2013-2014 Regular Sessions

IN ASSEMBLY

May 8, 2013

Introduced by M. of A. MONTESANO -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, the public health law and the financial services law, in relation to establishing protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, adequacy of and access to out-of-network care and prohibition of excessive emergency charges; and providing for the repeal of certain provisions upon expiration thereof

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

1 Section 1. Paragraphs 11, 12, 13, 14, 16 and 17 of subsection (a) of 2 section 3217-a of the insurance law, as added by chapter 705 of the laws 3 of 1996, are amended and three new paragraphs 16-a, 18 and 19 are added 4 to read as follows:

5 (11)where applicable, notice that an insured enrolled in a managed 6 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer may obtain a referral to a health care 7 8 provider outside of the insurer's network or panel when the insurer does 9 not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the 10 insured and the procedure by which the insured can obtain such referral; 11 12 where applicable, notice that an insured enrolled in a managed (12)13 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with a condition which requires ongoing 14 15 care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a stand-16 17 ing referral;

18 (13) where applicable, notice that an insured enrolled in a managed 19 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF 20 PROVIDERS offered by the insurer with (i) a life-threatening condition 21 or disease, or (ii) a degenerative and disabling condition or disease,

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

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1 either of which requires specialized medical care over a prolonged peri-2 od of time may request a specialist responsible for providing or coordi-3 nating the insured's medical care and the procedure for requesting and 4 obtaining such a specialist;

5 (14) where applicable, notice that an insured enrolled in a managed 6 care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF 7 PROVIDERS offered by the insurer with (i) a life-threatening condition 8 or disease, or (ii) a degenerative and disabling condition or disease, 9 either of which requires specialized medical care over a prolonged peri-10 od of time, may request access to a specialty care center and the proce-11 dure by which such access may be obtained;

12 (16) notice of all appropriate mailing addresses and telephone numbers 13 to be utilized by insureds seeking information or authorization; [and]

(16-A) WHERE APPLICABLE, NOTICE THAT AN INSURED SHALL HAVE DIRECT
ACCESS TO PRIMARY AND PREVENTIVE OBSTETRIC AND GYNECOLOGIC SERVICES
INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, FROM A QUALIFIED
PROVIDER OF SUCH SERVICES OF HER CHOICE FROM WITHIN THE PLAN OR FOR ANY
CARE RELATED TO A PREGNANCY;

20 (17) where applicable, a listing by specialty, which may be in a sepa-21 rate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and 22 23 in the case of physicians, board certification[.], in addition, 24 LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE LIST-25 SHALL ALSO BE POSTED ON THE INSURER'S WEBSITE AND THE INSURER SHALL ING 26 UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF 27 A PROVIDER FROM THE INSURER'S NETWORK OR A CHANGE IN A PHYSICIAN'S 28 HOSPITAL AFFILIATION;

29 (18) A DESCRIPTION OF THE METHOD BY WHICH AN INSURED MAY SUBMIT A 30 CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELEC-31 TRONIC MAIL OR BY FACSIMILE; AND

32 (19) WHERE APPLICABLE, WHEN A POLICY OFFERS OUT-OF-NETWORK COVERAGE 33 PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THREE THOUSAND TWO 34 HUNDRED FORTY OF THIS ARTICLE:

35 (A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE INSURER TO 36 DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(B) A DESCRIPTION OF THE AMOUNT THAT THE INSURER WILL REIMBURSE UNDER
THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A
PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH
CARE SERVICES; AND

41 (C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED 42 OUT-OF-NETWORK HEALTH CARE SERVICES.

S 2. Paragraphs 11 and 12 of subsection (b) of section 3217-a of the insurance law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs 13, 14 and 15 are added to read as follows:

46 (11) where applicable, provide the written application procedures and 47 minimum qualification requirements for health care providers to be 48 considered by the insurer for participation in the insurer's network for 49 a managed care product; [and]

50 (12) disclose such other information as required by the superinten-51 dent, provided that such requirements are promulgated pursuant to the 52 state administrative procedure act[.];

53 (13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A 54 HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER; 1 (14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, 2 DISCLOSE THE DOLLAR AMOUNT THAT THE INSURER WILL PAY FOR A SPECIFIC 3 OUT-OF-NETWORK HEALTH CARE SERVICE; AND

4 (15)PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE 5 THAT REASONABLY PERMITS AN INSURED OR PROSPECTIVE INSURED TO DETERMINE 6 ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH THE CARE 7 SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE 8 BETWEEN WHAT THE INSURER WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE 9 SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE 10 SERVICES.

