STATE OF NEW YORK

4714

2021-2022 Regular Sessions

IN SENATE

February 9, 2021

Introduced by Sen. BRESLIN -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to enacting the "automobile insurance fraud prevention act of 2021"

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

Section 1. This act shall be known and may be cited as the "automobile insurance fraud prevention act of 2021".

§ 2. Section 5106 of the insurance law, subsection (b) as amended by chapter 452 of the laws of 2005, and subsection (d) as amended by section 8 of part AAA of chapter 59 of the laws of 2017, is amended to read as follows:

§ 5106. Fair claims settlement. (a) **(1)** Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.

(2) The failure to issue a denial of a claim within thirty days shall not preclude the insurer or self-insurer from presenting evidence to establish that (A) the services or items billed for in a claim were not provided; (B) certain portions of the charges for services in a claim exceed, by more than ten percent, the charges permissible under schedules prepared and established pursuant to subsections (a) and (b) of section five thousand one hundred eight of this article, or (C) the

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

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event from which the claim arose was based upon an intent to defraud an insurer or self-insurer. Nothing contained in this paragraph shall preclude an insurer from contesting the existence of applicable insurance coverage for the loss claimed.

(3) An insurer may deny a claim on the basis of lack of medical necessity not later than sixty days after the date upon which the claim became overdue. Any denial of a claim which is based upon a lack of medical necessity shall be based upon review by a licensed provider who typically diagnoses and provides treatment for the condition under review, or typically provides the health care service or treatment under review. Copies of all reports prepared by a health care provider who examines a claimant at the request of an insurer or reviews a claim for medical benefits at the request of an insurer shall be provided to the claimant, the claimant's attorney and the claimant's treating health care provider within thirty business days of such examination or review.

(b) [~~Every insurer shall provide a~~] (1) A claimant [~~with~~] shall have the option of submitting any dispute involving the insurer's liability to pay first party benefits, or additional first party benefits, the amount thereof or any other matter which may arise pursuant to subsection (a) of this section to arbitration pursuant to simplified procedures to be promulgated or approved by the superintendent. Such simplified procedures shall include an expedited eligibility hearing option, when required, to designate the insurer for first party benefits pursuant to subsection [~~(d)~~] (f) of this section. The expedited eligibility hearing option shall be a forum for eligibility disputes only, and shall not include the submission of any particular bill, payment or claim for any specific benefit for adjudication, nor shall it consider any other defense to payment.

[~~(c)~~] (2) The commencement of a court proceeding or the submission of a dispute to arbitration shall not preclude a claimant from electing to submit other disputes arising from the same instance of use or operation of a motor vehicle to the alternate forum. However, with the exception of a proceeding brought pursuant to article seventy-five of the civil practice law and rules, a claimant may not submit a dispute regarding the same denial to multiple forums.

(3) Arbitrators are required to follow and apply substantive law. An award by an arbitrator shall be binding except where vacated or modified by a master arbitrator in accordance with simplified procedures to be promulgated or approved by the superintendent, which shall offer the parties the opportunity to submit written briefs. The grounds for vacating or modifying an arbitrator's award by a master arbitrator shall not be limited to those grounds for review set forth in article seventy-five of the civil practice law and rules and shall include factual, legal and procedural errors. The award of a master arbitrator shall be binding except for the grounds for review set forth in article seventy-five of the civil practice law and rules, and provided further that where the amount of such master arbitrator's award is five thousand dollars or greater, exclusive of interest and attorney's fees, the insurer or the claimant may institute a court action to adjudicate the dispute de novo.

[~~(d)~~] (c) With respect to an action for serious personal injury pursuant to section five thousand one hundred four of this article, the award of an arbitrator or master arbitrator rendered in a proceeding brought pursuant to this article, other than an award pertaining to the issue of the existence of insurance coverage, shall not constitute collateral estoppel of the issues arbitrated.

(d) With respect to an arbitration or an action commenced in a court of competent jurisdiction initiated to obtain payment of an overdue claim for the payment of medical benefits prima facie entitlement to benefits shall be established by filing a verification by the claimant with the arbitration demand or complaint, setting forth that:

(1) the claimant was licensed to render the services or the items provided at the time they were provided;

(2) the services were rendered or items supplied by the claimant;

(3) the services or items were medically necessary, or, for services or supplies provided pursuant to prescription, that such were properly supported by a prescription;

(4) the claimant received an assignment of benefits from the injured party or the guardian or parent of the injured party; and

(5) the claimant authorized the particular attorney or law firm to commence the suit.

(e) With respect to an action commenced in a court of competent jurisdiction to obtain benefits pursuant to this article:

(1) A rebuttable presumption of admissibility attaches to claims forms, denial of claims forms, verification requests and responses thereto, when such are accompanied by an affidavit establishing that such forms are business records pursuant to rule forty-five hundred eighteen of the civil practice law and rules.

(2) A rebuttable evidentiary presumption shall attach to such documents referenced in paragraph one of this subsection that such are valid.

