

5129--A

2015-2016 Regular Sessions

I N   A S S E M B L Y

February 12, 2015

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Introduced by M. of A. BRAUNSTEIN, WEPRIN, GOTTFRIED, OTIS, BRONSON, SKOUFIS, GALEF, GUNTHER, CRESPO, O'DONNELL, GOODELL, MONTESANO, ZEBROWSKI, McDONOUGH, HOOPER, STECK, ABINANTI, FRIEND -- Multi-Sponsored by -- M. of A. COOK, KEARNS, PEOPLES-STOKES, PERRY, RAMOS, RIVERA, SCHIMEL, SEPULVEDA, SIMANOWITZ -- read once and referred to the Committee on Insurance -- recommitted to the Committee on Insurance in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health law, in relation to shortening time frames during which an insurer has to determine whether a pre-authorization request is medically necessary

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

1     Section 1. Subsection (b) of section 4903 of the insurance law, as  
2     amended by section 12 of part H of chapter 60 of the laws of 2014, is  
3     amended to read as follows:  
4     (b) A utilization review agent shall make a utilization review deter-  
5     mination involving health care services which require pre-authorization  
6     and provide notice of a determination to the insured or insured's desig-  
7     nee and the insured's health care provider by telephone and in writing  
8     within three [business] days of receipt of the necessary information. To  
9     the extent practicable, such written notification to the enrollee's  
10    health care provider shall be transmitted electronically, in a manner  
11    and in a form agreed upon by the parties. The notification shall iden-  
12    tify: (1) whether the services are considered in-network or out-of-net-  
13    work; (2) whether the insured will be held harmless for the services and  
14    not be responsible for any payment, other than any applicable co-pay-  
15    ment, co-insurance or deductible; (3) as applicable, the dollar amount  
16    the health care plan will pay if the service is out-of-network; and (4)  
17    as applicable, information explaining how an insured may determine the

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

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1 anticipated out-of-pocket cost for out-of-network health care services  
2 in a geographical area or zip code based upon the difference between  
3 what the health care plan will reimburse for out-of-network health care  
4 services and the usual and customary cost for out-of-network health care  
5 services.

6 S 1-a. Subsection (b) of section 4903 of the insurance law, as amended  
7 by chapter 371 of the laws of 2015, is amended to read as follows:

8 (b) (1) A utilization review agent shall make a utilization review  
9 determination involving health care services which require pre-authori-  
10 zation and provide notice of a determination to the insured or insured's  
11 designee and the insured's health care provider by telephone and in  
12 writing within three [business] days of receipt of the necessary infor-  
13 mation. To the extent practicable, such written notification to the  
14 enrollee's health care provider shall be transmitted electronically, in  
15 a manner and in a form agreed upon by the parties. The notification  
16 shall identify: (i) whether the services are considered in-network or  
17 out-of-network; (ii) whether the insured will be held harmless for the  
18 services and not be responsible for any payment, other than any applica-  
19 ble co-payment, co-insurance or deductible; (iii) as applicable, the  
20 dollar amount the health care plan will pay if the service is out-of-  
21 network; and (iv) as applicable, information explaining how an insured  
22 may determine the anticipated out-of-pocket cost for out-of-network  
23 health care services in a geographical area or zip code based upon the  
24 difference between what the health care plan will reimburse for out-of-  
25 network health care services and the usual and customary cost for out-  
26 of-network health care services.

27 (2) With regard to individual or group contracts authorized pursuant  
28 to article thirty-two, forty-three or forty-seven of this chapter or  
29 article forty-four of the public health law, for utilization and review  
30 determinations involving proposed mental health and/or substance use  
31 disorder services where the insured or the insured's designee has, in a  
32 format prescribed by the superintendent, certified in the request that  
33 the proposed services are for an individual who will be appearing, or  
34 has appeared, before a court of competent jurisdiction and may be  
35 subject to a court order requiring such services, the utilization review  
36 agent shall make a determination and provide notice of such determi-  
37 nation to the insured or the insured's designee by telephone within  
38 seventy-two hours of receipt of the request. Written notice of the  
39 determination to the insured or insured's designee shall follow within  
40 three business days. Where feasible, such telephonic and written notice  
41 shall also be provided to the court.