11 S 3. Section 3217-a of the insurance law is amended by adding a new 12 subsection (f) to read as follows:

FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL (F) 13 14 MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH 15 CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY 16 AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING 17 DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPER-NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN 18 INTENDENT. THE 19 INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A 20 MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE 21 FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTI-22 FIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

23 S 4. Section 3217-d of the insurance law is amended by adding a new 24 subsection (d) to read as follows:

25 (D) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES А NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT 26 27 DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE AS 28 CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK OF THIS SERVICES CONSISTENT WITH THE REOUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOU-29 SAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF 30 SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) 31 32 (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, AND PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF 33 SECTION FOUR THOUSAND 34 NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARA-GRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR-35 36 TEEN OF THIS CHAPTER.

37 S 5. Section 3224-a of the insurance law is amended by adding a new 38 subsection (j) to read as follows:

(J) 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 ACCEPT CLAIMS SUBMITTED BY
A POLICYHOLDER OR COVERED PERSON THROUGH THE INTERNET, ELECTRONIC MAIL
OR BY FACSIMILE.

44 S 6. The insurance law is amended by adding a new section 3240 to read 45 as follows:

S 3240. NETWORK COVERAGE. (A) AN INSURER, A CORPORATION ORGANIZED 46 47 PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, OR A MUNICIPAL COOPER-48 ATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF 49 THIS CHAPTER THAT ISSUES A HEALTH INSURANCE POLICY OR CONTRACT WITH A 50 NETWORK OF HEALTH CARE PROVIDERS SHALL ENSURE THAT THE NETWORK IS ADEOUATE TO MEET THE HEALTH NEEDS OF INSUREDS AND PROVIDE AN APPROPRIATE 51 CHOICE OF PROVIDERS SUFFICIENT TO RENDER THE SERVICES COVERED UNDER THE 52 POLICY OR CONTRACT. THE SUPERINTENDENT SHALL REVIEW THE NETWORK OF 53 54 HEALTH CARE PROVIDERS FOR ADEQUACY AT THE TIME OF THE SUPERINTENDENT'S 55 INITIAL APPROVAL OF A HEALTH INSURANCE POLICY OR CONTRACT; AT LEAST 56 EVERY THREE YEARS THEREAFTER; AND UPON APPLICATION FOR EXPANSION OF ANY

SERVICE AREA ASSOCIATED WITH THE POLICY OR CONTRACT. TO THE EXTENT 1 THAT 2 NETWORK HAS BEEN DETERMINED BY THE COMMISSIONER OF HEALTH TO MEET THE 3 THE STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND 4 FOUR HUNDRED THREE OF THEPUBLIC HEALTH LAW, SUCH NETWORK SHALL BE 5 DEEMED ADEQUATE BY THE SUPERINTENDENT.

6 INSURER, A CORPORATION ORGANIZED PURSUANT ТΟ (B) AN ARTICLE 7 FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN 8 PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH CERTIFIED MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE 9 10 PUBLIC HEALTH LAW, THAT PROVIDES COVERAGE FOR OUT-OF-NETWORK SERVICES SHALL PROVIDE SIGNIFICANT COVERAGE OF THE USUAL AND CUSTOMARY COSTS OF 11 12 OUT-OF-NETWORK HEALTH CARE SERVICES.

13 (C) AN INSURER, A CORPORATION ORGANIZED PURSUANT TΟ ARTICLE 14 FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN 15 CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH 16 MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE 17 PUBLIC HEALTH LAW, THAT PROVIDES COVERAGE FOR OUT-OF-NETWORK SERVICES SHALL OFFER AT LEAST ONE POLICY OR CONTRACT OPTION IN EACH GEOGRAPHICAL 18 19 REGION COVERED THAT PROVIDES COVERAGE FOR AT LEAST EIGHTY PERCENT OF THE 20 USUAL AND CUSTOMARY COST OF OUT-OF-NETWORK HEALTH CARE SERVICES AFTER 21 IMPOSITION OF A DEDUCTIBLE.

22 FOR THE PURPOSES OF THIS SECTION "USUAL AND CUSTOMARY COST" SHALL (D) 23 MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH 24 CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY 25 AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING 26 DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPER-27 INTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS ARTICLE, A 28 MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE 29 FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTI-30 FIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW. 31

32 S 7. Section 4306-c of the insurance law is amended by adding a new 33 subsection (d) to read as follows:

34 (D) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFIT 35 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS 36 AND 37 IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION 38 (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL 39 PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REOUIRE-40 SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF MENTS OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE 41 HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR 42 43 THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF 44 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAP-TER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) 45 OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER. 46

S 8. Paragraphs 11, 12, 13, 14, 16-a, 17, and 18 of subsection (a) of section 4324 of the insurance law, as added by chapter 705 of the laws of 1996, paragraph 16-a as added by chapter 554 of the laws of 2002, are amended and two new paragraphs 19 and 20 are added to read as follows:

