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

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I N A S S E M B L Y

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Introduced by M. of A. BARCLAY, KOLB, GIGLIO, McKEVITT, BLANKENBUSH, TENNEY, MONTESANO, WALTER, OAKS, CORWIN -- Multi-Sponsored by -- M. of A. BUTLER, CROUCH, CURRAN, DiPIETRO, FINCH, McDONOUGH, McLAUGHLIN, PALMESANO, THIELE -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, the penal law and the executive law, in relation to establishing the New York automobile insurance fraud and premium reduction act; and making an appropriation therefor

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

Section 1. This act shall be known and may be cited as the "New York automobile insurance fraud and premium reduction act".

S 2. The insurance law is amended by adding a new section 5110 to read as follows:

S 5110. CERTIFICATION OF MANAGED CARE ORGANIZATIONS. (A)(1) ANY INDIVIDUAL OR GROUP AUTHORIZED TO PROVIDE MEDICAL OR OTHER HEALTH CARE SERVICES IN THIS STATE MAY, DIRECTLY OR THROUGH AN AUTHORIZED INSURER, MAKE WRITTEN APPLICATION TO THE SUPERINTENDENT TO BECOME CERTIFIED TO PROVIDE MANAGED CARE TO INJURED COVERED PERSONS UNDER THIS ARTICLE.

(2) CERTIFICATION SHALL BE VALID FOR SUCH PERIOD AND FOR SUCH SERVICE AREAS AS THE SUPERINTENDENT MAY PRESCRIBE, UNLESS SOONER REVOKED, SUSPENDED OR AMENDED.

(3) EACH APPLICATION FOR CERTIFICATION SHALL BE ACCOMPANIED BY A REASONABLE FEE PRESCRIBED BY THE SUPERINTENDENT AND A PROPOSED MANAGED CARE PROGRAM DETAILING ITS SIGNIFICANT FEATURES, METHODS AND PROCEDURES.

(B) APPLICATION FOR CERTIFICATION SHALL BE MADE IN SUCH FORM AND MANNER, AND SHALL SET FORTH SUCH INFORMATION REGARDING THE PROPOSED PLAN OF MANAGED CARE FOR PROVIDING MEDICAL AND OTHER HEALTH CARE SERVICES, AS THE SUPERINTENDENT MAY PRESCRIBE, INCLUDING:

(1) THE NAMES AND CREDENTIALS OF ALL INDIVIDUALS OR ORGANIZATIONS THAT WILL PROVIDE SERVICES UNDER THE MANAGED CARE PROGRAM, TOGETHER WITH APPROPRIATE EVIDENCE OF COMPLIANCE WITH ANY LICENSING OR CERTIFICATION REQUIREMENTS FOR SUCH INDIVIDUALS OR ORGANIZATIONS TO PRACTICE IN THIS STATE;

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

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(2) A DESCRIPTION OF THE TIMES, PLACES AND MANNER OF PROVIDING SERVICES UNDER THE MANAGED CARE PROGRAM;

(3) A DESCRIPTION OF THE TIMES, PLACES AND MANNER OF PROVIDING OTHER RELATED OPTIONAL SERVICES THE APPLICANT MAY WISH TO PROVIDE; AND

(4) A DESCRIPTION AND REPRESENTATIVE COPIES OF ALL REMUNERATION AND RELATED ARRANGEMENTS BETWEEN THE MANAGED CARE ORGANIZATION AND INDIVIDUAL PROVIDERS OF SERVICES UNDER THE MANAGED CARE PROGRAM.

(C) THE SUPERINTENDENT SHALL CERTIFY AN APPLICANT, IF THE SUPERINTENDENT FINDS THAT THE MANAGED CARE PROGRAM:

(1) PROVIDES MEDICAL AND OTHER HEALTH CARE SERVICES THAT MEET QUALITY, CONTINUITY AND OTHER TREATMENT STANDARDS PRESCRIBED BY THE SUPERINTENDENT OR THE COMMISSIONER OF HEALTH, IN A MANNER THAT IS TIMELY, EFFECTIVE AND CONVENIENT FOR INJURED PERSONS;

(2) INCLUDES A SUFFICIENT NUMBER OF EACH CATEGORY OF PROVIDER THROUGHOUT THE PROPOSED SERVICE AREAS TO GIVE INJURED PERSONS ADEQUATE FLEXIBILITY TO CHOOSE AN AUTHORIZED PROVIDER FROM AMONG THOSE HEALTH CARE PROVIDERS WHO PARTICIPATE IN THE MANAGED CARE PROGRAM;

