STATE OF NEW YORK

383

2019-2020 Regular Sessions

IN ASSEMBLY

(Prefiled)

January 9, 2019

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:

Section 1. 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:

(b) (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 of receipt of the necessary information. 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-

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

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

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

§ 2. 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:

2. (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 of receipt of the necessary information. 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 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.

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

§ 3. This act shall take effect immediately.