51 (11) where applicable, notice that a subscriber enrolled in a managed 52 care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF 53 PROVIDERS offered by the corporation may obtain a referral to a health 54 care provider outside of the corporation's network or panel when the 55 corporation does not have a health care provider with appropriate train-56 ing and experience in the network or panel to meet the particular health 1 care needs of the subscriber and the procedure by which the subscriber 2 can obtain such referral;

3 (12) where applicable, notice that a subscriber enrolled in a managed 4 care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF 5 PROVIDERS offered by the corporation with a condition which requires 6 ongoing care from a specialist may request a standing referral to such a 7 specialist and the procedure for requesting and obtaining such a stand-8 ing referral;

9 (13) where applicable, notice that a subscriber enrolled in a managed 10 care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with (i) a life-threatening condi-11 tion or disease, or (ii) a degenerative and disabling condition or 12 either of which requires specialized medical 13 disease, care over a 14 prolonged period of time may request a specialist responsible for 15 providing or coordinating the subscriber's medical care and the proce-16 dure for requesting and obtaining such a specialist;

17 (14) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF 18 19 PROVIDERS offered by the corporation with (i) a life-threatening condi-20 disease, or (ii) a degenerative and disabling condition or tion or 21 disease, either of which requires specialized medical care over a 22 prolonged period of time may request access to a specialty care center 23 and the procedure by which such access may be obtained;

24 (16-a) where applicable, notice that an enrollee shall have direct 25 access to primary and preventive obstetric and gynecologic services 26 INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINA-27 TIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no 28 29 fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall 30 31 have direct access to primary and preventive obstetric and gynecologic 32 services required as a result of such annual examinations or as a result 33 of an acute gynecologic condition];

34 (17) where applicable, a listing by specialty, which may be in a sepa-35 rate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and 36 37 in addition, in the case of physicians, board certification[; and], 38 LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE 39 LISTING SHALL ALSO BE POSTED ON THE CORPORATION'S WEBSITE AND THE CORPO-40 RATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE CORPORATION'S NETWORK OR A CHANGE IN 41 42 A PHYSICIAN'S HOSPITAL AFFILIATION;

43 (18) a description of the mechanisms by which subscribers may partic-44 ipate in the development of the policies of the corporation[.];

45 (19) A DESCRIPTION OF THE METHOD BY WHICH A SUBSCRIBER MAY SUBMIT A 46 CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELEC-47 TRONIC MAIL OR BY FACSIMILE; AND

48 (20) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE 49 PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THREE THOUSAND TWO 50 HUNDRED FORTY OF THIS CHAPTER:

51 (A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE CORPORATION TO 52 DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

53 (B) A DESCRIPTION OF THE AMOUNT THAT THE CORPORATION WILL REIMBURSE 54 UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH 55 AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK 56 HEALTH CARE SERVICES; AND A. 7253

(C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED 1 2 OUT-OF-NETWORK HEALTH CARE SERVICES. 3 Paragraphs 11 and 12 of subsection (b) of section 4324 of the S 9. 4 insurance law, as added by chapter 705 of the laws of 1996, are amended 5 and three new paragraphs 13, 14 and 15 are added to read as follows: 6 where applicable, provide the written application procedures and (11)7 minimum qualification requirements for health care providers to be 8 considered by the corporation for participation in the corporation's 9 network for a managed care product; [and] 10 (12) disclose such other information as required by the superinten-11 dent, provided that such requirements are promulgated pursuant to the 12 state administrative procedure act[.]; (13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO 13 PROVIDE Α 14 HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER; WHERE 15 (14)APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE CORPORATION WILL PAY FOR A SPECIFIC 16 17 OUT-OF-NETWORK HEALTH CARE SERVICE; AND INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE 18 (15)PROVIDE 19 THAT REASONABLY PERMITS A SUBSCRIBER OR PROSPECTIVE SUBSCRIBER TO DETER-MINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH 20 CARE 21 SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE 22 BETWEEN WHAT THE CORPORATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH 23 24 CARE SERVICES. 25 10. Section 4324 of the insurance law is amended by adding a new S 26 subsection (f) to read as follows: 27 (F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL 28 EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH MEAN THE 29 CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING 30 DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPER-31 INTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED 32 WITH AN 33 A CORPORATION SUBJECT TO THIS ARTICLE, A MUNICIPAL COOPERATIVE INSURER, HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN 34 OF THIS 35 CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW. 36 37 S 11. Subsection (g-7) of section 4900 of the insurance law is redes-38 ignated subsection (g-8) and a new subsection (g-7) is added to read as 39 follows: 40 (G-7) "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL UNDER A MANAGED CARE PRODUCT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT 41 HUNDRED ONE OF THIS CHAPTER OF A REQUEST FOR AN AUTHORIZATION OR REFER-42 43 RAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS 44 PORTION OF ITS 45 NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR 46 HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE 47 THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK REOUESTED HEALTH SERVICE. 48 REFERRAL PROVIDED TO AN INSURED SHALL INCLUDE INFORMATION EXPLAINING 49 WHAT INFORMATION THE INSURED MUST SUBMIT IN ORDER TO APPEAL THE DENIAL 50 OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBSECTION (A-2) OF SECTION THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A DENIAL OF AN OUT-OF-51 FOUR NETWORK REFERRAL UNDER THIS SUBSECTION DOES NOT CONSTITUTE AN 52 ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK 53 REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS 54 DEFINED IN SUBSECTION (G-6) OF THIS SECTION. 55

