

# STATE OF NEW YORK

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383

2019-2020 Regular Sessions

## IN ASSEMBLY

(Prefiled)

January 9, 2019

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Introduced by M. of A. BRAUNSTEIN, WEPRIN, GOTTFRIED, OTIS, BRONSON, GALEF, GUNTHER, CRESPO, O'DONNELL, GOODELL, MONTESANO, ZEBROWSKI, McDONOUGH, STECK, ABINANTI, FRIEND -- Multi-Sponsored by -- M. of A. COOK, PEOPLES-STOKES, PERRY, RAMOS, RIVERA -- read once and referred to the Committee on Insurance

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 chapter 371 of the laws of 2015, is amended to read as  
3 follows:  
4 (b) (1) A utilization review agent shall make a utilization review  
5 determination involving health care services which require pre-authori-  
6 zation and provide notice of a determination to the insured or insured's  
7 designee and the insured's health care provider by telephone and in  
8 writing within three [~~business~~] days of receipt of the necessary infor-  
9 mation. To the extent practicable, such written notification to the  
10 enrollee's health care provider shall be transmitted electronically, in  
11 a manner and in a form agreed upon by the parties. The notification  
12 shall identify: (i) whether the services are considered in-network or  
13 out-of-network; (ii) whether the insured will be held harmless for the  
14 services and not be responsible for any payment, other than any applica-  
15 ble co-payment, co-insurance or deductible; (iii) as applicable, the  
16 dollar amount the health care plan will pay if the service is out-of-  
17 network; and (iv) as applicable, information explaining how an insured  
18 may determine the anticipated out-of-pocket cost for out-of-network  
19 health care services in a geographical area or zip code based upon the  
20 difference between what the health care plan will reimburse for out-of-

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

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1 network health care services and the usual and customary cost for out-  
2 of-network health care services.

3 (2) With regard to individual or group contracts authorized pursuant  
4 to article thirty-two, forty-three or forty-seven of this chapter or  
5 article forty-four of the public health law, for utilization and review  
6 determinations involving proposed mental health and/or substance use  
7 disorder services where the insured or the insured's designee has, in a  
8 format prescribed by the superintendent, certified in the request that  
9 the proposed services are for an individual who will be appearing, or  
10 has appeared, before a court of competent jurisdiction and may be  
11 subject to a court order requiring such services, the utilization review  
12 agent shall make a determination and provide notice of such determi-  
13 nation to the insured or the insured's designee by telephone within  
14 seventy-two hours of receipt of the request. Written notice of the  
15 determination to the insured or insured's designee shall follow within  
16 three business days. Where feasible, such telephonic and written notice  
17 shall also be provided to the court.

18 § 2. Subdivision 2 of section 4903 of the public health law, as  
19 amended by chapter 371 of the laws of 2015, is amended to read as  
20 follows:

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

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

54 § 3. This act shall take effect immediately.