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

7813

2013-2014 Regular Sessions

I N A S S E M B L Y

June 5, 2013

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

AN ACT to amend the public health law, in relation to prohibiting excessive charges for emergency services; to amend the public health law, in relation to certain provider disclosures; to amend the public health law and the insurance law, in relation to out-of-network services; and providing for the repeal of certain provisions upon the expiration thereof

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

Section 1. The public health law is amended by adding a new article 30-D to read as follows:

ARTICLE 30-D

EMERGENCY SERVICES, PROVIDER CHARGES

SECTION 3080. DEFINITIONS.
3081. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES.
3082. DISPUTE RESOLUTION.
3083. CRITERIA FOR DETERMINING EXCESSIVE CHARGES.
3084. DESIGNATION OF INDEPENDENT DISPUTE RESOLUTION ENTITIES; REGULATIONS.

S 3080. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE:

1. "EMERGENCY CONDITION" MEANS A MEDICAL OR BEHAVIORAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, SUCH THAT A PRUDENT LAYPERSON, POSSESSING AN AVERAGE KNOWLEDGE OF MEDICINE AND HEALTH, COULD REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO RESULT IN:

(A) PLACING THE HEALTH OF THE 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 SERIOUS JEOPARDY;

(B) SERIOUS IMPAIRMENT TO SUCH PERSON'S BODILY FUNCTIONS;

(C) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART OF SUCH PERSON;

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

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(D) SERIOUS DISFIGUREMENT OF SUCH PERSON; OR
(E) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.
2. "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION:
(A) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT, TO EVALUATE SUCH EMERGENCY CONDITION, OR OTHER HEALTH CARE;
(B) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL OR HEALTH CARE PROVIDER, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT; AND
(C) EMERGENCY MEDICAL SERVICES PROVIDED UNDER ARTICLE THIRTY OF THIS CHAPTER.
3. "EXCESSIVE FEE" MEANS A FEE THAT IS IN EXCESS OF AN AMOUNT DETERMINED IN ACCORDANCE WITH SECTION THREE THOUSAND EIGHTY-THREE OF THIS ARTICLE.
4. "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIRTY-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 THIS CHAPTER; OR OTHER THIRD-PARTY PAYER FOR HEALTH CARE SERVICES.
5. "HEALTH CARE PROVIDER" MEANS (I) A HEALTH CARE PROFESSIONAL LICENSED, CERTIFIED OR REGISTERED UNDER TITLE EIGHT OF THE EDUCATION LAW; (II) A HOSPITAL UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER; (III) A PROVIDER OF EMERGENCY MEDICAL SERVICES UNDER ARTICLE THIRTY OF THIS CHAPTER; AND (IV) ANY LAWFUL COMBINATION OF HEALTH CARE PROVIDERS.
6. "INDEPENDENT DISPUTE RESOLUTION ENTITY" MEANS AN ENTITY DESIGNATED BY THE COMMISSIONER UNDER SECTION THREE THOUSAND EIGHTY-FOUR OF THIS ARTICLE.
7. "INSURED" MEANS A PATIENT COVERED UNDER A POLICY OR CONTRACT WITH A HEALTH CARE PLAN.
8. "PATIENT" MEANS A PERSON WHO RECEIVES EMERGENCY SERVICES IN THIS STATE.
9. "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 COMMISSIONER, WHERE THE SERVICE IS INCLUDED IN THAT DATABASE. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE 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 THIS CHAPTER.
S 3081. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES. 1. A HEALTH CARE PROVIDER WHICH PROVIDES HEALTH CARE SERVICES IN THIS STATE SHALL NOT CHARGE AN EXCESSIVE FEE BASED ON THE CRITERIA FOR PROVIDING EMERGENCY SERVICES IN SECTION THREE THOUSAND EIGHTY-THREE OF THIS ARTICLE.
2. THIS ARTICLE DOES 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 3082. DISPUTE RESOLUTION. 1. A HEALTH CARE PLAN OR A PATIENT ALLEGING THAT A HEALTH CARE PROVIDER HAS CHARGED AN EXCESSIVE FEE FOR PROVIDING EMERGENCY SERVICES MAY SUBMIT THE DISPUTE FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

2. A PATIENT SHALL NOT BE REQUIRED TO PAY THE HEALTH CARE PROVIDER'S FEE IN ORDER TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE RESOLUTION ENTITY.

