THE NOTICE BY THE HEALTH CARE PLAN, THE  
34 HEALTH CARE PROFESSIONAL MAY, WITHIN THIRTY DAYS OF THE DATE OF THE  
35 NOTICE, GIVE WRITTEN NOTICE TO THE HEALTH CARE PLAN TO TERMINATE HIS OR  
36 HER CONTRACT WITH THE HEALTH CARE PLAN EFFECTIVE UPON THE IMPLEMENTATION  
37 DATE OF THE ADVERSE REIMBURSEMENT CHANGE. FOR THE PURPOSES OF THIS  
38 SUBDIVISION, THE TERM "ADVERSE REIMBURSEMENT CHANGE" SHALL MEAN A  
39 PROPOSED CHANGE THAT COULD REASONABLY BE EXPECTED TO HAVE A MATERIAL  
40 ADVERSE IMPACT ON THE AGGREGATE LEVEL OF PAYMENT TO A HEALTH CARE  
41 PROFESSIONAL, AND THE TERM "HEALTH CARE PROFESSIONAL" SHALL MEAN A  
42 HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO  
43 TITLE EIGHT OF THE EDUCATION LAW. THE NOTICE PROVISIONS REQUIRED BY THIS  
44 SUBDIVISION SHALL NOT APPLY WHERE: (I) SUCH CHANGE IS OTHERWISE REQUIRED  
45 BY LAW, REGULATION OR APPLICABLE REGULATORY AUTHORITY, OR IS REQUIRED AS  
46 A RESULT OF CHANGES IN FEE SCHEDULES, REIMBURSEMENT METHODOLOGY OR  
47 PAYMENT POLICIES ESTABLISHED BY A GOVERNMENT AGENCY OR BY THE AMERICAN  
48 MEDICAL ASSOCIATION'S CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES,  
49 REPORTING GUIDELINES AND CONVENTIONS; OR (II) SUCH CHANGE IS EXPRESSLY  
50 PROVIDED FOR UNDER THE TERMS OF THE CONTRACT BY THE INCLUSION OF OR  
51 REFERENCE TO A SPECIFIC FEE OR FEE SCHEDULE, REIMBURSEMENT METHODOLOGY  
52 OR PAYMENT POLICY INDEXING MECHANISM.