(3) PROVIDES APPROPRIATE FINANCIAL INCENTIVES OR OTHER APPROACHES TO REDUCE COSTS AND MINIMIZE IMPROPER UTILIZATION WITHOUT SACRIFICING QUALITY OF SERVICE;

(4) PROVIDES ADEQUATE METHODS OF PEER REVIEW, UTILIZATION REVIEW, AND DISPUTE RESOLUTION, INCLUDING WHERE APPLICABLE, ACCESS TO THE EXTERNAL APPEAL PROCESS AS PROVIDED IN ARTICLE FORTY-NINE OF THIS CHAPTER, IN ORDER TO: (A) PREVENT INAPPROPRIATE OR EXCESSIVE TREATMENT; (B) AVOID CONFLICTS OF INTEREST; (C) EXCLUDE FROM PARTICIPATION IN THE PROGRAM THOSE PROVIDERS WHO VIOLATE REASONABLE TREATMENT STANDARDS; AND (D) PROVIDE FOR THE RESOLUTION OF MEDICAL DISPUTES;

(5) PROVIDES A TIMELY AND ACCURATE METHOD OF REPORTING TO THE SUPERINTENDENT OR THE COMMISSIONER OF HEALTH AS APPROPRIATE, NECESSARY INFORMATION REGARDING MEDICAL AND HEALTH CARE SERVICE COST AND UTILIZATION TO MONITOR THE EFFECTIVENESS OF THE MANAGED CARE PROGRAM;

(6) PROVIDES A MECHANISM FOR AN INJURED PERSON TO OBTAIN TREATMENT OUTSIDE OF THE MANAGED CARE PROGRAM IF THE SERVICES ARE NOT AVAILABLE OR ACCESSIBLE WITHIN THE PROGRAM;

(7) PROVIDES FOR A REASONABLE AND APPROPRIATE COORDINATION WITH ANOTHER HEALTH CARE PROVIDER WHERE THE INJURED PERSON HAS BEEN RECEIVING TREATMENT FROM ANOTHER HEALTH CARE PROVIDER FOR A PREVIOUSLY EXISTING CONDITION OR INJURY WHICH HAS BEEN AGGRAVATED BY THE MOTOR VEHICLE ACCIDENT;

(8) PROVIDES FOR A MECHANISM FOR NOTIFICATION ABOUT AND TRANSITION FROM EMERGENCY CARE; AND

(9) COMPLIES WITH ANY OTHER REQUIREMENT THE SUPERINTENDENT DETERMINES IS NECESSARY TO PROVIDE QUALITY MEDICAL AND OTHER HEALTH CARE SERVICES TO INJURED PERSONS.

(D) THE SUPERINTENDENT MAY CERTIFY A HEALTH MAINTENANCE ORGANIZATION ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR LICENSED UNDER ARTICLE FORTY-THREE OF THIS CHAPTER, IF IT MEETS THE REQUIREMENTS OF THIS SECTION. THE SUPERINTENDENT MAY ALSO CERTIFY AN ACCIDENT AND HEALTH INSURER, INCLUDING A CORPORATION ORGANIZED UNDER ARTICLE FORTY-THREE OF THIS CHAPTER, WHICH HAS A PARTICIPATING OR PREFERRED NETWORK OF PROVIDERS IF SUCH INSURER MEETS THE REQUIREMENTS OF THIS SECTION. TO THE EXTENT A MANAGED CARE ORGANIZATION HAS BEEN REVIEWED, APPROVED OR CERTIFIED BY ANOTHER STATE AGENCY AS TO ACCESSIBILITY, QUALITY OR CONTINUITY OF CARE OR FOR ANY OF THE OTHER MATTERS WITHIN THE SUPERINTENDENT'S REVIEW, THE SUPERINTENDENT SHALL CONSIDER THE REVIEW, APPROVAL OR CERTIFICATION OF ANOTHER STATE AGENCY

SO AS NOT TO DUPLICATE THOSE REVIEWS, APPROVALS OR CERTIFICATIONS. HOWEVER, NOTHING IN THIS SUBSECTION SHALL BE DEEMED TO LIMIT THE SUPERINTENDENT'S AUTHORITY TO IMPOSE AND REVIEW ADDITIONAL REQUIREMENTS OR STANDARDS ABOVE AND BEYOND THOSE IMPOSED BY ANOTHER STATE AGENCY TO THE EXTENT THOSE REQUIREMENTS OR STANDARDS ARE NECESSARY OR APPROPRIATE FOR IMPLEMENTATION OF THIS SECTION.

