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

1538

2011-2012 Regular Sessions

I N A S S E M B L Y

January 10, 2011

Introduced by M. of A. GOTTFRIED, LAVINE, MAGNARELLI, GALEF, BURLING, PAULIN, JACOBS, SCHIMEL, HIKIND, LIFTON, JAFFEE, ZEBROWSKI, MONTESANO, McDONOUGH, LANCMAN, SCARBOROUGH -- Multi-Sponsored by -- M. of A. GLICK, McENENY, PHEFFER, REILLY, SWEENEY, THIELE -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to insurer recovery from health care providers

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

Section 1. Paragraph 3 of subsection (b) of section 3224-b of the insurance law, as amended by chapter 237 of the laws of 2009, is amended and two new paragraphs 6 and 7 are added to read as follows:

(3) A health plan shall not initiate overpayment recovery efforts more than [twenty-four] TWELVE months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts 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 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.]

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

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(6) A HEALTH PLAN SHALL NOT DETERMINE AN OVERPAYMENT AMOUNT THROUGH THE USE OF EXTRAPOLATION EXCEPT WITH THE CONSENT OF THE HEALTH CARE PROVIDER, EXCEPT WHERE THERE IS A REASONABLE BELIEF OF FRAUD OR INTENTIONAL MISCONDUCT.

(7) A HEALTH CARE PLAN MAY NOT THREATEN TO SANCTION A HEALTH CARE PROVIDER INCLUDING A REPORT TO A RELEVANT DISCIPLINARY BODY AS A RESULT OF A HEALTH CARE PROVIDER CHALLENGING AN ALLEGED OVERPAYMENT EXCEPT WHERE THERE IS A REASONABLE BELIEF OF FRAUD OR INTENTIONAL MISCONDUCT. A HEALTH CARE PLAN FOUND TO HAVE VIOLATED THIS PARAGRAPH SHALL BE SUBJECT TO A FINE OF FIFTY THOUSAND DOLLARS PER VIOLATION.

S 2. This act shall take effect immediately.