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

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

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

22 (B) IF THE COMPLETED APPLICATION OF A NEWLY-LICENSED HEALTH CARE  
23 PROFESSIONAL OR A HEALTH CARE PROFESSIONAL WHO HAS RECENTLY RELOCATED TO  
24 THIS STATE FROM ANOTHER STATE AND HAS NOT PREVIOUSLY PRACTICED IN THIS  
25 STATE, WHO JOINS A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS EACH OF  
26 WHOM PARTICIPATES IN THE IN-NETWORK PORTION OF A HEALTH CARE PLAN'S  
27 NETWORK, IS NEITHER APPROVED NOR DECLINED WITHIN NINETY DAYS PURSUANT TO  
28 PARAGRAPH (A) OF THIS SUBDIVISION, THE HEALTH CARE PROFESSIONAL SHALL BE  
29 DEEMED "PROVISIONALLY CREDENTIALLED" AND MAY PARTICIPATE IN THE IN-NET-  
30 WORK PORTION OF THE HEALTH CARE PLAN'S NETWORK; PROVIDED, HOWEVER, THAT  
31 A PROVISIONALLY CREDENTIALLED PHYSICIAN MAY NOT BE DESIGNATED AS AN  
32 ENROLLEE'S PRIMARY CARE PHYSICIAN UNTIL SUCH TIME AS THE PHYSICIAN HAS  
33 BEEN FULLY CREDENTIALLED. THE NETWORK PARTICIPATION FOR A PROVISIONALLY  
34 CREDENTIALLED HEALTH CARE PROFESSIONAL SHALL BEGIN ON THE DAY FOLLOWING  
35 THE NINETIETH DAY OF RECEIPT OF THE COMPLETED APPLICATION AND SHALL LAST  
36 UNTIL THE FINAL CREDENTIALING DETERMINATION IS MADE BY THE HEALTH CARE  
37 PLAN. A HEALTH CARE PROFESSIONAL SHALL ONLY BE ELIGIBLE FOR PROVISIONAL  
38 CREDENTIALING IF THE GROUP PRACTICE OF HEALTH CARE PROFESSIONALS NOTI-  
39 FIES THE HEALTH CARE PLAN IN WRITING THAT, SHOULD THE APPLICATION ULTI-  
40 MATELY BE DENIED, THE HEALTH CARE PROFESSIONAL OR THE GROUP PRACTICE:  
41 (I) SHALL REFUND ANY PAYMENTS MADE BY THE HEALTH CARE PLAN FOR IN-NET-  
42 WORK SERVICES PROVIDED BY THE PROVISIONALLY CREDENTIALLED HEALTH CARE  
43 PROFESSIONAL THAT EXCEED ANY OUT-OF-NETWORK BENEFITS PAYABLE UNDER THE  
44 ENROLLEE'S CONTRACT WITH THE HEALTH CARE PLAN; AND (II) SHALL NOT PURSUE  
45 REIMBURSEMENT FROM THE ENROLLEE, EXCEPT TO COLLECT THE COPAYMENT THAT  
46 OTHERWISE WOULD HAVE BEEN PAYABLE HAD THE ENROLLEE RECEIVED SERVICES  
47 FROM A HEALTH CARE PROFESSIONAL PARTICIPATING IN THE IN-NETWORK PORTION  
48 OF A HEALTH CARE PLAN'S NETWORK. INTEREST AND PENALTIES PURSUANT TO  
49 SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW  
50 SHALL NOT BE ASSESSED BASED ON THE DENIAL OF A CLAIM SUBMITTED DURING  
51 THE PERIOD WHEN THE HEALTH CARE PROFESSIONAL WAS PROVISIONALLY CREDEN-  
52 TIALED; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT A HEALTH  
53 CARE PLAN FROM PAYING A CLAIM FROM A HEALTH CARE PROFESSIONAL WHO IS  
54 PROVISIONALLY CREDENTIALLED UPON SUBMISSION OF SUCH CLAIM. A HEALTH CARE  
55 PLAN SHALL NOT DENY, AFTER APPEAL, A CLAIM FOR SERVICES PROVIDED BY A

1 PROVISIONALLY CREDENTIALLED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND  
2 THAT THE CLAIM WAS NOT TIMELY FILED.

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

5 7-G. "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION OR  
6 DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY  
7 BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH  
8 NETWORK OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED STATES  
9 RESIDENTS PER YEAR, AND (2) FOR WHICH THERE DOES NOT EXIST A STANDARD  
10 HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN THAT IS MORE  
11 CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR TREATMENT. A  
12 PHYSICIAN, OTHER THAN THE ENROLLEE'S TREATING PHYSICIAN, SHALL CERTIFY  
13 IN WRITING THAT THE CONDITION IS A RARE DISEASE AS DEFINED IN THIS  
14 SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A LICENSED, BOARD-CERTI-  
15 FIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN THE AREA OF PRACTICE  
16 APPROPRIATE TO TREAT THE ENROLLEE'S RARE DISEASE. THE CERTIFICATION  
17 SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE DISEASE IS CURRENTLY  
18 OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE NATIONAL INSTITUTES OF  
19 HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK; OR (2) THAT THE  
20 INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED  
21 STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY ON MEDICAL AND  
22 SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH SERVICE OR PROCE-  
23 DURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A STATEMENT THAT, BASED  
24 ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS NO STANDARD TREATMENT  
25 THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO THE ENROLLEE THAN THE  
26 REQUESTED HEALTH SERVICE OR PROCEDURE AND THE REQUESTED HEALTH SERVICE  
27 OR PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE  
28 ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS  
29 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE. THE CERTIFYING PHYSICIAN  
30 SHALL DISCLOSE ANY MATERIAL FINANCIAL OR PROFESSIONAL RELATIONSHIP WITH  
31 THE PROVIDER OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AS PART OF THE  
32 APPLICATION FOR EXTERNAL APPEAL OF DENIAL OF A RARE DISEASE TREATMENT.  
33 IF THE PROVISION OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AT A  
34 HEALTH CARE FACILITY REQUIRES PRIOR APPROVAL OF AN INSTITUTIONAL REVIEW  
35 BOARD, AN ENROLLEE OR ENROLLEE'S DESIGNEE SHALL ALSO SUBMIT SUCH  
36 APPROVAL AS PART OF THE EXTERNAL APPEAL APPLICATION.