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3 (b) A utilization review agent shall make a utilization review deter-4 mination involving health care services which require pre-authorization 5 and provide notice of a determination to the insured or insured's desig-6 nee and the insured's health care provider by telephone and in writing 7 within three business days of receipt of the necessary information. THE 8 NOTIFICATION SHALL IDENTIFY WHETHER THE SERVICES ARE CONSIDERED IN-NET-9 WORK OR OUT-OF-NETWORK.

10 S 13. Section 4904 of the insurance law is amended by adding a new 11 subsection (a-2) to read as follows:

12 INSURED OR THE INSURED'S DESIGNEE MAY APPEAL A DENIAL OF AN (A-2) AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN 13 14 STATEMENT FROM THE INSURED'S ATTENDING PHYSICIAN, WHO MUST BEΑ 15 LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRAC-16 TICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED 17 THE HEALTH SERVICE SOUGHT THAT: (1) THE IN-NETWORK HEALTH CARE FOR PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT 18 HAVE 19 THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED FOR THE HEALTH SERVICE; AND (2) RECOMMENDS 20 AN 21 OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO 22 MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED, AND WHO IS ABLE TO 23 PROVIDE THE REQUESTED HEALTH SERVICE.

24 S 14. Subsection (b) of section 4910 of the insurance law is amended 25 by adding a new paragraph 4 to read as follows:

26 (4) (A) THE INSURED HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE 27 GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE 28 IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND 29 EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND 30 WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(B) THE INSURED'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, 31 BOARD 32 OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE CERTIFIED 33 SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THEINSURED FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVID-34 PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE 35 ER OR APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE 36 37 NEEDS OF AN INSURED, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE 38 APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE 39 NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH 40 SERVICE.

41 S 15. Paragraph 4 of subsection (b) of section 4914 of the insurance 42 law is amended by adding a new subparagraph (D) to read as follows:

43 (D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH FOUR OF 44 SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE 45 RELATING TO AN OUT-OF-NETWORK REFERRAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, 46 47 ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMI-IN48 NATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE 49 HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

50 (I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER 51 REVIEWERS;

52 (II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

53 (I) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH 54 CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEW-55 ERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE 56 IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE

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TRAINING AND EXPERIENCE OF THE REOUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE INSURED, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE INSURED'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR (II) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE; (III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN; (IV) BE BINDING ON THE PLAN AND THE INSURED; AND (V) BE ADMISSIBLE IN ANY COURT PROCEEDING. S 16. The public health law is amended by adding two new sections 23 and 24 to read as follows: A PHYSICIAN SHALL INCLUDE A CLAIM FORM FOR A 23. CLAIM FORMS. S THIRD-PARTY PAYOR WITH A PATIENT BILL FOR HEALTH CARE SERVICES, OTHER THAN A BILL FOR THE PATIENT'S CO-PAYMENT, COINSURANCE OR DEDUCTIBLE. 24. DISCLOSURE. 1. A HEALTH CARE PROFESSIONAL SHALL DISCLOSE TO S PATIENTS OR PROSPECTIVE PATIENTS IN WRITING OR THROUGH AN INTERNET WEBSITE THE HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROFESSIONAL IS A PARTICIPATING PROVIDER AND THE HOSPITALS WITH WHICH THE HEALTH CARE PROFESSIONAL IS AFFILIATED. 2. IF A HEALTH CARE PROFESSIONAL DOES NOT PARTICIPATE IN THE NETWORK OF A PATIENT'S OR PROSPECTIVE PATIENT'S HEALTH CARE PLAN, THE HEALTH CARE PROFESSIONAL SHALL, UPON RECEIPT OF A REQUEST FROM A PATIENT OR PROSPECTIVE PATIENT, DISCLOSE TO THE PATIENT OR PROSPECTIVE PATIENT IN WRITING THE AMOUNT OR ESTIMATED AMOUNT THE HEALTH CARE PROFESSIONAL WILL BILL THE PATIENT OR PROSPECTIVE PATIENT FOR HEALTH CARE SERVICES PROVIDED OR ANTICIPATED TO BE PROVIDED TO THE PATIENT OR PROSPECTIVE PATIENT. 3. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING 37 ADDRESS, AND TELEPHONE NUMBER OF ANY HEALTH CARE PROVIDER OF ANESTHE-SIOLOGY, LABORATORY, PATHOLOGY, RADIOLOGY OR ASSISTANT SURGEON SERVICES PERFORMED IN THE PHYSICIAN'S OFFICE OR COORDINATED OR REFERRED BY THE PHYSICIAN. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL, FOR A 4. PATIENT'S SCHEDULED HOSPITAL ADMISSION OR SCHEDULED OUTPATIENT HOSPITAL SERVICES, PROVIDE A PATIENT AND THE HOSPITAL WITH THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY OTHER PHYSICIAN WHOSE SERVICES WILL BE ARRANGED BY THE PHYSICIAN AND ARE SCHEDULED AT THE TIME OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION. 5. A HOSPITAL SHALL ESTABLISH, UPDATE, MAKE PUBLIC AND POST ON THE