(E) THE SUPERINTENDENT SHALL REFUSE TO CERTIFY, OR MAY REVOKE, OR SUSPEND OR AMEND THE CERTIFICATION OF, ANY MANAGED CARE ORGANIZATION, IF THE SUPERINTENDENT FINDS THAT:

(1) THE MANAGED CARE PROGRAM FOR PROVIDING SERVICES FAILS TO MEET THE REQUIREMENTS OF THIS SECTION; OR

(2) SERVICE UNDER THE MANAGED CARE PROGRAM IS NOT BEING PROVIDED IN ACCORDANCE WITH ITS TERMS AS DESCRIBED IN THE APPLICATION FOR CERTIFICATION.

(F) FOR PURPOSES OF THIS SECTION, THE SUPERINTENDENT MAY CONSIDER WHETHER PROVIDERS UTILIZED BY A MANAGED CARE ORGANIZATION OR OTHERWISE AUTHORIZED TO PROVIDE SERVICES UNDER THE CONTRACT ARE AUTHORIZED TO RENDER MEDICAL CARE IN ACCORDANCE WITH SECTION THIRTEEN-B OF THE WORKERS' COMPENSATION LAW.

(G) UTILIZATION REVIEW, QUALITY ASSURANCE AND PEER REVIEW ACTIVITIES PURSUANT TO THIS SECTION SHALL BE SUBJECT TO REVIEW BY THE SUPERINTENDENT AND THE COMMISSIONER OF HEALTH. FINDINGS BY THE COMMISSIONER OF HEALTH OF PROFESSIONAL MISCONDUCT, OR DISCIPLINARY ACTIONS IN RELATION THERETO, SHALL BE REPORTED TO THE APPROPRIATE LICENSING BOARDS AND THE SUPERINTENDENT.

(H) DATA GENERATED BY OR RECEIVED IN CONNECTION WITH THESE ACTIVITIES, INCLUDING WRITTEN REPORTS, NOTES OR RECORDS OF ANY SUCH ACTIVITIES OR OF THE REVIEW THEREOF, SHALL BE CONFIDENTIAL AND SHALL NOT BE DISCLOSED, EXCEPT TO THE EXTENT DETERMINED TO BE NECESSARY BY THE SUPERINTENDENT OR THE COMMISSIONER OF HEALTH. NO DATA GENERATED BY UTILIZATION REVIEW, QUALITY ASSURANCE OR PEER REVIEW ACTIVITIES PURSUANT TO THIS SECTION, OR THE REVIEW THEREOF, SHALL BE USED IN ANY ACTION, SUIT OR PROCEEDING, EXCEPT TO THE EXTENT DETERMINED TO BE NECESSARY BY THE SUPERINTENDENT OR THE COMMISSIONER.

(I) A PERSON PARTICIPATING IN UTILIZATION REVIEW, QUALITY ASSURANCE, OR PEER REVIEW ACTIVITIES PURSUANT TO THIS SECTION SHALL NOT BE EXAMINED AS TO ANY COMMUNICATION MADE IN THE COURSE OF SUCH ACTIVITIES OR THE FINDINGS THEREOF, NOR SHALL ANY SUCH PERSON BE SUBJECT TO A CIVIL ACTION FOR ACTIONS TAKEN OR STATEMENTS MADE IN GOOD FAITH.

(J) PROVIDED THAT THERE IS COMPLIANCE WITH STANDARDS GOVERNING MANAGED CARE ESTABLISHED BY THE SUPERINTENDENT, NO PERSON WHO PARTICIPATES IN FORMING ANY NETWORK, COLLECTIVELY NEGOTIATING FEES, OR OTHERWISE SOLICITS OR ENTERS INTO CONTRACTS IN A GOOD FAITH EFFORT, TO PROVIDE MEDICAL OR OTHER HEALTH CARE SERVICES ON A MANAGED CARE BASIS IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION, SHALL BE SUBJECT TO ANTITRUST LIABILITY REGARDING SUCH PARTICIPATION.

(K) THE PROVISIONS OF THIS SECTION SHALL NOT AFFECT THE CONFIDENTIALITY OR ADMISSION IN EVIDENCE OF A CLAIMANT'S MEDICAL TREATMENT RECORDS.

(L) THE SUPERINTENDENT, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, SHALL ADOPT SUCH RULES AS MAY BE NECESSARY TO CARRY OUT THE PROVISIONS OF THIS SECTION.

