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

6016

2009-2010 Regular Sessions

I N S E N A T E

June 19, 2009

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:

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

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

S 2. Subparagraph (G) of paragraph 1 of subsection (d) of section 3216 of the insurance law is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

S 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.

(b) 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 or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:

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

(2) to request all additional information needed to determine liability to pay the claim or make the health care payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A HEALTH PLAN SHALL PROVIDE A HEALTH CARE PROVIDER WITH THE OPPORTUNITY TO CHALLENGE AN OVERPAYMENT RECOVERY, INCLUDING THE SHARING OF CLAIMS INFORMATION, AND SHALL ESTABLISH WRITTEN POLICIES AND PROCEDURES FOR HEALTH CARE PROVIDERS TO FOLLOW TO CHALLENGE AN OVERPAYMENT RECOVERY. SUCH CHALLENGE SHALL SET FORTH THE SPECIFIC GROUNDS ON WHICH THE PROVIDER IS CHALLENGING THE OVERPAYMENT RECOVERY.

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

(4) FOR THE PURPOSES OF THIS SUBSECTION THE TERM "HEALTH CARE PROVIDER" SHALL MEAN AN ENTITY LICENSED OR CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT, THIRTY-SIX OR FORTY OF THE PUBLIC HEALTH LAW, A FACILITY LICENSED PURSUANT TO ARTICLE NINETEEN, THIRTY-ONE OR THIRTY-TWO OF THE

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

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

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

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

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

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

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

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

(C) FOR PURPOSES OF THIS PARAGRAPH, A "HEALTH CARE PROVIDER" IS A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPARABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

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

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

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

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

(C) FOR PURPOSES OF THIS PARAGRAPH, A "HEALTH CARE PROVIDER" IS A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPARABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

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

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

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

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

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

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

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

(3) FOR PURPOSES OF THIS SUBSECTION, A "HEALTH CARE PROVIDER" IS A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPARABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) (1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) FOR PURPOSES OF THIS SUBDIVISION, A "HEALTH CARE PROVIDER" IS A HEALTH CARE PROFESSIONAL LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW OR A HEALTH CARE PROFESSIONAL COMPARABLY LICENSED, REGISTERED OR CERTIFIED BY ANOTHER STATE.

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

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

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

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

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

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

PROVISIONALLY CREDENTIALED HEALTH CARE PROFESSIONAL SOLELY ON THE GROUND THAT THE CLAIM WAS NOT TIMELY FILED.

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

7-G. "RARE DISEASE" MEANS A LIFE THREATENING OR DISABLING CONDITION OR DISEASE THAT (1)(A) IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK OR (B) AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED STATES RESIDENTS PER YEAR, AND (2) FOR WHICH THERE DOES NOT EXIST A STANDARD HEALTH SERVICE OR PROCEDURE COVERED BY THE HEALTH CARE PLAN THAT IS MORE CLINICALLY BENEFICIAL THAN THE REQUESTED HEALTH SERVICE OR TREATMENT. A PHYSICIAN, OTHER THAN THE ENROLLEE'S TREATING PHYSICIAN, SHALL CERTIFY IN WRITING THAT THE CONDITION IS A RARE DISEASE AS DEFINED IN THIS SUBSECTION. THE CERTIFYING PHYSICIAN SHALL BE A LICENSED, BOARD-CERTIFIED OR BOARD-ELIGIBLE PHYSICIAN WHO SPECIALIZES IN THE AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE'S RARE DISEASE. THE CERTIFICATION SHALL PROVIDE EITHER: (1) THAT THE INSURED'S RARE DISEASE IS CURRENTLY OR HAS BEEN SUBJECT TO A RESEARCH STUDY BY THE NATIONAL INSTITUTES OF HEALTH RARE DISEASES CLINICAL RESEARCH NETWORK; OR (2) THAT THE INSURED'S RARE DISEASE AFFECTS FEWER THAN TWO HUNDRED THOUSAND UNITED STATES RESIDENTS PER YEAR. THE CERTIFICATION SHALL RELY ON MEDICAL AND SCIENTIFIC EVIDENCE TO SUPPORT THE REQUESTED HEALTH SERVICE OR PROCEDURE, IF SUCH EVIDENCE EXISTS, AND SHALL INCLUDE A STATEMENT THAT, BASED ON THE PHYSICIAN'S CREDIBLE EXPERIENCE, THERE IS NO STANDARD TREATMENT THAT IS LIKELY TO BE MORE CLINICALLY BENEFICIAL TO THE ENROLLEE THAN THE REQUESTED HEALTH SERVICE OR PROCEDURE AND 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. THE CERTIFYING PHYSICIAN SHALL DISCLOSE ANY MATERIAL FINANCIAL OR PROFESSIONAL RELATIONSHIP WITH THE PROVIDER OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AS PART OF THE APPLICATION FOR EXTERNAL APPEAL OF DENIAL OF A RARE DISEASE TREATMENT. IF THE PROVISION OF THE REQUESTED HEALTH SERVICE OR PROCEDURE AT A HEALTH CARE FACILITY REQUIRES PRIOR APPROVAL OF AN INSTITUTIONAL REVIEW BOARD, AN ENROLLEE OR ENROLLEE'S DESIGNEE SHALL ALSO SUBMIT SUCH APPROVAL AS PART OF THE EXTERNAL APPEAL APPLICATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S 44. Subdivision 2 of section 20 of 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, is amended to read as follows:

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

S 45. Intentionally omitted.

S 46. Intentionally omitted.

S 47. Intentionally omitted.

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

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

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

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

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

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

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

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