S 3083. CRITERIA FOR DETERMINING EXCESSIVE CHARGES. 1. THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE WHETHER THE FEE CHARGED BY THE HEALTH CARE PROVIDER FOR THE SERVICES RENDERED IS AN EXCESSIVE FEE. IN MAKING SUCH A DETERMINATION THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL CONSIDER ALL RELEVANT FACTORS INCLUDING:

(A) WHETHER THERE IS A GROSS DISPARITY BETWEEN THE FEE CHARGED BY THE HEALTH CARE PROVIDER FOR SERVICES RENDERED AS COMPARED TO: (I) FEES PAID BY THE HEALTH CARE PLAN TO REIMBURSE SIMILARLY QUALIFIED HEALTH CARE PROVIDERS FOR THE SAME SERVICES IN THE SAME REGION WHO DO NOT PARTICIPATE WITH THE HEALTH CARE PLAN; (II) FEES PAID TO THE INVOLVED HEALTH CARE PROVIDER FOR THE SAME SERVICE RENDERED BY THE HEALTH CARE PROVIDER TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROVIDER DOES NOT PARTICIPATE; AND (III) FEES PAID TO THE INVOLVED HEALTH CARE PROVIDER FOR THE SAME SERVICES RENDERED BY THE HEALTH CARE PROVIDER TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROVIDER DOES PARTICIPATE;

(B) THE LEVEL OF TRAINING, EDUCATION AND EXPERIENCE OF THE HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL INVOLVED;

(C) THE HEALTH CARE PROVIDER'S USUAL CHARGE FOR COMPARABLE SERVICES WITH REGARD TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROVIDER DOES NOT PARTICIPATE;

(D) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING TIME AND PLACE OF THE SERVICE;

(E) INDIVIDUAL PATIENT CHARACTERISTICS; AND

(F) THE USUAL AND CUSTOMARY COST OF THE SERVICE, WHERE THAT CAN BE DETERMINED.

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

3. THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL BE BINDING ON THE HEALTH CARE PLAN, HEALTH CARE PROVIDER AND PATIENT, AND SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE HEALTH CARE PLAN, HEALTH CARE PROVIDER OR PATIENT, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN THIS STATE AND THE HEALTH CARE PROVIDER.

S 3084. DESIGNATION OF INDEPENDENT DISPUTE RESOLUTION ENTITIES; REGULATIONS. 1. THE COMMISSIONER SHALL DESIGNATE ENTITIES TO BE INDEPENDENT DISPUTE RESOLUTION ENTITIES, UPON APPLICATION BY AN ENTITY, PAYMENT OF AN APPROPRIATE FEE, AND A DETERMINATION BY THE COMMISSIONER THAT THE ENTITY COMPLIES WITH THIS ARTICLE AND REGULATIONS UNDER IT.

2. THE COMMISSIONER SHALL MAKE REGULATIONS TO IMPLEMENT THIS ARTICLE AND TO ESTABLISH REQUIREMENTS AND STANDARDS FOR THE DISPUTE RESOLUTION PROCESS INCLUDING:

(A) STANDARDS AND PROCEDURES FOR DESIGNATING AN ENTITY AS AN INDEPENDENT DISPUTE RESOLUTION ENTITY AND RENEWING, SUSPENDING OR REVOKING SUCH A DESIGNATION; AND

(B) STANDARDS FOR ESTABLISHING WHICH PARTY OR PARTIES SHALL BE RESPONSIBLE FOR PAYMENT OF THE COSTS OF THE DISPUTE RESOLUTION PROCESS.

