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

5068

2011-2012 Regular Sessions

I N S E N A T E

May 3, 2011

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

AN ACT to amend the public health law and the insurance law, in relation to prohibiting the approval of a health care plan which does not provide coverage of out of network care

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

Section 1. Paragraph (a) of subdivision 2 of section 4406 of the public health law, as amended by chapter 504 of the laws of 1995, is amended and two new paragraphs (j) and (k) are added to read as follows:

(a) Upon approval of the commissioner, an organization may implement an out-of-plan benefits system that allows enrollees to use providers not participating in the plan pursuant to a contract, employment or other association. The commissioner, in consultation with the superintendent, shall not approve an organization to implement an out-of-plan benefits system unless the organization demonstrates that:

(i) the requirements of this article and any regulations promulgated thereunder have been met and will continue to be met;

(ii) it can establish and maintain a contingent reserve fund of not less than two percent of the entire net premium income for the calendar year of the organization in addition to any other contingent reserve fund required by the commissioner in regulations subject to the approval of the superintendent; [and]

(iii) it has established mechanisms to ensure and monitor compliance with the provisions of paragraph (b) of this subdivision[.];

(IV) THE OUT OF PLAN BENEFITS SYSTEM WILL PROVIDE SIGNIFICANT COVERAGE OF THE USUAL COSTS OF OUT-OF-PLAN HEALTH SERVICES.

(J) AN ORGANIZATION OFFERING AN OUT-OF-PLAN BENEFITS SYSTEM PURSUANT TO THIS SUBDIVISION SHALL PROVIDE TO THEIR SUBSCRIBERS AND ENROLLEES A DESCRIPTION OF ITS METHODOLOGY FOR REIMBURSING OUT-OF-PLAN BENEFITS, WHICH SHALL BE EXPRESSED AS A PERCENTAGE OF THE USUAL COST OF

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

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OUT-OF-PLAN HEALTH CARE SERVICES. SUCH ORGANIZATION SHALL INCLUDE WITHIN THIS DESCRIPTION EXAMPLES OF ANTICIPATED OUT OF POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-PLAN HEALTH CARE SERVICES PROVIDED BY VARIOUS PHYSICIAN SPECIALISTS. UPON REQUEST OF AN ENROLLEE, SUCH ORGANIZATION SHALL PROVIDE INFORMATION TO SUCH ENROLLEE IN WRITING OR THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS THE ENROLLEE TO DETERMINE THE ANTICIPATED OUT OF POCKET COSTS FOR A SPECIFIC OUT-OF-PLAN HEALTH CARE SERVICE BASED UPON THE DIFFERENCE BETWEEN THE ORGANIZATION'S METHODOLOGY FOR REIMBURSING OUT-OF-PLAN HEALTH CARE SERVICES AND THE USUAL COST OF OUT-OF-PLAN HEALTH CARE SERVICES.

(K) FOR THE PURPOSES OF THIS SUBDIVISION, "USUAL COST OF OUT-OF-PLAN HEALTH CARE SERVICES" SHALL MEAN THE EIGHTIETH PERCENTILE OF THE ACTUAL CHARGES FOR A HEALTH CARE SERVICE PROVIDED IN THE SAME COUNTY AND PERFORMED BY AN OUT-OF-PLAN PHYSICIAN IN THE SAME OR SIMILAR SPECIALTY, AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION WITHOUT AFFILIATION WITH AN ORGANIZATION CERTIFIED UNDER THIS ARTICLE OR AN INSURER LICENSED UNDER THE INSURANCE LAW, CREATED AS A RESULT OF SETTLEMENTS ENTERED INTO DURING THE YEAR TWO THOUSAND NINE BETWEEN THE DEPARTMENT OF LAW AND INDIVIDUAL HEALTH INSURANCE ORGANIZATIONS.

S 2. Section 4322 of the insurance law is amended by adding a new subsection (g-1) to read as follows:

(G-1) A HEALTH MAINTENANCE ORGANIZATION ISSUED A CERTIFICATE PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR A CORPORATION SUBJECT TO THE PROVISIONS OF THIS ARTICLE OFFERING AN OUT-OF-PLAN BENEFITS SYSTEM PURSUANT TO THIS SECTION SHALL PROVIDE TO AN ENROLLEE OF A CONTRACT A DESCRIPTION OF ITS METHODOLOGY FOR REIMBURSING OUT-OF-PLAN BENEFITS, WHICH SHALL BE EXPRESSED AS A PERCENTAGE OF THE USUAL COST OF OUT-OF-PLAN HEALTH CARE SERVICES. SUCH ORGANIZATION OR CORPORATION SHALL INCLUDE WITHIN THIS DESCRIPTION EXAMPLES OF ANTICIPATED OUT OF POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-PLAN HEALTH CARE SERVICES PROVIDED BY VARIOUS PHYSICIAN SPECIALISTS. UPON REQUEST OF AN ENROLLEE OF SUCH A CONTRACT, SUCH ORGANIZATION OR CORPORATION SHALL PROVIDE INFORMATION TO SUCH PURCHASER IN WRITING OR THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS THE ENROLLEE TO DETERMINE THE ANTICIPATED OUT OF POCKET COSTS FOR A SPECIFIC OUT-OF-PLAN HEALTH CARE SERVICE BASED UPON THE DIFFERENCE BETWEEN THE ORGANIZATION'S METHODOLOGY FOR REIMBURSING OUT-OF-PLAN HEALTH CARE SERVICES AND THE USUAL COST OF OUT-OF-PLAN HEALTH CARE SERVICES. FOR THE PURPOSES OF THIS SUBDIVISION, "USUAL COST OF OUT-OF-PLAN HEALTH CARE SERVICES" SHALL MEAN THE EIGHTIETH PERCENTILE OF THE ACTUAL CHARGES FOR A HEALTH CARE SERVICE PROVIDED IN THE SAME COUNTY AND PERFORMED BY AN OUT-OF-PLAN PHYSICIAN IN THE SAME OR SIMILAR SPECIALITY, AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION WITHOUT AFFILIATION WITH AN ORGANIZATION CERTIFIED UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR CORPORATION LICENSED PURSUANT TO THIS ARTICLE, CREATED AS A RESULT OF SETTLEMENTS ENTERED INTO DURING THE YEAR TWO THOUSAND NINE BETWEEN THE DEPARTMENT OF LAW AND INDIVIDUAL HEALTH INSURANCE ORGANIZATIONS.

S 3. This act shall take effect August 1, 2011.