(3) A rebuttable evidentiary presumption shall attach to such documents referenced in paragraph one of this subsection that such were mailed to the address contained thereon, on the date contained thereon.

(4) A rebuttable evidentiary presumption shall attach to proofs of payment that such payments were made by the insurer and received by the plaintiff.

(5) In matters where the insurer's denial is based upon an alleged lack of medical necessity, a rebuttable presumption of admissibility attaches to medical reports of the claimant's treating providers.

(6) Nothing contained in this subsection shall preclude a party from offering evidence at trial to rebut any presumption in this subsection, nor to preclude an insurer from offering evidence at trial on any meritorious, non-precluded defense to payment of the benefits.

(7) The deposition of any person may be used by any party without the necessity of showing unavailability or special circumstances, subject to the right of any party to move pursuant to section thirty-one hundred three of the civil practice law and rules to prevent abuse, provided that the party against whom the evidence is offered had been afforded an opportunity to participate and question the witness at the deposition.

(f) (1) Except as provided in paragraph two of this subsection, where there is reasonable belief more than one insurer would be the source of first party benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially. If there is no such agreement, then the first insurer to whom notice of claim is given shall be responsible for payment. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section five thousand one hundred five of this article and regulations as promulgated by the superintendent, and any insurer paying first-party benefits shall be reimbursed by other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the

provisions entitled "other coverage" contained in regulation and the provisions entitled "other sources of first-party benefits" contained in regulation. If there is no such insurer and the motor vehicle accident occurs in this state, then an applicant who is a qualified person as defined in article fifty-two of this chapter shall institute the claim against the motor vehicle accident indemnification corporation.

(2) A group policy issued pursuant to section three thousand four hundred fifty-five of this chapter shall provide first party benefits when a dispute exists as to whether a driver was using or operating a motor vehicle in connection with a transportation network company when loss, damage, injury, or death occurs. A transportation network company shall notify the insurer that issued the owner's policy of liability insurance of the dispute within ten business days of becoming aware that the dispute exists. When there is a dispute, the group insurer liable for the payment of first party benefits under a group policy shall have the right to recover the amount paid from the driver's insurer to the extent that the driver would have been liable to pay damages in an action at law.

§ 3. Section 5109 of the insurance law, as added by chapter 423 of the laws of 2005, is amended to read as follows:

§ 5109. Unauthorized providers of health services. (a) The superintendent[~~, in consultation with the commissioner of health and the commissioner of education,~~] shall by regulation, promulgate standards and procedures for investigating and suspending or removing the authorization for providers of health services to demand or request payment for health services as specified in paragraph one of subsection (a) of section five thousand one hundred two of this article upon findings reached after investigation pursuant to this section. Such regulations shall ensure the same or greater due process provisions, [~~including~~] **and include** notice and opportunity to be heard, as those afforded physicians investigated under article two of the workers' compensation law and shall include provision for notice to all providers of health services of the provisions of this section and regulations promulgated thereunder at least ninety days in advance of the effective date of such regulations. **As used in this section, "health services" means services, supplies, therapies or other treatment as specified in subparagraph (i), (ii) or (iv) of paragraph one of subsection (a) of section five thousand one hundred two of this article.**

(b) [~~The commissioner of health and the commissioner of education shall provide a list of the names of all providers of health services who the commissioner of health and the commissioner of education shall deem, after reasonable investigation, not authorized to demand or request any payment for medical services in connection with any claim under this article because such~~] **Following the hearing conducted pursuant to the procedures and regulation promulgated pursuant to this section, the superintendent may prohibit a provider of health services from demanding or requesting payment for health services subsequently rendered under this article, for a period not exceeding three years, if the superintendent determines, after notice and hearing, that the** provider of health services:

(1) has **admitted to, or** been **found** guilty of**,** professional [~~or other~~] misconduct [~~or incompetency~~]**, as defined in the education law,** in connection with [~~medical~~] **health** services rendered under this article; or

(2) has exceeded the limits of his or her professional competence in rendering medical care under this article or has knowingly made a false

statement or representation as to a material fact in any medical report made in connection with any claim under this article; or

(3) solicited, or has employed another to solicit for himself or herself or for another, professional treatment, examination or care of an injured person in connection with any claim under this article; or

(4) has refused to appear before, or to answer upon request of, the [~~commissioner of health, the~~] superintendent[~~,~~] or any duly authorized officer of the state, any legal question, or **refused** to produce any relevant information concerning [~~his or her~~] **the** conduct **of the provider of health services** in connection with [~~rendering medical~~] **health** services **rendered** under this article; or

(5) has engaged in [~~patterns~~] **a pattern** of billing for**: health** services [~~which were not provided.~~] **alleged to have been rendered under this article, when the health services were not rendered, provided that this shall not be construed to apply to good faith disputes regarding the appropriateness of a particular coding to describe a health care service; or**

(6) utilized unlicensed persons to render health services under this article, when only a person licensed in this state may render the health services; or

(7) utilized licensed persons to render health services under this article, when rendering the health services is beyond the authorized scope of the license of such person; or

(8) unlawfully ceded ownership, operation or control of a business entity authorized to provide professional health services in this state, including but not limited to a professional service corporation, professional limited liability company or registered limited liability partnership, to a person not licensed to render the health services which the entity is legally authorized to provide; or

(9) committed a fraudulent insurance act as defined in section 176.05 of the penal law; or

(10) has been convicted of a crime involving fraudulent or dishonest practices; or

(11) has, after warning by the superintendent, engaged in a pattern of unlawfully attempting to collect payment directly from the patient or eligible person for services rendered under this article when such attempts violate the terms of an enforceable assignment of benefits.

