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

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2013-2014 Regular Sessions

I N A S S E M B L Y

March 25, 2013

Introduced by M. of A. BRENNAN, SCARBOROUGH, JAFFEE, BARRON -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to physical therapy services and utilization practices

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

Section 1. Paragraph 23 of subsection (i) of section 3216 of the insurance law, as added by chapter 593 of the laws of 2000, is amended to read as follows:

(23) If a policy provides for reimbursement for physical and occupational therapy service which is within the lawful scope of practice of a duly licensed physical or occupational therapist, an insured shall be entitled to reimbursement for such service whether the said service is performed by a physician or through a duly licensed physical or occupational therapist, provided however, that nothing contained herein shall be construed to impair any terms of such policy including appropriate utilization review and the requirement that said service be performed pursuant to a medical order, or a similar or related service of a physician PROVIDED THAT SUCH TERMS SHALL NOT IMPOSE DIFFERENT DEDUCTIBLES, CO-PAYMENTS OR CO-INSURANCE AMOUNTS ON THE BASIS OF THE SETTING IN WHICH SUCH PHYSICAL THERAPY SERVICES ARE RENDERED OR WHETHER THE SERVICES ARE PERFORMED BY A PHYSICAL THERAPIST OR PHYSICIAN.

S 2. Clause (ii) of subparagraph (A) of paragraph 1 of subsection (f) of section 4235 of the insurance law, as amended by chapter 219 of the laws of 2011, is amended to read as follows:

(ii) a policy under which coverage terminates at a specified age shall not so terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap and who became so incapable prior to attainment of the age at which coverage would otherwise terminate and who is chiefly

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

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dependent upon such employee or member for support and maintenance, while the insurance of the employee or member remains in force and the child remains in such condition, if the insured employee or member has within thirty-one days of such child's attainment of the termination age submitted proof of such child's incapacity as described herein. NO POLICY OF GROUP ACCIDENT, GROUP HEALTH OR GROUP ACCIDENT AND HEALTH INSURANCE SHALL IMPOSE DIFFERENT DEDUCTIBLES, CO-PAYMENTS OR CO-INSURANCE AMOUNTS ON THE BASIS OF THE SETTING IN WHICH SUCH PHYSICAL THERAPY SERVICES ARE RENDERED OR WHETHER THE SERVICES ARE PERFORMED BY A PHYSICAL THERAPIST OR PHYSICIAN.

S 3. Subparagraph (A) of paragraph 4 of subsection (f) of section 4235 of the insurance law, as amended by chapter 593 of the laws of 2000, is amended to read as follows:

(A) any physical and occupational therapy service which is within the lawful scope of practice of a licensed physical and occupational therapist, a subscriber to such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or licensed physical and occupational therapist pursuant to prescription or referral by a physician; AND A POLICY OF GROUP ACCIDENT, GROUP HEALTH OR GROUP ACCIDENT AND HEALTH INSURANCE SHALL NOT IMPOSE DIFFERENT DEDUCTIBLES, CO-PAYMENTS OR CO-INSURANCE AMOUNTS ON THE BASIS OF THE SETTING IN WHICH SUCH PHYSICAL THERAPY SERVICES ARE RENDERED OR WHETHER THE SERVICES ARE PERFORMED BY A PHYSICAL THERAPIST OR PHYSICIAN.

S 4. Subparagraph (G) of paragraph 1 of subsection (b) of section 4301 of the insurance law, as amended by chapter 593 of the laws of 2000, is amended to read as follows:

(G) physical and occupational therapy care provided through licensed physical and occupational therapists upon the prescription of a physician AND ANY CO-PAYMENTS, DEDUCTIBLES, OR CO-INSURANCE AMOUNTS RELATED TO REIMBURSEMENT FOR PHYSICAL THERAPY SERVICES SHALL NOT DIFFER ON THE BASIS OF THE SETTING IN WHICH SUCH PHYSICAL THERAPY SERVICES ARE RENDERED OR WHETHER THE SERVICES ARE PERFORMED BY A PHYSICAL THERAPIST OR PHYSICIAN,

S 5. Paragraph 13 of subsection (b) of section 4322 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(13) Outpatient physical therapy up to ninety visits per condition per calendar year AND ANY CO-PAYMENTS, DEDUCTIBLES OR CO-INSURANCE AMOUNTS RELATED TO REIMBURSEMENT OF PHYSICAL THERAPY SERVICES SHALL NOT DIFFER ON THE BASIS OF THE SETTING IN WHICH SUCH PHYSICAL THERAPY SERVICES ARE RENDERED OR WHETHER THE SERVICES ARE PERFORMED BY A PHYSICAL THERAPIST OR PHYSICIAN.