S 2. The public health law is amended by adding a new section 23 to read as follows:

S 23. DISCLOSURE BY HEALTH CARE PROFESSIONALS RELATING TO HEALTH CARE PLANS. 1. A HEALTH CARE PROFESSIONAL SHALL DISCLOSE TO 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 SHALL PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY HEALTH CARE PROVIDER OF ANESTHESIOLOGY, LABORATORY, PATHOLOGY, RADIOLOGY OR ASSISTANT SURGEON SERVICES WHO ARE REASONABLY EXPECTED TO BE INVOLVED IN THE PATIENT'S CARE IN THE PROFESSIONAL'S OFFICE OR COORDINATED OR REFERRED BY THE HEALTH CARE PROFESSIONAL.

4. A HEALTH CARE PROFESSIONAL SHALL, FOR A 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 PROFESSIONALS WHOSE SERVICES WILL BE ARRANGED BY THE PROFESSIONAL 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 HOSPITAL'S WEBSITE, A LIST OF THE HOSPITAL'S STANDARD CHARGES FOR ITEMS AND SERVICES PROVIDED BY THE HOSPITAL, INCLUDING FOR DIAGNOSIS-RELATED GROUPS ESTABLISHED UNDER SECTION 1886(D)(4) OF THE FEDERAL SOCIAL SECURITY ACT.

6. A HOSPITAL SHALL POST ON THE HOSPITAL'S WEBSITE: (A) THE HEALTH CARE PLANS IN WHICH THE HOSPITAL IS A PARTICIPATING PROVIDER; AND (B) THE NAME, PRACTICE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF ANY HEALTH CARE PROFESSIONAL WHOSE SERVICES WILL BE PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL CHARGES.

7. A HOSPITAL SHALL, AT THE EARLIER OF EITHER PRE-ADMISSION TESTING, OUTPATIENT REGISTRATION OR A NON-EMERGENCY HOSPITAL ADMISSION: (A) PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY HEALTH CARE PROFESSIONAL WHOSE SERVICES ARE REASONABLY ANTICIPATED AT THE TIME OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION AND WILL BE PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL CHARGES; AND (B) DISCLOSE WHETHER THE SERVICES OF HEALTH CARE PROFESSIONALS WHO TYPICALLY PROVIDE HOSPITAL SERVICES SUCH AS, BUT NOT LIMITED TO, ANESTHESIOLOGY, PATHOLOGY OR RADIOLOGY ARE BILLED AS PART OF THE HOSPITAL CHARGES.

8. FOR PURPOSES OF THIS SECTION:

(A) "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIRTY-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 THIS CHAPTER; OR OTHER THIRD-PARTY PAYER FOR HEALTH CARE SERVICES.

(B) "HEALTH CARE PROFESSIONAL" MEANS AN APPROPRIATELY LICENSED, REGISTERED OR CERTIFIED HEALTH CARE PROFESSIONAL PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

S 3. Paragraphs (p-1), (q) and (r) of subdivision 1 of section 4408 of the public health law, as added by chapter 705 of the laws of 1996, paragraph (p-1) as added by chapter 554 of the laws of 2002, are amended and two new paragraphs (s) and (t) are added to read as follows:

(p-1) notice that an enrollee 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 [for no fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

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

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

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

(T) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THIRTY-TWO HUNDRED FORTY OF THE INSURANCE LAW: (I) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE HEALTH MAINTENANCE ORGANIZATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES; (II) A DESCRIPTION OF THE AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION 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 (III) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES.

S 4. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the public health law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs (m), (n) and (o) are added to read as follows:

(k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization; [and]

(l) disclose other information as required by the commissioner, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(M) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

(N) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

(O) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN ENROLLEE OR PROSPECTIVE ENROLLEE TO DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES EXPRESSED IN DOLLAR AMOUNTS.

S 5. Section 4408 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN 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 OF FINANCIAL SERVICES. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE 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 THIS ARTICLE.

