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

6551

I N S E N A T E

February 27, 2012

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to prohibiting providers of health care benefits from denying payment of claims for medically necessary service for failure to provide timely notice; and to amend the insurance law and the public health law, in relation to expanding the time limit to initiate an external appeal by an insureds health care provider to four months

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

Section 1. Section 3224-a of the insurance law is amended by adding a new subsection (i) to read as follows:

(I)(1) 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 SHALL NOT DENY PAYMENT FOR A CLAIM FOR A MEDICALLY NECESSARY SERVICE PROVIDED BY A GENERAL HOSPITAL CERTIFIED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW ON THE BASIS THAT THE HOSPITAL DID NOT TIMELY NOTIFY SUCH INSURER, ORGANIZATION OR CORPORATION THAT THE SERVICE HAD BEEN PROVIDED.

(2) NOTHING IN THIS SUBSECTION SHALL PRECLUDE A HOSPITAL AND 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 FROM AGREEING TO REQUIREMENTS FOR TIMELY NOTIFICATION THAT A SERVICE HAS BEEN PROVIDED OR PAYMENT PENALTIES FOR UNTIMELY NOTIFICATION; PROVIDED, HOWEVER, THAT ANY AGREED TO REDUCTIONS IN PAYMENT FOR CLAIMS FOR SERVICES FOR WHICH THE HOSPITAL FAILS TO TIMELY NOTIFY SHALL NOT: (I) EXCEED TWELVE PERCENT OF THE PAYMENT AMOUNT OTHERWISE DUE FROM SUCH INSURER, ORGANIZATION OR CORPORATION FOR THE SERVICES PROVIDED, AND (II) BE IMPOSED IF THE SERVICE WAS PREAUTHORIZED BY SUCH INSURER, ORGANIZATION OR CORPORATION, OR IF THE PATIENT'S INSURANCE COVERAGE WAS NOT KNOWN TO THE HOSPITAL UNTIL AFTER THE PATIENT WAS DISCHARGED.

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

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S 2. Paragraph 1 of subsection (b) of section 4914 of the insurance law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(1) The insured shall have four months to initiate an external appeal after the insured receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial, or after both the plan and the insured have jointly agreed to waive any internal appeal, or after the insured is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the insured's health care provider shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the insured or the insured's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the insured have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subsection (e) of this section. The insured, and the insured's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 3. Paragraph (a) of subdivision 2 of section 4914 of the public health law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(a) The enrollee shall have four months to initiate an external appeal after the enrollee receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal, or after the enrollee is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. S 300gg-19. Where applicable, the enrollee's health care provider shall have [forty-five days] FOUR MONTHS to initiate an external appeal after the enrollee or the enrollee's health care provider, as applicable, receives notice from the health care plan, or such plan's utilization review agent if applicable, of a final adverse determination or denial or after both the plan and the enrollee have jointly agreed to waive any internal appeal. Such request shall be in writing in accordance with the instructions and in such form prescribed by subdivision five of this section. The enrollee, and the enrollee's health care provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the external appeal agent within the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the utilization review agent based its adverse determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such adverse determination.

S 4. This act shall take effect on the thirtieth day after it shall have become a law.