S 6. The opening paragraph of subdivision 4 of section 4905 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

A utilization review agent OR THE HEALTH CARE PLAN FOR WHICH THE AGENT PROVIDES UTILIZATION REVIEW shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

S 7. The opening paragraph of subsection (d) of section 4905 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

A utilization review agent OR THE HEALTH CARE PLAN FOR WHICH THE AGENT PROVIDES UTILIZATION REVIEW shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:

S 8. Subdivision 5 of section 4406-d of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

5. No health care plan shall terminate, OR THREATEN TO TERMINATE a contract or employment, [or] refuse to renew, OR THREATEN REFUSAL TO RENEW a contract, [solely] because a health care provider has:

(a) advocated on behalf of an enrollee;

(b) filed a complaint against the health care plan;

(c) appealed a decision of the health care plan;

(d) provided information or filed a report pursuant to section forty-four hundred six-c of this article; [or]

(e) requested a hearing or review pursuant to this section; OR

(F) ORDERED OR RENDERED MEDICALLY NECESSARY CARE.

S 9. Subsection (e) of section 4803 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(e) No insurer shall terminate [or], THREATEN TO TERMINATE, refuse to renew OR THREATEN REFUSAL TO RENEW a contract for participation in the in-network benefits portion of an insurer's network for a managed care product [solely] because the health care professional has (1) advocated on behalf of an insured; (2) has filed a complaint against the insurer; (3) has appealed a decision of the insurer; (4) provided information or filed a report pursuant to section forty-four hundred six-c of the public health law; [or] (5) requested a hearing or review pursuant to this section; OR (6) ORDERED OR RENDERED MEDICALLY NECESSARY CARE.

S 10. Paragraph (d) of subdivision 1 of section 4902 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(d) Establishment of a process for rendering utilization review determinations which shall, at a minimum, include: written procedures to assure that utilization reviews and determinations are conducted within the timeframes established herein; procedures to notify an enrollee, an enrollee's designee [and/or] AND an enrollee's health care provider of adverse determinations; and procedures for appeal of adverse determinations including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the enrollee;

S 11. Paragraph 4 of subsection (a) of section 4902 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(4) Establishment of a process for rendering utilization review determinations which shall, at a minimum, include: written procedures to assure that utilization reviews and determinations are conducted within the timeframes established herein; procedures to notify an insured, an insured's designee [and/or] AND an insured's health care provider of adverse determinations; and procedures for appeal of adverse determinations including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the insured;

S 12. Paragraph (a) of subdivision 2 of section 4901 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(a) The utilization review plan, INCLUDING BUT NOT LIMITED TO THE CLINICAL REVIEW CRITERIA AND STANDARDS AND THE DEFINITION/STANDARDS OF MEDICAL NECESSITY USED UNDER THE UTILIZATION REVIEW PLAN. A UTILIZATION REVIEW AGENT SHALL REPORT ANY AMENDMENT OR CHANGES TO THE UTILIZATION REVIEW PLAN TO THE COMMISSIONER WITHIN THIRTY DAYS OF MAKING SUCH AMENDMENT OR CHANGE;

S 13. Paragraph 1 of subsection (b) of section 4901 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(1) The utilization review plan, INCLUDING BUT NOT LIMITED TO THE CLINICAL REVIEW CRITERIA AND STANDARDS AND THE DEFINITION/STANDARDS OF MEDICAL NECESSITY USED UNDER THE UTILIZATION REVIEW PLAN. A UTILIZATION REVIEW AGENT SHALL REPORT ANY AMENDMENT OR CHANGES TO THE UTILIZATION REVIEW PLAN TO THE SUPERINTENDENT WITHIN THIRTY DAYS OF MAKING SUCH AMENDMENT OR CHANGE;