S 3. Paragraph 1 of subsection (a) of section 5102 of the insurance law, as amended by chapter 298 of the laws of 2006, is amended to read as follows:

(1) All necessary expenses incurred for: (i) medical, hospital (including services rendered in compliance with article forty-one of the

public health law, whether or not such services are rendered directly by a hospital), surgical, nursing, dental, ambulance, x-ray, prescription drug and prosthetic services; (ii) psychiatric, physical therapy (provided that treatment is rendered pursuant to a referral) and occupational therapy and rehabilitation; (iii) any non-medical remedial care and treatment rendered in accordance with a religious method of healing recognized by the laws of this state; and (iv) any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury. For the purpose of determining basic economic loss, the expenses incurred under this paragraph shall be in accordance with the limitations of section five thousand one hundred eight of this article. MEDICAL TREATMENTS, DIAGNOSTIC TESTS AND SERVICES PROVIDED BY THE POLICY SHALL BE RENDERED IN ACCORDANCE WITH COMMONLY ACCEPTED PROTOCOLS AND PROFESSIONAL STANDARDS AND PRACTICES WHICH ARE COMMONLY ACCEPTED AS BEING BENEFICIAL FOR THE TREATMENT OF THE COVERED INJURY. PROTOCOLS AND PROFESSIONAL STANDARDS AND PRACTICES WHICH ARE DEEMED TO BE COMMONLY ACCEPTED PURSUANT TO THIS SECTION SHALL BE THOSE RECOGNIZED BY NATIONAL STANDARD SETTING ORGANIZATIONS, NATIONAL OR STATE PROFESSIONAL ORGANIZATIONS OF THE SAME DISCIPLINE AS THE TREATING PROVIDER OR THOSE DESIGNATED OR APPROVED BY THE SUPERINTENDENT IN CONSULTATION WITH PROFESSIONAL LICENSING BOARDS IN THE DEPARTMENT OF HEALTH AND THE DEPARTMENT OF EDUCATION. THE SUPERINTENDENT, IN CONSULTATION WITH THE COMMISSIONERS OF HEALTH AND EDUCATION, MAY REJECT THE USE OF PROTOCOLS, STANDARDS AND PRACTICES OR LISTS OF DIAGNOSTIC TESTS SET BY ANY ORGANIZATION DEEMED NOT TO HAVE STANDING OR GENERAL RECOGNITION BY THE PROVIDER COMMUNITY OR APPLICABLE LICENSING BOARDS. PROTOCOLS SHALL BE DEEMED TO ESTABLISH GUIDELINES AS TO STANDARD APPROPRIATE TREATMENT AND DIAGNOSTIC TESTS FOR INJURIES SUSTAINED IN AUTOMOBILE ACCIDENTS, BUT THE ESTABLISHMENT OF STANDARD TREATMENT PROTOCOLS OR PROTOCOLS FOR THE ADMINISTRATION OF DIAGNOSTIC TESTS SHALL NOT BE INTERPRETED IN SUCH A MANNER AS TO PRECLUDE VARIANCE WHEN WARRANTED BY REASON OF MEDICAL NECESSITY. THE POLICY FORM MAY PROVIDE FOR PRE-CERTIFICATION OF CERTAIN PROCEDURES, TREATMENTS, DIAGNOSTIC TESTS OR OTHER SERVICES OR FOR THE PURCHASE OF DURABLE MEDICAL GOODS OR EQUIPMENT, EXCEPT THAT NO PRE-CERTIFICATION REQUIREMENT SHALL APPLY WITHIN TEN DAYS OF THE ACCIDENT GIVING RISE TO THE INJURY.

S 4. Subsection (d) of section 5103 of the insurance law is amended to read as follows:

(d) Insurance policy forms for insurance to satisfy the requirements of subsection (a) [hereof] OF THIS SECTION shall be subject to approval pursuant to article twenty-three of this chapter. Minimum benefit standards for such policies and for self-insurers, and rights of subrogation, examination and other such matters, shall be established by regulation pursuant to section three hundred one of this chapter, PROVIDED, HOWEVER, THAT EFFECTIVE IMMEDIATELY SUCH REGULATION SHALL BE DEEMED TO INCLUDE NEW PROVISIONS APPLICABLE TO INJURIES WHICH OCCUR ON OR AFTER THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN THAT AMENDED THIS SUBSECTION AND ESTABLISHED THE NEW YORK AUTOMOBILE INSURANCE FRAUD AND PREMIUM REDUCTION ACT. SUCH REGULATION SHALL PROVIDE THAT THE INITIAL FILING OF A NOTICE OF THE EXISTENCE OF A CLAIM OR CLAIMS FOR FIRST PARTY BENEFITS BY A COVERED PERSON SHALL BE MADE WITHIN THIRTY DAYS OF SUSTAINING AN INJURY FOR WHICH SUCH CLAIM OR CLAIMS MAY BE MADE, BUT WHICH PERMIT THE FILING OF SUCH INITIAL NOTICE OF THE EXISTENCE OF A CLAIM OR CLAIMS AS SOON AS REASONABLY PRACTICABLE