(c) [~~Providers~~] **The superintendent shall by regulation develop due process procedures to assure a health provider accused under this section has appropriate notice, an opportunity for a fair hearing and appeal prior to a determination that the health provider may not bill for services under this section. A provider** of health services shall [~~refrain from subsequently treating for remuneration, as a private patient, any person seeking medical treatment~~] **not demand or request payment for any health services** under this article [~~if such provider pursuant to this section has been prohibited from demanding or requesting any payment for medical services under this article. An injured claimant so treated or examined may raise this as~~] **that are rendered during the term of the prohibition ordered by the superintendent pursuant to subsection (b) of this section. The prohibition ordered by the superintendent may be** a defense in any action by [~~such~~] **the** provider **of health services** for payment for [~~treatment~~] **health services** rendered **pursuant to this article** at any time after such provider has been prohibited from demanding or requesting payment for [~~medical~~] **such health** services in connection with any claim under this article.

(d) The [~~commissioner of health and the commissioner of education~~] superintendent shall maintain and regularly update a database containing a list of providers of health services prohibited by this section from demanding or requesting any payment [~~for health services connected to a claim~~] rendered under this article and shall make [~~such~~] the information available to the public [~~by means of a website and by a toll free number~~].

(e) The superintendent may levy a civil penalty not exceeding fifty thousand dollars on any provider of health services that the superintendent prohibits from demanding or requesting payment for health services pursuant to subsection (b) of this section. Any civil penalty imposed for a fraudulent insurance act, as defined in section 176.05 of the penal law, shall be levied pursuant to article four of this chapter.

(f) Nothing in this section shall be construed as limiting in any respect the powers and duties of the commissioner of health, commissioner of education or the superintendent to investigate instances of misconduct by a [~~health care~~] provider [~~and, after a hearing and upon written notice to the provider, to temporarily prohibit a provider of health services under such investigation from demanding or requesting any payment for medical services under this article for up to ninety days from the date of such notice~~] of health services and take appropriate action pursuant to any other provision of law. A determination of the superintendent pursuant to subsection (b) of this section shall not be binding upon the commissioner of health or the commissioner of education in a professional discipline proceeding relating to the same conduct.

§ 4. Subsection (d) of section 5102 of the insurance law, as amended by chapter 955 of the laws of 1984, is amended to read as follows:

(d) "Serious injury" means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; a complete tear or rupture of a nerve, tendon, ligament, cartilage or muscle; a tear, rupture or impingement of a nerve, tendon, ligament, cartilage or muscle which results in a significant impairment of a body organ, member, function or system; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

§ 5. Subsection (j) of section 3420 of the insurance law is amended by adding a new paragraph 4 to read as follows:

(4) The term "covered person" as used in this article shall mean any pedestrian injured through the use or operation of, or any owner, operator or occupant of, a motor vehicle which has in effect the financial security required by article six or eight of the vehicle and traffic law or which is referred to in subdivision two of section three hundred twenty-one of such law; or any other person entitled to first party benefits. For the purposes of this article, "covered person" shall also include any person injured as the result of a staged, planned or intentional accident, provided that such person is not a perpetrator of or a knowing participant in the staging or planning of the accident.

§ 6. Section 5202 of the insurance law is amended by adding a new subsection (m) to read as follows:

(m) "Covered person" means any pedestrian injured through the use or operation of, or any owner, operator or occupant of, a motor vehicle which has in effect the financial security required by article six or eight of the vehicle and traffic law or which is referred to in subdivision two of section three hundred twenty-one of such law; or any other person entitled to first party benefits. For the purposes of this article, "covered person" shall also include any person injured as the result of a staged, planned or intentional accident, provided that such person is not a perpetrator of or a knowing participant in the staging or planning of the accident.

§ 7. This act shall take effect immediately; provided that:

(a) section two of this act shall apply to benefits initiated on or after the one hundred eightieth day after this act shall have become a law; and

(b) sections three, five and six of this act shall take effect on the one hundred eightieth day after it shall have become a law provided that the superintendent of financial services shall immediately promulgate rules and regulations pursuant to section 5109 of the insurance law as amended by section three of this act and sections five and six of this act shall apply to all new policies and policies that are renewed or modified after such one hundred eightieth day.