47 48 HOSPITAL'S WEBSITE, A LIST OF THE HOSPITAL'S STANDARD CHARGES FOR ITEMS 49 AND SERVICES PROVIDED BY THE HOSPITAL, INCLUDING FOR DIAGNOSIS-RELATED 50 GROUPS ESTABLISHED UNDER SECTION 1886(D)(4) OF THE FEDERAL SOCIAL SECU-51 RITY ACT.

6. A HOSPITAL SHALL POST ON THE HOSPITAL'S WEBSITE: (A) THE HEALTH 52 CARE PLANS IN WHICH THE HOSPITAL IS A PARTICIPATING PROVIDER; AND (B) 53 THE NAME, PRACTICE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF ANY 54 55 HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN AND WHOSE SERVICES WILL BE

1 PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL 2 CHARGES.

3 7. A HOSPITAL SHALL, AT THE EARLIER OF EITHER PRE-ADMISSION TESTING, 4 OUTPATIENT REGISTRATION, OR A NON-EMERGENCY HOSPITAL ADMISSION: (A) 5 PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, PROVIDE A 6 MAILING ADDRESS AND TELEPHONE NUMBER OF ANY HEALTH CARE PROFESSIONAL WHO 7 IS A PHYSICIAN AND WHOSE SERVICES ARE REASONABLY ANTICIPATED AT THE TIME 8 OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION AND WILL BEPROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL 9 10 CHARGES, AS REPORTED BY THE PATIENT'S PHYSICIAN; AND (B) DISCLOSE WHETH-HEALTH CARE PROFESSIONALS WHO ARE PHYSICIANS AND 11 ER THE SERVICES OF 12 TYPICALLY PROVIDE HOSPITAL SERVICES SUCH AS, BUT NOT LIMITED TO, ANESTH-13 ESIOLOGY, PATHOLOGY OR RADIOLOGY ARE BILLED AS PART OF THE HOSPITAL 14 CHARGES.

15 8. FOR PURPOSES OF THIS SECTION:

16 "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER (A) 17 LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIR-TY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE 18 19 FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT 20 PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A 21 HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR 22 OF THIS CHAPTER; OR A SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN.

23 (B) "HEALTH CARE PROFESSIONAL" MEANS AN APPROPRIATELY LICENSED, REGIS-24 TERED OR CERTIFIED HEALTH CARE PROFESSIONAL PURSUANT TO TITLE EIGHT OF 25 THE EDUCATION LAW.

S 17. Paragraphs (p-1), (q) and (r) of subdivision 1 of section 4408 of the public health law, paragraph (p-1) as added by chapter 554 of the laws of 2002, and paragraphs (q) and (r) as added by chapter 705 of the laws of 1996, are amended and two new paragraphs (s) and (t) are added to read as follows:

31 notice that an enrollee shall have direct access to primary and (p-1)preventive obstetric and gynecologic services INCLUDING ANNUAL EXAMINA-32 33 RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF TIONS, CARE 34 ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no fewer than two examinations 35 annually for such services] or [to] FOR any care related to A pregnancy 36 37 [and that additionally, the enrollee shall have direct access to primary 38 and preventive obstetric and gynecologic services required as a result 39 of such annual examinations or as a result of an acute gynecologic 40 condition];