AFTER THE EXPIRATION OF SUCH THIRTY DAY PERIOD WHERE THE NATURE OF THE INJURY RESULTS IN A REASONABLY JUSTIFIABLE DELAY IN FILING THE INITIAL NOTICE DURING SUCH THIRTY DAY PERIOD.

S 5. Section 5108 of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) PROOF OF THE FACT AND COST OF A MEDICAL OR HEALTH SERVICE OR TREATMENT WHICH IS NEEDED FOR A COVERED PERSON TO RECEIVE PAYMENT OR REIMBURSEMENT FOR THAT PORTION OF A CLAIM OR CLAIMS ATTRIBUTABLE TO SUCH SERVICE OR TREATMENT, WHETHER SUCH PROOF IS SUBMITTED TO A FIRST PARTY OR ADDITIONAL FIRST PARTY BENEFITS INSURER BY THE COVERED PERSON OR DIRECTLY BY A MEDICAL PROFESSIONAL OR HEALTH SERVICES PROVIDER ON BEHALF OF SUCH COVERED PERSON, FOR A SERVICE RENDERED BY THE MEDICAL OR HEALTH SERVICES PROVIDER TO THE COVERED PERSON SHALL BE SUBMITTED WITHIN FORTY-FIVE DAYS FROM THE DATE THE SERVICE WAS RENDERED TO THE COVERED PERSON. AT THE OPTION OF THE INSURER, IN ANY CASE WHERE MULTIPLE OR CONTINUING MEDICAL OR HEALTH TREATMENTS OR SERVICES ARE REQUIRED, SUCH TIME LIMIT MAY BE WAIVED AND THE CLAIMS OF ONE OR MORE SUCH MEDICAL OR HEALTH SERVICE PROVIDERS MAY BE BUNDLED.

S 6. Section 5106 of the insurance law, subsection (b) as amended and subsection (d) as added by chapter 452 of the laws of 2005, is amended to read as follows:

S 5106. Fair claims settlement. (a) Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within [thirty] FORTY-FIVE days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within [thirty] FORTY-FIVE days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations. THE FAILURE TO ISSUE A DENIAL OF A CLAIM WITHIN THE FORTY-FIVE DAY PERIOD PROVIDED FOR IN THIS SUBSECTION SHALL NOT PRECLUDE THE INSURER FROM RAISING A DEFENSE TO THE CLAIM WHERE THE INSURER HAS MADE A REPORT TO THE INSURANCE FRAUDS BUREAU PURSUANT TO SECTION FOUR HUNDRED FIVE OF THIS CHAPTER. AN INSURER WILL ALSO NOT BE PRECLUDED FROM ESTABLISHING THAT THE CLAIMANT HAS FAILED TO MEET ITS PRIMA FACIE BURDEN OF PROOF.

(b) Every insurer shall [provide] NOTIFY a claimant [with the option of submitting] THAT any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section [to] MUST BE SETTLED BY arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent. Such simplified procedures shall include an expedited eligibility hearing option, when required, to designate the insurer for first party benefits pursuant to subsection (d) of this section. The expedited eligibility hearing option shall be a forum for eligibility disputes only, and shall not include the submission of any particular bill, payment or claim for any specific benefit for adjudication, nor shall it consider any other defense to payment.

(c) An award by an arbitrator shall be binding except where vacated or modified by a master arbitrator in accordance with simplified procedures to be promulgated or approved by the superintendent. The grounds for vacating or modifying an arbitrator's award by a master arbitrator shall

not be limited to those grounds for review set forth in article seventy-five of the civil practice law and rules. The award of a master arbitrator shall be binding except for the grounds for review set forth in article seventy-five of the civil practice law and rules[, and provided further that where the amount of such master arbitrator's award is five thousand dollars or greater, exclusive of interest and attorney's fees, the insurer or the claimant may institute a court action to adjudicate the dispute de novo].

