STATE OF NEW YORK

2680--A

2023-2024 Regular Sessions

IN SENATE

January 24, 2023

Introduced by Sens. BRESLIN, CLEARE, COONEY, GALLIVAN, SKOUFIS -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- recommitted to the Committee on Insurance in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health law, in relation to requiring insurers and health plans to grant automatic preauthorization approvals to eligible health care professionals in certain circumstances

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

Section 1. Subsection (a) of section 4902 of the insurance law is amended by adding a new paragraph 15 to read as follows:

(15) Establishment of automatic preauthorization approval requirements for insurers to provide to health care professionals providing health care services which shall include that:

(i) an insurer that uses a preauthorization process for health care services shall provide an automatic preauthorization approval to a health care professional for a particular health care service, as defined under this title including but not limited to health care procedures, treatments, services, pharmaceutical products, services or durable medical equipment if, in the most recent six-month evaluation period, the insurer has approved not less than ninety percent of the preauthorization requests submitted by such health care professional for the particular health care service. For the purposes of this requirement, a preauthorization request submitted during the evaluation period shall be considered and counted as a single request and single approval if the request was approved at any point between the date the request was submitted by the health care professional and the final determination by the insurer, including any re-review or appeal process. Each

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

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insurer shall complete its initial evaluation and issue its determination to each health care professional in its network no later than one hundred eighty days after the effective date of this paragraph. The automatic preauthorization approval shall become effective two hundred twenty-five days after the effective date of this paragraph;

(ii) after the initial evaluation has been completed the insurer shall annually thereafter evaluate whether a health care professional qualifies for an automatic preauthorization approval under subparagraph (i) of this paragraph for additional health care services. Each year, the evaluation shall review preauthorization determinations made in the first six months of the year. Each insurer shall issue its determination to each health care professional in its network no later than November fifteenth to be effective January first of the following year;

(iii) the insurer may continue the automatic preauthorization approval under subparagraph (i) of this paragraph without evaluating whether the health care professional qualifies for automatic preauthorization approval for a particular evaluation period;

(iv) a health care professional shall not be required to request an automatic preauthorization approval to qualify for such approval;

(v) a health care professional's automatic preauthorization approval under subparagraph (i) of this paragraph shall remain in effect until the thirtieth calendar day after:

(A) the date the insurer notifies the health care professional of the insurer's determination to rescind the automatic preauthorization approval pursuant to subparagraph (vii) of this paragraph if the health care professional does not appeal such determination; or

(B) where the health care professional appeals the determination, the date the insurer notifies the health care professional that an independent review organization has affirmed the insurer's determination to rescind the automatic preauthorization approval;

(vi) where an insurer does not finalize a rescission determination as specified in subparagraph (vii) of this paragraph, the health care professional shall be considered to have met the criteria to continue to qualify for the automatic preauthorization approval, which shall remain in effect until the following evaluation period;

(vii) an insurer may rescind an automatic preauthorization approval under subparagraph (i) of this paragraph only:

(A) effective January of each year;

(B) if the insurer makes a determination on the basis of a retrospective review as specified in subparagraph (ii) of this paragraph for the most recent evaluation period that less than ninety percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the insurer when conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(C) the insurer complies with all other applicable requirements of this paragraph and the insurer notifies the health care professional not less than thirty calendar days before the proposed rescission is to take effect, together with the sample of claims used to make the determination pursuant to clause (B) of this subparagraph and a plain language explanation of the health care professional's right to appeal such determination and instructions on how to initiate such appeal;

(viii) notwithstanding any contrary provision of subparagraph (i) of this paragraph, an insurer may deny an automatic preauthorization approval:

(A) if the health care professional does not have the approval at the time of the relevant evaluation period; and

(B) the insurer provides the health care professional with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the health care professional does not meet the criteria for an automatic preauthorization approval pursuant to subparagraph (i) of this paragraph for the particular health care service;

(ix) after a final determination or review affirming the rescission or denial of an automatic preauthorization approval for a specific health care service under this paragraph, a health care professional shall be eligible for consideration of such approval for the same health care service after the evaluation period following the evaluation period which formed the basis of the rescission or denial of such approval;

(x) the insurer shall, not later than five business days after determining that a health care professional qualifies for an automatic preauthorization approval pursuant to subparagraph (i) of this paragraph, provide to a health care professional a notice that shall include:

(A) a statement that the health care professional qualifies for an automatic preauthorization approval pursuant to this paragraph;

(B) a description of the health care services to which such automatic preauthorization applies; and

(C) a statement of the duration that such automatic approval shall remain in effect;

(xi) when the health care professional submits a preauthorization request for a health care service for which the health care professional qualifies for an automatic preauthorization approval under subparagraph (i) of this paragraph, the insurer shall promptly issue an automatic preauthorization approval for such health care service;

(xii) nothing in this paragraph may be construed to:

(A) authorize a health care professional to provide a health care service outside the scope of such health care professional's applicable license; or