42 S 2. Subdivision 2 of section 4903 of the public health law, as  
43 amended by section 22 of part H of chapter 60 of the laws of 2014, is  
44 amended to read as follows:

45 2. A utilization review agent shall make a utilization review determi-  
46 nation involving health care services which require pre-authorization  
47 and provide notice of a determination to the enrollee or enrollee's  
48 designee and the enrollee's health care provider by telephone and in  
49 writing within three [business] days of receipt of the necessary infor-  
50 mation. To the extent practicable, such written notification to the  
51 enrollee's health care provider shall be transmitted electronically, in  
52 a manner and in a form agreed upon by the parties. The notification  
53 shall identify: (a) whether the services are considered in-network or  
54 out-of-network; (b) and whether the enrollee will be held harmless for  
55 the services and not be responsible for any payment, other than any  
56 applicable co-payment or co-insurance; (c) as applicable, the dollar

1 amount the health care plan will pay if the service is out-of-network;  
2 and (d) as applicable, information explaining how an enrollee may deter-  
3 mine the anticipated out-of-pocket cost for out-of-network health care  
4 services in a geographical area or zip code based upon the difference  
5 between what the health care plan will reimburse for out-of-network  
6 health care services and the usual and customary cost for out-of-network  
7 health care services.

8 S 2-a. Subdivision 2 of section 4903 of the public health law, as  
9 amended by chapter 371 of the laws of 2015, is amended to read as  
10 follows:

11 2. (a) A utilization review agent shall make a utilization review  
12 determination involving health care services which require pre-authori-  
13 zation and provide notice of a determination to the enrollee or  
14 enrollee's designee and the enrollee's health care provider by telephone  
15 and in writing within three [business] days of receipt of the necessary  
16 information. To the extent practicable, such written notification to the  
17 enrollee's health care provider shall be transmitted electronically, in  
18 a manner and in a form agreed upon by the parties. The notification  
19 shall identify; (i) whether the services are considered in-network or  
20 out-of-network; (ii) and whether the enrollee will be held harmless for  
21 the services and not be responsible for any payment, other than any  
22 applicable co-payment or co-insurance; (iii) as applicable, the dollar  
23 amount the health care plan will pay if the service is out-of-network;  
24 and (iv) as applicable, information explaining how an enrollee may  
25 determine the anticipated out-of-pocket cost for out-of-network health  
26 care services in a geographical area or zip code based upon the differ-  
27 ence between what the health care plan will reimburse for out-of-network  
28 health care services and the usual and customary cost for out-of-network  
29 health care services.

30 (b) With regard to individual or group contracts authorized pursuant  
31 to article forty-four of this chapter, for utilization review determi-  
32 nations involving proposed mental health and/or substance use disorder  
33 services where the enrollee or the enrollee's designee has, in a format  
34 prescribed by the superintendent of financial services, certified in the  
35 request that the proposed services are for an individual who will be  
36 appearing, or has appeared, before a court of competent jurisdiction and  
37 may be subject to a court order requiring such services, the utilization  
38 review agent shall make a determination and provide notice of such  
39 determination to the enrollee or the enrollee's designee by telephone  
40 within seventy-two hours of receipt of the request. Written notice of  
41 the determination to the enrollee or enrollee's designee shall follow  
42 within three business days. Where feasible, such telephonic and written  
43 notice shall also be provided to the court.

44 S 3. This act shall take effect immediately, provided, however, that  
45 sections one-a and two-a of this act shall take effect on the same date  
46 and in the same manner as chapter 371 of the laws of 2015, takes effect.