(d) Where there is reasonable belief more than one insurer would be the source of first party benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, then the first insurer to whom notice of claim is given shall be responsible for payment. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section five thousand one hundred five of this article and regulation as promulgated by the superintendent, and any insurer paying first-party benefits shall be reimbursed by other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the provisions entitled "other coverage" contained in regulation and the provisions entitled "other sources of first-party benefits" contained in regulation. If there is no such insurer and the motor vehicle accident occurs in this state, then an applicant who is a qualified person as defined in article fifty-two of this chapter shall institute the claim against motor vehicle accident indemnification corporation.

S 7. Subsection (c) of section 5303 of the insurance law is amended to read as follows:

(c) Such plan shall provide for the method of classifying risks, establishing territories and making rates applicable thereto. Such rates[, except with respect to rates for the minimum limits of insurance required by article six or seven of the vehicle and traffic law,] shall be based upon loss and expense experience of the risks insured pursuant to the plan.

S 8. The insurance law is amended by adding a new section 405-a to read as follows:

S 405-A. COMPENSATION FOR REPORT OF INSURANCE FRAUD TO LAW ENFORCEMENT AUTHORITIES. (A) ANY PERSON, OTHER THAN PERSONS DESCRIBED IN SUBSECTION (A) OF SECTION FOUR HUNDRED FIVE OF THIS ARTICLE, WHO HAS REASON TO BELIEVE THAT A FRAUDULENT INSURANCE ACT PROHIBITED PURSUANT TO ARTICLE ONE HUNDRED SEVENTY-SIX OF THE PENAL LAW HAS BEEN COMMITTED OR THAT AN INSURANCE TRANSACTION MAY BE FRAUDULENT, OR HAS KNOWLEDGE THAT A FRAUDULENT INSURANCE TRANSACTION IS ABOUT TO TAKE PLACE, OR HAS TAKEN PLACE MAY REPORT SUCH ACT OR TRANSACTION AND ANY ADDITIONAL INFORMATION RELATIVE TO THE FACTUAL CIRCUMSTANCES OF THE TRANSACTION AND THE PARTIES INVOLVED TO THE ATTORNEY GENERAL, DISTRICT ATTORNEY OR INSURANCE FRAUDS BUREAU.

(B) IF THE INSURANCE FRAUDS BUREAU RECOMMENDS TO THE ATTORNEY GENERAL OR DISTRICT ATTORNEY TO COMMENCE AN ACTION OR IF THE ATTORNEY GENERAL OR DISTRICT ATTORNEY COMMENCES AN ACTION BASED ON INFORMATION PROVIDED BY A PERSON PURSUANT TO SUBSECTION (A) OF THIS SECTION, THEN SUCH PERSON SHALL BE ENTITLED TO RECEIVE AN AWARD OF AT LEAST FIFTEEN PERCENT, BUT NOT MORE THAN TWENTY-FIVE PERCENT OF THE PROCEEDS OF THE ACTION OR SETTLEMENT OF THE CLAIM UP TO A MAXIMUM OF TWENTY-FIVE THOUSAND DOLLARS. THE ATTORNEY GENERAL OR DISTRICT ATTORNEY SHALL RECOMMEND TO THE COURT WHEN A SETTLEMENT IS ENTERED THE AMOUNT OF SUCH AWARD. THE COURT SHALL

BASE SUCH AWARD DECISION ON THE EXTENT TO WHICH THE PERSON SUBSTANTIALLY CONTRIBUTED TO THE PROSECUTION OF THE ACTION.

S 9. Section 176.00 of the penal law is amended by adding three new subdivisions 6, 7 and 8 to read as follows:

6. "PROVIDER" MEANS AN ATTORNEY, A HEALTH CARE PROFESSIONAL, AN OWNER OR OPERATOR OF A HEALTH CARE PRACTICE OR FACILITY, ANY PERSON WHO CREATES THE IMPRESSION THAT HE OR SHE, OR HIS OR HER PRACTICE CAN PROVIDE LEGAL OR HEALTH CARE SERVICES, OR ANY PERSON EMPLOYED OR ACTING ON BEHALF OF ANY SUCH PERSON.

7. "PUBLIC MEDIA" MEANS TELEPHONE DIRECTORIES, PROFESSIONAL DIRECTORIES, NEWSPAPERS AND OTHER PERIODICALS, RADIO AND TELEVISION, BILLBOARDS, AND MAILED OR ELECTRONICALLY TRANSMITTED WRITTEN COMMUNICATIONS THAT DO NOT INVOLVE IN-PERSON CONTACT WITH A SPECIFIC PROSPECTIVE CLIENT, PATIENT, OR CUSTOMER.

