STATE OF NEW YORK

9588

IN ASSEMBLY

January 24, 2018

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

AN ACT to amend the public health law and the insurance law, in relation to utilization review program standards and prescription drug formulary changes during a contract year, and in relation to pre-authorization of health care services

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

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

(c) Utilization of written clinical review criteria developed pursuant to a utilization review plan**. Such clinical review criteria shall utilize recognized evidence-based and peer reviewed clinical review criteria that takes into account the needs of atypical patient populations and diagnoses**;

§ 2. Paragraph (a) of subdivision 2 of section 4903 of the public health law, as amended by chapter 371 of the laws of 2015, is amended to read as follows:

(a) 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~~] **forty-eight hours** of receipt of the necessary information**, or within twenty-four hours of the receipt of necessary information if the request is for an enrollee with a medical condition that places the health of the insured in serious jeopardy without the health care services recommended by the enrollee's health care professional**. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify; (i) whether the services are considered in-network or out-of-network; (ii) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other

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

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than any applicable co-payment or co-insurance; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an enrollee may 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 care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services. **An approval for a request for pre-authorization shall be valid for the duration of the prescription or treatment as requested by the enrollee's health care provider.**

§ 3. The public health law is amended by adding a new section 4909 to read as follows:

§ 4909. Prescription drug formulary changes. 1. A health care plan required to provide essential health benefits shall not, except as otherwise provided in subdivision two of this section, remove a prescription drug from a formulary:

(a) if the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a drug to a tier with a larger deductible, copayment or coinsurance, or

(b) add utilization management restrictions to a formulary drug, unless such changes occur at the time of enrollment or issuance of coverage. Such prohibition shall apply beginning on the date on which open enrollment begins for a plan year and through the end of the plan year to which such open enrollment period applies.

2. (a) A health care plan with a formulary that includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to prescription drugs in each tier may move a prescription drug to a tier with a larger deducible, copayment or coinsurance if an AB-rated generic drug for such prescription drug is added to the formulary at the same time.

(b) A health care plan may remove a prescription drug from a formulary if the federal food and drug administration determines that such drug should be removed from the market.

§ 4. Paragraph 3 of subsection (a) of section 4902 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(3) Utilization of written clinical review criteria developed pursuant to a utilization review plan**. Such clinical review criteria shall utilize recognized evidence-based and peer reviewed clinical review criteria that takes into account the needs of atypical patient populations and diagnoses**;

§ 5. Paragraph 1 of subsection (b) of section 4903 of the insurance law, as amended by chapter 371 of the laws of 2015, is amended to read as follows:

(1) 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~~] **forty-eight hours** of receipt of the necessary information**, or within twenty-four hours of the receipt of necessary information if the request is for an insured with a medical condition that places the health of the insured in serious jeopardy without the health care services recommended by the insured's health care provider**. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in

a manner and in a form agreed upon by the parties. The notification shall identify: (i) whether the services are considered in-network or out-of-network; (ii) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an insured may 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 care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services. **An approval of request for pre-authorization shall be valid for the duration of the prescription or treatment requested for pre-authorization.**

§ 6. The insurance law is amended by adding a new section 4909 to read as follows:

§ 4909. Prescription drug formulary changes. (a) A health care plan required to provide essential health benefits shall not, except as otherwise provided in subsection (b) of this section, remove a prescription drug from a formulary:

(i) if the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a drug to a tier with a larger deductible, copayment or coinsurance, or

(ii) add utilization management restrictions to a formulary drug, unless such changes occur at the time of enrollment or issuance of coverage. Such prohibition shall apply beginning on the date on which open enrollment begins for a plan year and through the end of the plan year to which such open enrollment period applies.

(b) (i) A health care plan with a formulary that includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to prescription drugs in each tier may move a prescription drug to a tier with a larger deducible, copayment or coinsurance if an AB-rated generic drug for such prescription drug is added to the formulary at the same time.

(ii) A health care plan may remove a prescription drug from a formulary if the federal food and drug administration determines that such drug should be removed from the market.

§ 7. Subsection (a) of section 3238 of the insurance law, as added by chapter 451 of the laws of 2007, is amended to read as follows:

(a) An insurer, corporation organized pursuant to article forty-three of this chapter, municipal cooperative health benefits plan certified pursuant to article forty-seven of this chapter, or health maintenance organization and other organizations certified pursuant to article forty-four of the public health law ("health plan") shall pay claims for a health care service for which a pre-authorization was required by, and received from, the health plan prior to the rendering of such health care service, **and eligibility confirmed on the day of the service,** unless:

(1) [~~**(i) the insured, subscriber, or enrollee was not a covered person at the time the health care service was rendered.**~~

~~**(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, a health plan shall not deny a claim on this basis if the insured's, subscriber's or enrollee's coverage was retroactively terminated more than one hundred twenty days after the date of the health care service, provided that the claim is submitted within ninety days**~~

~~after the date of the health care service. If the claim is submitted more than ninety days after the date of the health care service, the health plan shall have thirty days after the claim is received to deny the claim on the basis that the insured, subscriber or enrollee was not a covered person on the date of the health care service.~~

~~(2)~~] the submission of the claim with respect to an insured, subscriber or enrollee was not timely under the terms of the applicable provider contract, if the claim is submitted by a provider, or the policy or contract, if the claim is submitted by the insured, subscriber or enrollee;

[~~(3)~~] **(2)** at the time the pre-authorization was issued, the insured, subscriber or enrollee had not exhausted contract or policy benefit limitations based on information available to the health plan at such time, but subsequently exhausted contract or policy benefit limitations after authorization was issued; provided, however, that the health plan shall include in the notice of determination required pursuant to subsection (b) of section four thousand nine hundred three of this chapter and subdivision two of section forty-nine hundred three of the public health law that the visits authorized might exceed the limits of the contract or policy and accordingly would not be covered under the contract or policy;

[~~(4)~~] **(3)** the pre-authorization was based on materially inaccurate or incomplete information provided by the insured, subscriber or enrollee, the designee of the insured, subscriber or enrollee, or the health care provider such that if the correct or complete information had been provided, such pre-authorization would not have been granted; **or**

[~~(5) the pre-authorized service was related to a pre-existing condition that was excluded from coverage; or~~

~~(6)~~] **(4)** there is a reasonable basis supported by specific information available for review by the superintendent that the insured, subscriber or enrollee, the designee of the insured, subscriber or enrollee, or the health care provider has engaged in fraud or abuse.

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