S 6. Subdivision 7-g of section 4900 of the public health law is renumbered subdivision 7-h and a new subdivision 7-g is added to read as follows:

7-G. "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS 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. THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK REFERRAL PROVIDED TO AN ENROLLEE SHALL INCLUDE INFORMATION EXPLAINING WHAT INFORMATION THE ENROLLEE MUST SUBMIT IN ORDER TO APPEAL THE DENIAL OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBDIVISION ONE-B OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL UNDER THIS SUBDIVISION DOES NOT CONSTITUTE AN ADVERSE DETERMINATION BASED ON MEDICAL NECESSITY AS DEFINED IN THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS DEFINED IN SUBDIVISION SEVEN-F OF THIS SECTION.

S 7. Subdivision 2 of section 4903 of the public health law, as added 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 CONSIDERED IN-NETWORK OR OUT-OF-NETWORK.

S 8. Section 4904 of the public health law is amended by adding a new subdivision 1-b to read as follows:

1-B. AN INSURED OR THE INSURED'S DESIGNEE MAY APPEAL A DENIAL OF AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE INSURED'S ATTENDING HEALTH CARE PROFESSIONAL, WHO SHALL BE THE INSURED'S IN-NETWORK PRIMARY CARE PROVIDER OR A HEALTH CARE PROFESSIONAL QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT (WHO MAY BE THE PROPOSED OUT-OF-NETWORK HEALTH CARE PROVIDER), THAT:

(A) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED FOR THE HEALTH SERVICE; AND

(B) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 9. Subdivision 2 of section 4910 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D)(I) THE INSURED 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 INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. (II) THE INSURED'S ATTENDING HEALTH CARE PROFESSIONAL, WHO SHALL BE THE INSURED'S IN-NETWORK PRIMARY CARE PROVIDER OR A HEALTH CARE PROFESSIONAL QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT (WHO MAY BE THE PROPOSED OUT-OF-NETWORK HEALTH CARE PROVIDER), CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WHOSE APPROPRIATE TRAINING AND EXPERIENCE MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 10. Paragraph (d) of subdivision 2 of section 4914 of the public health law is amended by adding a new subparagraph (D) to read as 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 DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL: (I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS; (II) BE ACCOMPANIED BY A WRITTEN STATEMENT: (1) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE INFORMATION PROVIDED CONCERNING THE ENROLLEE, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE ENROLLEE'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 ENROLLEE 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 ENROLLEE, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE,

AND IS LIKELY TO PRODUCE A CLINICALLY BENEFICIAL OUTCOME; OR (2) 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 ENROLLEE; AND (V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

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

(11) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer may obtain a referral to a health care provider outside of the insurer's network or panel when the insurer does 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 insured and the procedure by which the insured can obtain such referral;

(12) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist;

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

(16) notice of all appropriate mailing addresses and telephone numbers 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;

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

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

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

(A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE INSURER TO 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

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

S 12. 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:

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

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

(14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE INSURER WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

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

S 13. Section 3217-a of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN 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 ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 14. Section 3217-d of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF

SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 15. Section 3224-a of the insurance law is amended by adding a new 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.

S 16. The insurance law is amended by adding a new section 3240 to read as follows:

S 3240. NETWORK COVERAGE. (A) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, OR A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER THAT ISSUES A HEALTH INSURANCE POLICY OR CONTRACT WITH A NETWORK OF HEALTH CARE PROVIDERS SHALL ENSURE THAT THE NETWORK IS ADEQUATE TO MEET THE HEALTH NEEDS OF INSUREDS AND PROVIDE AN APPROPRIATE CHOICE OF PROVIDERS SUFFICIENT TO RENDER THE SERVICES COVERED UNDER THE POLICY OR CONTRACT. THE SUPERINTENDENT SHALL REVIEW THE NETWORK OF HEALTH CARE PROVIDERS FOR ADEQUACY AT THE TIME OF THE SUPERINTENDENT'S INITIAL APPROVAL OF A HEALTH INSURANCE POLICY OR CONTRACT; AT LEAST EVERY THREE YEARS THEREAFTER; AND UPON APPLICATION FOR EXPANSION OF ANY SERVICE AREA ASSOCIATED WITH THE POLICY OR CONTRACT. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED BY THE COMMISSIONER OF HEALTH TO MEET THE STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE BY THE SUPERINTENDENT.