8. "RUNNER" MEANS A PERSON WHO, FOR A PECUNIARY BENEFIT, PROCURES OR ATTEMPTS TO PROCURE A CLIENT, PATIENT OR CUSTOMER AT THE DIRECTION OF, REQUEST OF OR IN COOPERATION WITH A PROVIDER WHEN SUCH PERSON KNOWS OR HAS REASON TO KNOW THAT THE PURPOSE OF SUCH PROVIDER IS TO SEEK TO FALSELY OR FRAUDULENTLY: OBTAIN BENEFITS UNDER A CONTRACT OF INSURANCE; OR ASSERT A CLAIM AGAINST AN INSURED OR AN INSURANCE CARRIER FOR PROVIDING SERVICES TO THE CLIENT, PATIENT OR CUSTOMER. SUCH TERM SHALL NOT INCLUDE A PERSON WHO PROCURES OR ATTEMPTS TO PROCURE CLIENTS, PATIENTS OR CUSTOMERS FOR A PROVIDER THROUGH PUBLIC MEDIA OR A PERSON WHO REFERS CLIENTS, PATIENTS OR CUSTOMERS AS AUTHORIZED BY LAW. NOTHING IN THIS ARTICLE SHALL BE DEEMED TO PROHIBIT AN AGENT, BROKER OR EMPLOYEE OF A HEALTH MAINTENANCE ORGANIZATION FROM SEEKING TO SELL HEALTH MAINTENANCE ORGANIZATION COVERAGE OR HEALTH INSURANCE COVERAGE TO AN INDIVIDUAL OR GROUP.

S 10. Subdivision 1 of section 176.05 of the penal law, as amended by chapter 211 of the laws of 2011, is amended to read as follows:

1. any written statement as part of, or in support of, an application for the issuance of, or the rating of a POLICY INSURING AGAINST LOSSES OR LIABILITIES ARISING OUT OF THE OWNERSHIP, OPERATION, OR USE OF A MOTOR VEHICLE, A commercial insurance policy, or certificate or evidence of self insurance for commercial insurance or commercial self insurance, or a claim for payment or other benefit pursuant to an insurance policy or self insurance program for commercial or personal insurance that he or she knows to:

(a) contain materially false information concerning any fact material thereto; or

(b) conceal, for the purpose of misleading, information concerning any fact material thereto; or

S 11. The penal law is amended by adding a new section 176.66 to read as follows:

S 176.66 UNLAWFUL PROCUREMENT OF CLIENTS, PATIENTS OR CUSTOMERS.

A PERSON IS GUILTY OF UNLAWFUL PROCUREMENT OF CLIENTS, PATIENTS OR CUSTOMERS WHEN, HE OR SHE KNOWINGLY:

1. ACTS AS A RUNNER; OR

2. USES, SOLICITS, DIRECTS, HIRES OR EMPLOYS ANOTHER PERSON TO ACT AS A RUNNER.

UNLAWFUL PROCUREMENT OF CLIENTS, PATIENTS OR CUSTOMERS IS A CLASS E FELONY.

S 12. Section 176.15 of the penal law, as amended by chapter 515 of the laws of 1986, is amended to read as follows:

S 176.15 Insurance fraud in the fourth degree.

A person is guilty of insurance fraud in the fourth degree when he OR SHE commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of [one thousand] FIVE HUNDRED dollars.

Insurance fraud in the fourth degree is a class E felony.

S 13. Section 176.20 of the penal law, as amended by chapter 515 of the laws of 1986, is amended to read as follows:

S 176.20 Insurance fraud in the third degree.

A person is guilty of insurance fraud in the third degree when he OR SHE commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of [three] ONE thousand FIVE HUNDRED dollars.

Insurance fraud in the third degree is a class D felony.

S 14. Section 176.25 of the penal law, as added by chapter 515 of the laws of 1986, is amended to read as follows:

S 176.25 Insurance fraud in the second degree.

A person is guilty of insurance fraud in the second degree when he OR SHE commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of [fifty] TWENTY-FIVE thousand dollars.

Insurance fraud in the second degree is a class C felony.

S 15. Section 176.30 of the penal law, as added by chapter 515 of the laws of 1986, is amended to read as follows:

S 176.30 Insurance fraud in the first degree.

A person is guilty of insurance fraud in the first degree when he OR SHE commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of [one million] FIVE HUNDRED THOUSAND dollars.

Insurance fraud in the first degree is a class B felony.

S 16. Section 176.35 of the penal law, as added by chapter 635 of the laws of 1996, is amended to read as follows:

S 176.35 Aggravated insurance fraud IN THE THIRD DEGREE.