41 (q) notice of all appropriate mailing addresses and telephone numbers 42 to be utilized by enrollees seeking information or authorization; [and]

43 listing by specialty, which may be in a separate document that (r) а 44 is updated annually, of the name, address and telephone number of all 45 participating providers, including facilities, and, in addition, in the case of physicians, board certification[.], LANGUAGES SPOKEN AND AFFIL-46 47 IATION WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON 48 THE HEALTH MAINTENANCE ORGANIZATION'S WEBSITE AND THE HEALTH MAINTENANCE 49 ORGANIZATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDI-50 TION OR TERMINATION OF A PROVIDER FROM THE HEALTH MAINTENANCE ORGANIZA-51 TION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

52 (S) WHERE APPLICABLE, A DESCRIPTION OF THE METHOD BY WHICH AN ENROLLEE 53 MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE 54 INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

(T) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE 1 2 PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THREE THOUSAND TWO 3 HUNDRED FORTY OF THE INSURANCE LAW: 4 (I) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE HEALTH MAINTE-5 NANCE ORGANIZATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH 6 CARE SERVICES; 7 (II) A DESCRIPTION OF THE AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZA-8 TION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR 9 10 OUT-OF-NETWORK HEALTH CARE SERVICES; AND 11 (III) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREOUENTLY 12 BILLED OUT-OF-NETWORK HEALTH CARE SERVICES. 18. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the 13 S 14 public health law, as added by chapter 705 of the laws of 1996, are 15 amended and three new paragraphs (m), (n) and (o) are added to read as 16 follows: 17 (k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the 18 19 health maintenance organization; [and] 20 (1) disclose other information as required by the commissioner, 21 provided that such requirements are promulgated pursuant to the state 22 administrative procedure act[.]; (M) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE 23 Α 24 HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER; 25 WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, (N) DISCLOSE THE DOLLAR AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL 26 27 PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND 28 (O) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE 29 THAT REASONABLY PERMITS AN ENROLLEE OR PROSPECTIVE ENROLLEE TO DETERMINE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH 30 THE CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE 31 DIFFERENCE 32 BETWEEN WHAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE FOR 33 OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR 34 OUT-OF-NETWORK HEALTH CARE SERVICES. 35 S 19. Section 4408 of the public health law is amended by adding a new subdivision 7 to read as follows: 36 37 7. FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL 38 EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH MEAN THE39 CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY 40 AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPER-41 DATABASE INTENDENT OF FINANCIAL SERVICES. THE NONPROFIT ORGANIZATION SHALL NOT BE 42 43 AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE 44 OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTI-45 FIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO THIS ARTICLE. 46 47 Subdivision 7-g of section 4900 of the public health law is 20. S 48 renumbered subdivision 7-h and a new subdivision 7-g is added to read as 49 follows: 50 7-G. "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL OF A REQUEST FOR AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS AN

51 AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS 52 THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK 53 BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE 54 TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE 55 TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF A DENIAL OF AN 56 OUT-OF-NETWORK REFERRAL PROVIDED TO AN ENROLLEE SHALL INCLUDE INFORMA-

TION EXPLAINING WHAT INFORMATION THE ENROLLEE MUST SUBMIT IN ORDER TO 1 2 APPEAL THE DENIAL OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBDIVISION 3 SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A ONE-B OF 4 DENIAL OF AN OUT-OF-NETWORK REFERRAL UNDER THIS SUBDIVISION DOES NOT 5 CONSTITUTE AN ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. A DENIAL 6 OF AN OUT-OF-NETWORK REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-7 OF-NETWORK DENIAL AS DEFINED IN SUBDIVISION SEVEN-F OF THIS SECTION.

8 S 21. Subdivision 2 of section 4903 of the public health law, as added 9 by chapter 705 of the laws of 1996, is amended to read as follows:

2. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information. THE NOTIFICATION SHALL IDENTIFY WHETHER THE SERVICES ARE CONSID-ERED IN-NETWORK OR OUT-OF-NETWORK.

17 S 22. Section 4904 of the public health law is amended by adding a new 18 subdivision 1-b to read as follows:

19 1-B. AN ENROLLEE OR THE ENROLLEE'S DESIGNEE MAY APPEAL A DENIAL OF AN 20 OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN 21 STATEMENT FROM THE ENROLLEE'S ATTENDING PHYSICIAN, WHO MUST BEΑ 22 LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRAC-TICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE 23 24 FOR THE HEALTH SERVICE SOUGHT THAT: (A) THE IN-NETWORK HEALTH CARE 25 PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE 26 THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE FOR THE HEALTH SERVICE; AND (B) RECOMMENDS AN 27 OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE 28 то 29 MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. 30

31 S 23. Subdivision 2 of section 4910 of the public health law is 32 amended by adding a new paragraph (d) to read as follows:

(D) (I) THE ENROLLEE HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE
GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE
IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND
EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND
WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

38 (II) THE ENROLLEE'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, 39 BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE 40 SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVID-41 ER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE 42 THE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE 43 APPROPRIATE 44 NEEDS OF AN ENROLLEE, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE 45 APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH 46 NEEDS OF 47 SERVICE.