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

39 3. A utilization review agent shall make a determination involving  
40 continued or extended health care services, [or] additional services for  
41 an enrollee undergoing a course of continued treatment prescribed by a  
42 health care provider, OR HOME HEALTH CARE SERVICES FOLLOWING AN INPA-  
43 TIENT HOSPITAL ADMISSION, and SHALL provide notice of such determination  
44 to the enrollee or the enrollee's designee, which may be satisfied by  
45 notice to the enrollee's health care provider, by telephone and in writ-  
46 ing within one business day of receipt of the necessary information  
47 EXCEPT, WITH RESPECT TO HOME HEALTH CARE SERVICES FOLLOWING AN INPATIENT  
48 HOSPITAL ADMISSION, WITHIN SEVENTY-TWO HOURS OF RECEIPT OF THE NECESSARY  
49 INFORMATION WHEN THE DAY SUBSEQUENT TO THE REQUEST FALLS ON A WEEKEND  
50 OR HOLIDAY. Notification of continued or extended services shall  
51 include the number of extended services approved, the new total of  
52 approved services, the date of onset of services and the next review  
53 date. PROVIDED THAT A REQUEST FOR HOME HEALTH CARE SERVICES AND ALL  
54 NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PRIOR  
55 TO DISCHARGE FROM AN INPATIENT HOSPITAL ADMISSION PURSUANT TO THIS  
56 SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF

1 MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR HOME  
2 HEALTH CARE SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW  
3 AGENT IS PENDING.

4 S 36. Subdivision 2 of section 4904 of the public health law, as added  
5 by chapter 705 of the laws of 1996, paragraph (b) as amended by chapter  
6 586 of the laws of 1998, is amended to read as follows:

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

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

15 (b) an adverse determination in which the health care provider  
16 believes an immediate appeal is warranted except any retrospective  
17 determination. Such process shall include mechanisms which facilitate  
18 resolution of the appeal including but not limited to the sharing of  
19 information from the enrollee's health care provider and the utilization  
20 review agent by telephonic means or by facsimile. The utilization review  
21 agent shall provide reasonable access to its clinical peer reviewer  
22 within one business day of receiving notice of the taking of an expe-  
23 dited appeal. Expedited appeals shall be determined within two business  
24 days of receipt of necessary information to conduct such appeal. Expe-  
25 dited appeals which do not result in a resolution satisfactory to the  
26 appealing party may be further appealed through the standard appeal  
27 process, or through the external appeal process pursuant to section  
28 forty-nine hundred fourteen of this article as applicable.

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

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

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

40 S 38. The opening paragraph of subdivision 2 of section 4910 of the  
41 public health law, as added by chapter 586 of the laws of 1998, is  
42 amended to read as follows:

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

46 S 39. Subparagraphs (ii) and (iii) of paragraph (b) of subdivision 2  
47 of section 4910 of the public health law, as added by chapter 586 of the  
48 laws of 1998, are amended to read as follows:

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

1 (iii) the enrollee's attending physician, who must be a licensed,  
2 board-certified or board-eligible physician qualified to practice in the  
3 area of practice appropriate to treat the enrollee's life threatening or  
4 disabling condition or disease, must have recommended either (a) a  
5 health service or procedure (including a pharmaceutical product within  
6 the meaning of subparagraph (B) of paragraph [b] (B) of subdivision five  
7 of section forty-nine hundred of this article) that, based on two docu-  
8 ments from the available medical and scientific evidence, is likely to  
9 be more beneficial to the enrollee than any covered standard health  
10 service or procedure OR, IN THE CASE OF A RARE DISEASE, BASED ON THE  
11 PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION  
12 FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROL-  
13 LEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY  
14 PRESENT, THAT THE REQUESTED HEALTH SERVICE OR PROCEDURE IS LIKELY TO  
15 BENEFIT THE ENROLLEE IN THE TREATMENT OF THE ENROLLEE'S RARE DISEASE AND  
16 THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS THE RISKS OF SUCH HEALTH  
17 SERVICE OR PROCEDURE; or (b) a clinical trial for which the enrollee is  
18 eligible. Any physician certification provided under this section shall  
19 include a statement of the evidence relied upon by the physician in  
20 certifying his or her recommendation, and

