STATE OF NEW YORK

562

2021-2022 Regular Sessions

IN ASSEMBLY

(Prefiled)

January 6, 2021

Introduced by M. of A. BRAUNSTEIN, WEPRIN, GOTTFRIED, OTIS, BRONSON, GALEF, GUNTHER, O'DONNELL, ZEBROWSKI, STECK, ABINANTI, GOODELL, MONTESANO, McDONOUGH, FRIEND -- Multi-Sponsored by -- M. of A. COOK, PEOPLES-STOKES, PERRY, RAMOS, J. 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. Paragraph 1 of subsection (b) of section 4903 of the insurance law, as separately amended by section 16 of part YY and section 7 of part KKK of chapter 56 of the laws of 2020, 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 of receipt of the necessary information, or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. 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

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

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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.

§ 2. Paragraph (a) of subdivision 2 of section 4903 of the public health law, as separately amended by section 13 of part YY and section 3 of part KKK of chapter 56 of the laws of 2020, 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 of receipt of the necessary information. 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.

§ 3. This act shall take effect immediately.