48 S 24. Paragraph (d) of subdivision 2 of section 4914 of the public 49 health law is amended by adding a new subparagraph (D) to read as 50 follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH (D) OF SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE
RELATING TO AN OUT-OF-NETWORK REFERRAL, THE EXTERNAL APPEAL AGENT SHALL
REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND,
IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMI-

NATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE 1 HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL: 2 3 (I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER 4 REVIEWERS; 5 (II) BE ACCOMPANIED BY A WRITTEN STATEMENT: 6 (1) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH 7 CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEW-DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE 8 ERS IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE 9 THE PLAN, 10 TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE 11 CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE 12 ENROLLEE, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE ENROLLEE 'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, 13 THAT THE HEALTH 14 PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERI-15 ENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK 16 17 PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTIC-ULAR HEALTH CARE NEEDS OF AN ENROLLEE, IS ABLE TO PROVIDE THE REOUESTED 18 19 HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL 20 OUTCOME; OR 21 (2) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE; 22 SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO (III) BE 23 BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN; 24 (IV) BE BINDING ON THE PLAN AND THE ENROLLEE; AND 25 (V) BE ADMISSIBLE IN ANY COURT PROCEEDING. 26 S 25. The financial services law is amended by adding a new article 7 27 to read as follows: 28 ARTICLE 7 29 EMERGENCY MEDICAL SERVICES 30 SECTION 701. DEFINITIONS. 702. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES. 31 32 703. DISPUTE RESOLUTION. 33 704. CRITERIA FOR DETERMINING EXCESSIVE CHARGES. 34 S 701. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE: (A) "EMERGENCY CONDITION" MEANS A MEDICAL OR BEHAVIORAL CONDITION THAT 35 MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING 36 37 SEVERE PAIN, SUCH THAT A PRUDENT LAYPERSON, POSSESSING AN AVERAGE KNOW-38 LEDGE OF MEDICINE AND HEALTH, COULD REASONABLY EXPECT THE ABSENCE OF 39 IMMEDIATE MEDICAL ATTENTION TO RESULT IN (1) PLACING THE HEALTH OF THE 40 PERSON AFFLICTED WITH SUCH CONDITION IN SERIOUS JEOPARDY, OR IN THE CASE OF A BEHAVIORAL CONDITION PLACING THE HEALTH OF SUCH PERSON OR OTHERS IN 41 JEOPARDY; (2) SERIOUS IMPAIRMENT TO SUCH PERSON'S BODILY FUNC-42 SERIOUS 43 TIONS; (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART OF SUCH 44 PERSON; (4) SERIOUS DISFIGUREMENT OF SUCH PERSON; OR (5) A CONDITION 45 DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT. 46 47 "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDI-(B) 48 TION: (1) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 49 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE 50 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCIL-51 LARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALU-ATE SUCH EMERGENCY MEDICAL CONDITION; AND (2) WITHIN THE CAPABILITIES OF 52 THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL 53 54 EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT. 55