21 S 40. Paragraphs (b) and (c) of subdivision 2 of section 4914 of the  
22 public health law, as added by chapter 586 of the laws of 1998, are  
23 amended to read as follows:

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

36 (c) Notwithstanding the provisions of paragraphs (a) and (b) of this  
37 subdivision, if the enrollee's attending physician states that a delay  
38 in providing the health care service would pose an imminent or serious  
39 threat to the health of the enrollee, the external appeal shall be  
40 completed within three days of the request therefor and the external  
41 appeal agent shall make every reasonable attempt to immediately notify  
42 the enrollee, THE ENROLLEE'S HEALTH CARE PROVIDER WHERE APPROPRIATE, and  
43 the health plan of its determination by telephone or facsimile, followed  
44 immediately by written notification of such determination.

45 S 41. Item 1 of clause (ii) of subparagraph (B) of paragraph (d) of  
46 subdivision 2 of section 4914 of the public health law, as added by  
47 chapter 586 of the laws of 1998, is amended to read as follows:

48 (1) that the patient costs of the proposed health service or procedure  
49 shall be covered by the health care plan either: when a majority of the  
50 panel of reviewers determines, BASED upon review of the applicable  
51 medical and scientific evidence AND, IN CONNECTION WITH RARE DISEASES,  
52 THE PHYSICIAN'S CERTIFICATION REQUIRED BY SUBDIVISION SEVEN-G OF SECTION  
53 FORTY-NINE HUNDRED OF THIS ARTICLE AND SUCH OTHER EVIDENCE AS THE ENROL-  
54 LEE, THE ENROLLEE'S DESIGNEE OR THE ENROLLEE'S ATTENDING PHYSICIAN MAY  
55 PRESENT (or upon confirmation that the recommended treatment is a clin-  
56 ical trial), the enrollee's medical record, and any other pertinent

1 information, that the proposed health service or treatment (including a  
2 pharmaceutical product within the meaning of subparagraph (B) of para-  
3 graph (b) of subdivision five of section forty-nine hundred of this  
4 article) is likely to be more beneficial than any standard treatment or  
5 treatments for the enrollee's life-threatening or disabling condition or  
6 disease OR, FOR RARE DISEASES, THAT THE REQUESTED HEALTH SERVICE OR  
7 PROCEDURE IS LIKELY TO BENEFIT THE ENROLLEE IN THE TREATMENT OF THE  
8 ENROLLEE'S RARE DISEASE AND THAT SUCH BENEFIT TO THE ENROLLEE OUTWEIGHS  
9 THE RISKS OF SUCH HEALTH SERVICE OR PROCEDURE (or, in the case of a  
10 clinical trial, is likely to benefit the enrollee in the treatment of  
11 the enrollee's condition or disease); or when a reviewing panel is even-  
12 ly divided as to a determination concerning coverage of the health  
13 service or procedure, or

14 S 42. Subdivision 4 of section 4914 of the public health law, as added  
15 by chapter 586 of the laws of 1998, is amended to read as follows:

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

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

34 (C) IF AN ENROLLEE'S HEALTH CARE PROVIDER REQUESTS AN EXTERNAL APPEAL  
35 OF A CONCURRENT ADVERSE DETERMINATION AND THE EXTERNAL APPEAL AGENT  
36 UPHOLDS THE HEALTH CARE PLAN'S DETERMINATION IN PART, PAYMENT FOR THE  
37 EXTERNAL APPEAL SHALL BE EVENLY DIVIDED BETWEEN THE HEALTH CARE PLAN AND  
38 THE ENROLLEE'S HEALTH CARE PROVIDER WHO REQUESTED THE EXTERNAL APPEAL  
39 AND SHALL BE MADE BY THE HEALTH CARE PLAN AND THE ENROLLEE'S HEALTH CARE  
40 PROVIDER IN THE MANNER AND SUBJECT TO THE TIMEFRAMES AND REQUIREMENTS  
41 SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION; PROVIDED, HOWEVER, THAT  
42 THE COMMISSIONER MAY, UPON A DETERMINATION BY THE SUPERINTENDENT OF  
43 INSURANCE THAT HEALTH CARE PLANS OR HEALTH CARE PROVIDERS ARE EXPERIENC-  
44 ING A SUBSTANTIAL HARDSHIP AS A RESULT OF PAYMENT FOR THE EXTERNAL  
45 APPEAL WHEN THE EXTERNAL APPEAL AGENT UPHOLDS THE HEALTH CARE PLAN'S  
46 DETERMINATION IN PART, IN CONSULTATION WITH THE SUPERINTENDENT, PROMUL-  
47 GATE REGULATIONS TO LIMIT SUCH HARDSHIP.