A person is guilty of aggravated insurance fraud in the [fourth] THIRD degree when he OR SHE commits [a fraudulent insurance act] THE OFFENSE OF INSURANCE FRAUD IN THE FIFTH DEGREE, and has been previously convicted within the preceding five years of any offense, an essential element of which is the commission of a fraudulent insurance act.

Aggravated insurance fraud in the [fourth] THIRD degree is a class D felony.

S 17. The penal law is amended by adding two new sections 176.36 and 176.37 to read as follows:

S 176.36 AGGRAVATED INSURANCE FRAUD IN THE SECOND DEGREE.

A PERSON IS GUILTY OF AGGRAVATED INSURANCE FRAUD IN THE SECOND DEGREE WHEN HE OR SHE COMMITS THE OFFENSE OF INSURANCE FRAUD IN THE FOURTH DEGREE, AND HAS BEEN PREVIOUSLY CONVICTED WITHIN THE PRECEDING FIVE YEARS OF ANY OFFENSE, AN ESSENTIAL ELEMENT OF WHICH IS THE COMMISSION OF A FRAUDULENT INSURANCE ACT.

AGGRAVATED INSURANCE FRAUD IN THE SECOND DEGREE IS A CLASS C FELONY.

S 176.37 AGGRAVATED INSURANCE FRAUD IN THE FIRST DEGREE.

A PERSON IS GUILTY OF AGGRAVATED INSURANCE FRAUD IN THE FIRST DEGREE WHEN HE OR SHE COMMITS THE OFFENSE OF INSURANCE FRAUD IN THE THIRD DEGREE, AND HAS BEEN PREVIOUSLY CONVICTED WITHIN THE PRECEDING FIVE YEARS OF ANY OFFENSE, AN ESSENTIAL ELEMENT OF WHICH IS THE COMMISSION OF A FRAUDULENT INSURANCE ACT.

AGGRAVATED INSURANCE FRAUD IN THE FIRST DEGREE IS A CLASS B FELONY.

S 18. Paragraph (a) of subdivision 2 of section 846-m of the executive law, as amended by section 6 of part T of chapter 57 of the laws of 2000, is amended to read as follows:

(a) The moneys received by the fund shall be expended in a manner that is consistent with the plan of operation, pursuant to appropriation, only to reimburse costs incurred by provider agencies for pilot program activities relating to the detection, prevention or reduction of motor vehicle theft and motor vehicle insurance fraud, PROVIDED, HOWEVER, THAT BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN, ADDITIONAL MONIES RECEIVED BY THE FUND PURSUANT TO AN APPROPRIATION MADE BY A CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN ESTABLISHING THE NEW YORK AUTOMOBILE INSURANCE FRAUD AND PREMIUM REDUCTION ACT SHALL BE USED EXCLUSIVELY TO SUPPORT EFFORTS UNDERTAKEN BY DISTRICT ATTORNEYS TO DETECT, IDENTIFY AND PROSECUTE FRAUD PERTAINING TO ARTICLE FIFTY-ONE OF THE INSURANCE LAW.

S 19. No later than eighteen months after the effective date of this act, the superintendent of insurance shall study, evaluate and report to the governor and legislature on the impact and effect of this act on private passenger automobile insurance costs, by rating territory, in New York state. The superintendent of insurance shall recommend for each insurer, by rating territory, a one-time premium reduction for the insurance required pursuant to article 51 of the insurance law that reflects the reduced cost of this type of coverage as a result of the provisions enacted pursuant to this act. Notwithstanding the provisions of article 23 of the insurance law, any such recommended reduction shall be binding unless demonstrated by an insurer, based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience, that such reduction would result in underwriting losses for policies issued in such rating territory.

S 20. The sum of three million one hundred thousand dollars ($3,100,000), or so much thereof as may be necessary, is hereby appropriated to the department of transportation out of any moneys in the state treasury in the general fund to the credit of the motor vehicle theft and insurance fraud prevention fund, not otherwise appropriated, and made immediately available, for the purpose of carrying out the provisions of paragraph (a) of subdivision 2 of section 846-m of the executive law, as amended pursuant to section eighteen of this act. Such moneys shall be payable on the audit and warrant of the comptroller on vouchers certified or approved by the commissioner of transportation in the manner prescribed by law.

S 21. Severability clause. If any clause, sentence, paragraph, subdivision, section or part contained in any part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part of this act contained in any part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 22. This act shall take effect on the ninetieth day after it shall have become a law.