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(C) "EXCESSIVE FEE" MEANS A FEE THAT IS IN EXCESS OF AN AMOUNT DETER-MINED IN ACCORDANCE WITH SECTION SEVEN HUNDRED FOUR OF THIS ARTICLE. "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER (D) LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIR-TY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW; OR A SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN. (E) "INSURED" MEANS A PATIENT COVERED UNDER A POLICY OR CONTRACT WITH A HEALTH CARE PLAN. (F) "PATIENT" MEANS A PERSON WHO RECEIVES EMERGENCY SERVICES IN THIS STATE. (G) "USUAL AND CUSTOMARY COST" MEANS THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTI-CLE FORTY-THREE OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW. S 702. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES. (A) A PHYSICIAN WHO PROVIDES HEALTH CARE SERVICES IN THIS STATE SHALL NOT CHARGE AN EXCESSIVE FEE BASED ON THE CRITERIA FOR PROVIDING EMERGENCY SERVICES IN SECTION SEVEN HUNDRED THREE OF THIS ARTICLE. (B) THIS ARTICLE SHALL NOT APPLY TO EMERGENCY SERVICES WHERE PROVIDER FEES ARE SUBJECT TO SCHEDULES OR OTHER MONETARY LIMITATIONS UNDER ANY OTHER LAW, INCLUDING THE WORKERS' COMPENSATION LAW AND ARTICLE FIFTY-ONE OF THE INSURANCE LAW, AND SHALL NOT PREEMPT ANY SUCH LAW. S 703. DISPUTE RESOLUTION. (A) A HEALTH CARE PLAN OR A PATIENT ALLEG-ING THAT A PHYSICIAN HAS CHARGED AN EXCESSIVE FEE FOR PROVIDING EMERGEN-CY SERVICES MAY SUBMIT THE DISPUTE FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY, IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE SUPERINTENDENT, IF THE PHYSICIAN'S CHARGE EXCEEDS THE USUAL AND CUSTOM-ARY COST OF THE HEALTH CARE SERVICES. (B) A PATIENT SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE IN ORDER TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE RESOLUTION ENTITY. S 704. CRITERIA FOR DETERMINING EXCESSIVE CHARGES. (A) (1) THE INDE-PENDENT DISPUTE RESOLUTION ENTITY SHALL DECIDE WHETHER THE FEE CHARGED BY THE PHYSICIAN FOR THE SERVICES RENDERED IS EXCESSIVE. IN MAKING SUCH A DETERMINATION THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL CONSIDER ALL RELEVANT FACTORS INCLUDING:

47 WHETHER THERE IS A GROSS DISPARITY BETWEEN THE FEE CHARGED BY THE (I) 48 PHYSICIAN FOR SERVICES RENDERED AS COMPARED TO: (A) FEES PAID BY THE 49 HEALTH CARE PLAN TO REIMBURSE SIMILARLY QUALIFIED PHYSICIANS FOR THE 50 SAME SERVICES IN THE SAME REGION WHO DO NOT PARTICIPATE WITH THE HEALTH CARE PLAN; AND (B) FEES PAID TO THE INVOLVED PHYSICIAN FOR THE SAME 51 SERVICES RENDERED BY THE PHYSICIAN TO PATIENTS IN HEALTH CARE PLANS IN 52 WHICH THE PHYSICIAN DOES NOT PARTICIPATE; 53

54 (II) THE LEVEL OF TRAINING, EDUCATION AND EXPERIENCE OF THE PHYSICIAN;

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1 (III) THE PHYSICIAN'S USUAL CHARGE FOR COMPARABLE SERVICES WITH REGARD 2 TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN DOES NOT PARTIC-3 IPATE;

4 (IV) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUD-5 ING TIME AND PLACE OF THE SERVICE;

(V) INDIVIDUAL PATIENT CHARACTERISTICS; AND

(VI) THE USUAL AND CUSTOMARY COST OF THE SERVICE.

8 (2) IF THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THAT THE FEE CHARGED IS EXCESSIVE, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY 9 10 SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES BASED UPON THE SAME CONDITIONS AND FACTORS SET FORTH IN THIS SUBDIVISION, WHICH FEE SHALL 11 12 NOT BE LESS THAN THE USUAL AND CUSTOMARY COST FOR SUCH SERVICES. THE PHYSICIAN SHALL RETURN TO THE HEALTH CARE PLAN ANY PORTION OF 13 THE FEE 14 PAID BY THE HEALTH CARE PLAN IN EXCESS OF THE AMOUNT DETERMINED TO BE REASONABLE BY THE INDEPENDENT DISPUTE RESOLUTION ENTITY. 15

16 (B) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY 17 SHALL BE BINDING ON THE HEALTH CARE PLAN, PHYSICIAN AND PATIENT, AND 18 SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE HEALTH CARE 19 PLAN, PHYSICIAN OR PATIENT, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN 20 THIS STATE AND THE PHYSICIAN.

(C) THE SUPERINTENDENT SHALL PROMULGATE REGULATIONS TO ESTABLISH STAN DARDS FOR THE DISPUTE RESOLUTION PROCESS INCLUDING STANDARDS FOR ESTAB LISHING WHICH PARTY SHALL BE RESPONSIBLE FOR PAYMENT OF THE DISPUTE
 RESOLUTION PROCESS.

25 S 26. This act shall take effect January 1, 2014, provided, however, 26 that:

27 1. for policies renewed on and after such date this act shall take 28 effect on the renewal date;

29 2. sections twelve, sixteen, twenty-one and twenty-five of this act 30 shall apply to health care services provided on and after such date and 31 section twenty-five of this act shall expire and be deemed repealed 32 January 1, 2016; and

33 3. sections eleven, thirteen, fourteen, fifteen, twenty, twenty-two, 34 twenty-three and twenty-four of this act shall apply to denials issued 35 on and after such date.