48 (D) IF AN ENROLLEE'S HEALTH CARE PROVIDER WAS ACTING AS THE ENROLLEE'S  
49 DESIGNEE, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE BY THE HEALTH  
50 CARE PLAN. THE EXTERNAL APPEAL AND ANY DESIGNATION SHALL BE SUBMITTED  
51 ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER IN CONSULTATION WITH  
52 THE SUPERINTENDENT OF INSURANCE PURSUANT TO SUBDIVISION FIVE OF THIS  
53 SECTION. THE SUPERINTENDENT OF INSURANCE SHALL HAVE THE AUTHORITY UPON  
54 RECEIPT OF AN EXTERNAL APPEAL TO CONFIRM THE DESIGNATION OR REQUEST  
55 OTHER INFORMATION AS NECESSARY, IN WHICH CASE THE SUPERINTENDENT OF  
56 INSURANCE SHALL MAKE AT LEAST TWO WRITTEN REQUESTS TO THE ENROLLEE TO

1 CONFIRM THE DESIGNATION. THE ENROLLEE SHALL HAVE TWO WEEKS TO RESPOND TO  
2 EACH SUCH REQUEST. IF THE ENROLLEE FAILS TO RESPOND TO THE SUPERINTEN-  
3 DENT OF INSURANCE WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF  
4 INSURANCE SHALL MAKE TWO WRITTEN REQUESTS TO THE HEALTH CARE PROVIDER TO  
5 FILE AN EXTERNAL APPEAL ON HIS OR HER OWN BEHALF. THE HEALTH CARE  
6 PROVIDER SHALL HAVE TWO WEEKS TO RESPOND TO EACH SUCH REQUEST. IF THE  
7 HEALTH CARE PROVIDER DOES NOT RESPOND TO THE SUPERINTENDENT OF INSURANCE  
8 REQUESTS WITHIN THE SPECIFIED TIMEFRAME, THE SUPERINTENDENT OF INSURANCE  
9 SHALL REJECT THE APPEAL. IF THE HEALTH CARE PROVIDER RESPONDS TO THE  
10 SUPERINTENDENT'S REQUESTS, PAYMENT FOR THE EXTERNAL APPEAL SHALL BE MADE  
11 IN ACCORDANCE WITH PARAGRAPHS (B) AND (C) OF THIS SUBDIVISION.

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

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

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

24 2. sections two, three and twelve of this act shall take effect on  
25 January 1, 2008; provided, however, that subparagraph (iii) of paragraph  
26 (1) of subsection (a) of section 3238 of the insurance law as added in  
27 section twelve of this act shall expire and be deemed repealed December  
28 31, [2009] 2011;

29 S 45. Intentionally omitted.

30 S 46. Intentionally omitted.

31 S 47. Intentionally omitted.

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

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

39 2. provided, further, that the amendments to subsection (i) of section  
40 3217-b of the insurance law made by section three of this act shall not  
41 affect the repeal of such subsection and shall be deemed repealed there-  
42 with;

43 3. provided, further, that the amendments to subsection (i) of section  
44 4325 of the insurance law made by section nineteen of this act shall not  
45 affect the repeal of such subsection and shall be deemed repealed there-  
46 with;

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

51 5. provided further that sections eight and forty-four of this act  
52 shall take effect immediately;

53 6. provided further that section nine of this act shall apply to dates  
54 of service on or after April 1, 2010; and

55 7. provided further that sections two, four, five, fifteen, sixteen  
56 and seventeen of this act shall take effect January 1, 2011.