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

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

(D) FOR THE PURPOSES OF THIS SECTION "USUAL AND CUSTOMARY COST" SHALL MEAN 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 ARTICLE FORTY-THREE OF THIS ARTICLE, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE

FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 17. Section 4306-c of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 18. 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:

(11) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation may obtain a referral to a health care provider outside of the corporation's network or panel when the corporation does 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 subscriber and the procedure by which the subscriber can obtain such referral;

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

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

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

(16-a) where applicable, notice that an enrollee 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 [for no fewer than two examinations annually for such services] or [to] FOR any

care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

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

(18) a description of the mechanisms by which subscribers may participate in the development of the policies of the corporation[.];

(19) A DESCRIPTION OF THE METHOD BY WHICH A SUBSCRIBER MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

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

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

(B) A DESCRIPTION OF THE AMOUNT THAT THE CORPORATION 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

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

S 19. Paragraphs 11 and 12 of subsection (b) of section 4324 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:

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

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

(14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE CORPORATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

(15) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS A SUBSCRIBER OR PROSPECTIVE SUBSCRIBER TO DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE CORPORATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES EXPRESSED IN DOLLAR AMOUNTS.

S 20. Section 4324 of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN 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 THIS ARTICLE, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 21. Subsection (g-7) of section 4900 of the insurance law is redesignated subsection (g-8) and a new subsection (g-7) is added to read as follows:

(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 HUNDRED ONE OF THIS CHAPTER OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS 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 INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK REFERRAL PROVIDED TO AN INSURED SHALL INCLUDE INFORMATION EXPLAINING WHAT INFORMATION THE INSURED MUST SUBMIT IN ORDER TO APPEAL THE DENIAL OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBSECTION (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL UNDER THIS SUBSECTION DOES NOT CONSTITUTE AN ADVERSE DETERMINATION BASED ON MEDICAL NECESSITY AS DEFINED IN THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS DEFINED IN SUBSECTION (G-6) OF THIS SECTION.

S 22. Subsection (b) of section 4903 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) 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 insured or insured's designee and the insured'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 CONSIDERED IN-NETWORK OR OUT-OF-NETWORK.

S 23. Section 4904 of the insurance law is amended by adding a new subsection (a-2) to read as follows:

(A-2) AN INSURED OR THE INSURED'S DESIGNEE MAY APPEAL A DENIAL OF AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE INSURED'S ATTENDING HEALTH CARE PROFESSIONAL, WHO SHALL BE THE INSURED'S IN-NETWORK PRIMARY CARE PROVIDER OR A HEALTH CARE PROFESSIONAL QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT (WHO MAY BE THE PROPOSED OUT-OF-NETWORK HEALTH CARE PROVIDER) THAT: (1) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED FOR THE HEALTH SERVICE; AND (2) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

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

(4)(A) THE INSURED 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 INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(B) THE INSURED'S ATTENDING HEALTH CARE PROFESSIONAL, WHO SHALL BE THE INSURED'S IN-NETWORK PRIMARY CARE PROVIDER OR A HEALTH CARE PROFESSIONAL QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT (WHO MAY BE THE PROPOSED OUT-OF-NETWORK HEALTH CARE PROVIDER), CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WHOSE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 25. Paragraph 4 of subsection (b) of section 4914 of the insurance law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH FOUR OF SUBSECTION (B) 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 DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL: (I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS; (II) BE ACCOMPANIED BY A WRITTEN STATEMENT: (I) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, 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 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 26. This act shall take effect January 1, 2014, provided, however, that:

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

2. sections one, two, seven, and twenty-two of this act shall apply to health care services provided on and after such date;

3. section twenty-six of this act shall expire and be deemed repealed January 1, 2016; and

4. sections six, eight, nine, ten, twenty-one, twenty-three, twenty-four and twenty-five of this act shall apply to denials issued on and after such date.