S 14. Section 4406-d of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-A. UPON WRITTEN REQUEST BY A PARTICIPATING HEALTH CARE PROFESSIONAL, A HEALTH CARE PLAN SHALL PROVIDE SPECIFIC WRITTEN CLINICAL REVIEW CRITERIA RELATING TO A PARTICULAR CONDITION, DISEASE, SERVICE OR PROCEDURE AND, WHERE APPROPRIATE, OTHER CLINICAL INFORMATION WHICH THE HEALTH CARE PLAN OR ITS UTILIZATION REVIEW AGENT MIGHT CONSIDER IN ITS UTILIZATION REVIEW AND THE HEALTH CARE PLAN SHALL INCLUDE WITH THE INFORMATION A DESCRIPTION OF HOW IT WILL BE USED IN THE UTILIZATION REVIEW PROCESS; PROVIDED, HOWEVER, THAT TO THE EXTENT SUCH INFORMATION IS PROPRIETARY TO THE HEALTH CARE PLAN, THE PARTICIPATING HEALTH CARE PROVIDER OR PROSPECTIVE HEALTH CARE PROVIDER SHALL ONLY USE THE INFORMATION FOR THE PURPOSES OF ASSISTING THE PARTICIPATING HEALTH CARE PROVIDER IN EVALUATING COVERED SERVICES PROVIDED BY THE ORGANIZATION, AN ADVERSE DETERMINATION OR AN APPEAL OF ADVERSE DETERMINATION.

S 15. Section 4803 of the insurance law is amended by adding a new subsection (a-1) to read as follows:

(A-1) UPON WRITTEN REQUEST BY A PARTICIPATING HEALTH CARE PROFESSIONAL, A HEALTH CARE PLAN SHALL PROVIDE SPECIFIC WRITTEN CLINICAL REVIEW CRITERIA RELATING TO A PARTICULAR CONDITION, DISEASE, SERVICE OR PROCEDURE AND, WHERE APPROPRIATE, OTHER CLINICAL INFORMATION WHICH THE HEALTH CARE PLAN OR ITS UTILIZATION REVIEW AGENT MIGHT CONSIDER IN ITS UTILIZATION REVIEW AND THE HEALTH CARE PLAN SHALL INCLUDE WITH THE INFORMATION A DESCRIPTION OF HOW IT WILL BE USED IN THE UTILIZATION REVIEW PROCESS; PROVIDED, HOWEVER, THAT TO THE EXTENT SUCH INFORMATION IS PROPRIETARY TO THE HEALTH CARE PLAN, THE PARTICIPATING HEALTH CARE PROVIDER OR PROSPECTIVE HEALTH CARE PROVIDER SHALL ONLY USE THE INFORMATION FOR THE PURPOSES OF ASSISTING THE PARTICIPATING HEALTH CARE PROVIDER IN EVALUATING COVERED SERVICES PROVIDED BY THE ORGANIZATION, AN ADVERSE DETERMINATION OR AN APPEAL OF ADVERSE DETERMINATION.

S 16. Section 4406-c of the public health law is amended by adding a new subdivision 5-e to read as follows:

5-E. NO HEALTH CARE PLAN SHALL BY CONTRACT, WRITTEN POLICY OR WRITTEN PROCEDURE REFUSE TO HONOR, PROHIBIT OR IN ANY WAY RESTRICT THE ABILITY OF AN ENROLLEE TO ASSIGN HIS OR HER BENEFITS ALLOWABLE OR OTHERWISE PAYABLE TO THE ENROLLEE AS PAYMENT FOR PROFESSIONAL SERVICES RENDERED.

S 17. The insurance law is amended by adding a new section 4803-a to read as follows:

S 4803-A. PROHIBITIONS. 1. NO MANAGED CARE HEALTH INSURANCE CONTRACT OR MANAGED CARE PRODUCT SHALL BY CONTRACT, WRITTEN POLICY OR WRITTEN PROCEDURE REFUSE TO HONOR, PROHIBIT OR IN ANY WAY RESTRICT THE ABILITY OF AN ENROLLEE TO ASSIGN HIS OR HER BENEFITS ALLOWABLE OR OTHERWISE PAYABLE TO THE ENROLLEE AS PAYMENT FOR PROFESSIONAL SERVICES RENDERED.

2. ANY CONTRACT PROVISION, WRITTEN POLICY OR WRITTEN PROCEDURE IN VIOLATION OF THIS SECTION SHALL BE DEEMED TO BE VOID AND UNENFORCEABLE.

S 18. Section 4905 of the public health law is amended by adding a new subdivision 16 to read as follows:

16. A HEALTH CARE PLAN SHALL PROVIDE NOTICE TO PARTICIPATING PROVIDERS SIXTY DAYS IN ADVANCE OF A CHANGE IN UTILIZATION REVIEW AGENTS.

S 19. Section 4905 of the insurance law is amended by adding a new subsection (p) to read as follows:

(P) A HEALTH CARE PLAN SHALL PROVIDE NOTICE TO PARTICIPATING PROVIDERS SIXTY DAYS IN ADVANCE OF A CHANGE IN UTILIZATION REVIEW AGENTS.

S 20. This act shall take effect on the one hundred eightieth day after it shall have become a law.