STATE OF NEW YORK

2498

2019-2020 Regular Sessions

IN SENATE

January 25, 2019

Introduced by Sen. MARTINEZ -- read twice and ordered printed, and when printed to be committed 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-
21 network health care services and the usual and customary cost for out-
22 of-network health care services.
23 (2) With regard to individual or group contracts authorized pursuant
24 to article thirty-two, forty-three or forty-seven of this chapter or

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

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1 article forty-four of the public health law, for utilization and review
2 determinations involving proposed mental health and/or substance use
3 disorder services where the insured or the insured's designee has, in a
4 format prescribed by the superintendent, certified in the request that
5 the proposed services are for an individual who will be appearing, or
6 has appeared, before a court of competent jurisdiction and may be
7 subject to a court order requiring such services, the utilization review
8 agent shall make a determination and provide notice of such determi-
9 nation to the insured or the insured's designee by telephone within
10 seventy-two hours of receipt of the request. Written notice of the
11 determination to the insured or insured's designee shall follow within
12 three business days. Where feasible, such telephonic and written notice
13 shall also be provided to the court.
14 § 2. Subdivision 2 of section 4903 of the public health law, as
15 amended by chapter 371 of the laws of 2015, is amended to read as
16 follows:
17 2. (a) A utilization review agent shall make a utilization review
18 determination involving health care services which require pre-authori-
19 zation and provide notice of a determination to the enrollee or
20 enrollee's designee and the enrollee's health care provider by telephone
21 and in writing within three [~~business~~] days of receipt of the necessary
22 information. To the extent practicable, such written notification to the
23 enrollee's health care provider shall be transmitted electronically, in
24 a manner and in a form agreed upon by the parties. The notification
25 shall identify; (i) whether the services are considered in-network or
26 out-of-network; (ii) and whether the enrollee will be held harmless for
27 the services and not be responsible for any payment, other than any
28 applicable co-payment or co-insurance; (iii) as applicable, the dollar
29 amount the health care plan will pay if the service is out-of-network;
30 and (iv) as applicable, information explaining how an enrollee may
31 determine the anticipated out-of-pocket cost for out-of-network health
32 care services in a geographical area or zip code based upon the differ-
33 ence between what the health care plan will reimburse for out-of-network
34 health care services and the usual and customary cost for out-of-network
35 health care services.
36 (b) With regard to individual or group contracts authorized pursuant
37 to article forty-four of this chapter, for utilization review determi-
38 nations involving proposed mental health and/or substance use disorder
39 services where the enrollee or the enrollee's designee has, in a format
40 prescribed by the superintendent of financial services, certified in the
41 request that the proposed services are for an individual who will be
42 appearing, or has appeared, before a court of competent jurisdiction and
43 may be subject to a court order requiring such services, the utilization
44 review agent shall make a determination and provide notice of such
45 determination to the enrollee or the enrollee's designee by telephone
46 within seventy-two hours of receipt of the request. Written notice of
47 the determination to the enrollee or enrollee's designee shall follow
48 within three business days. Where feasible, such telephonic and written
49 notice shall also be provided to the court.
50 § 3. This act shall take effect immediately.