(B) prohibit a health insurer from performing a retrospective review of the health care service pursuant to section forty-nine hundred three of this title;

(xiii) when a health care professional provides a health care service covered by the health care professional's automatic preauthorization approval, the service is deemed medically necessary by virtue of the automatic preauthorization approval. For every claim submitted by a health care professional for such service, each insurer shall promptly pay the full payment to the health care professional. An insurer is prohibited from denying, withholding, or reducing payment to a health care professional for such health care service. An insurer may not retroactively deny, reduce, or recoup payment from a health care professional for such health care service for reasons related to medical necessity or appropriateness of care;

(xiv) an insurer may not retroactively deny, reduce, or recoup payment from a health care professional for a health care service for which the health care professional has qualified for an automatic preauthorization approval under subparagraph (i) of this paragraph unless the insurer has proven that the health care professional:

(A) knowingly and materially misrepresented the health care service in a request for preauthorization or payment submitted to the insurer with the specific intent to deceive and obtain an unlawful payment from the insurer; or

(B) failed to substantially perform the health care service;

(xv) an insurer may not retroactively deny, reduce or recoup payment from a health care professional for a health care service for which the health care professional has qualified for an automatic preauthorization approval solely on the basis of the rescission of the health care professional's automatic preauthorization approval. Nothing herein shall limit a health care professional's ability to file a complaint with the department;

(xvi) the insurer shall make available and submit to the superintendent, at the superintendent's request, documentation that describes the insurer's process for:

(A) determining the specific health care service or services for which an individual health care professional is granted an automatic preauthorization approval; and

(B) any other activity, policy, decision, or determination related to automatic preauthorization approvals; and

(xvii) the superintendent shall promulgate regulations to implement the requirements of this section and establish additional minimum standards as appropriate.

§ 2. Subdivision 1 of section 4902 of the public health law is amended by adding a new paragraph (m) to read as follows:

(m) Establishment of automatic preauthorization approval requirements for health care plans to provide to health care professionals providing certain health care services which shall include that:

(i) a health care plan that uses a preauthorization process for health care services shall provide an automatic preauthorization approval to a health care professional for a particular health care service if, as defined under this title including but not limited to health care procedures, treatments, services, pharmaceutical products, services or durable medical equipment, in the most recent six-month evaluation period, the health care plan has approved not less than ninety percent of the preauthorization requests submitted by such health care professional for the particular health care service. For the purposes of this requirement, a preauthorization request submitted during the evaluation period shall be considered and counted as a single request and single approval if the request was approved at any point between the date the request was submitted by the health care professional and the final determination by the health care plan, including any re-review or appeal process. Each insurer shall complete its initial evaluation and issue its determination to each health care professional in its network no later than one hundred eighty days after the effective date of this paragraph. The automatic preauthorization approval shall become effective two hundred twenty-five days after the effective date of this paragraph;

(ii) after the initial evaluation has been completed the health care plan shall annually thereafter evaluate whether a health care professional qualifies for an automatic preauthorization approval under subparagraph (i) of this paragraph for additional health care services. Each year, the evaluation shall review preauthorization determinations made in the first six months of the year. Each health care plan shall issue its determination to each health care professional in its network no later than November fifteenth to be effective January first of the following year;

(iii) the health care plan may continue the automatic preauthorization approval under subparagraph (i) of this paragraph without evaluating whether the health care professional qualifies for the automatic preauthorization approval for a particular evaluation period;

(iv) a health care professional shall not be required to request an automatic preauthorization approval to qualify for such approval;

(v) a health care professional's automatic preauthorization approval under subparagraph (i) of this paragraph shall remain in effect until the thirtieth calendar day after:

(A) the date the health care plan notifies the health care professional of the health care plan's determination to rescind the automatic preauthorization approval pursuant to subparagraph (vii) of this paragraph if the health care professional does not appeal such determination; or

(B) where the health care professional appeals the determination, the date the health care plan notifies the health care professional that an independent review organization has affirmed the health care plan's determination to rescind the automatic preauthorization approval;

(vi) where a health care plan does not finalize a rescission determination as specified in subparagraph (vii) of this paragraph, the health care professional shall be considered to have met the criteria to continue to qualify for the automatic preauthorization approval, which shall remain in effect until the following evaluation period;

(vii) a health care plan may rescind an exemption from preauthorization requirements under subparagraph (i) of this paragraph only:

(A) effective January each year;

(B) if the health care plan makes a determination on the basis of a retrospective review as specified in subparagraph (ii) of this paragraph for the most recent evaluation period that less than ninety percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health care plan when conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(C) the health care plan complies with all other applicable requirements of this paragraph and the health care plan notifies the health care professional not less than thirty calendar days before the proposed rescission is to take effect, together with the sample of claims used to make the determination pursuant to clause (B) of this subparagraph and a plain language explanation of the health care professional's right to appeal such determination and instructions on how to initiate such appeal;

(viii) notwithstanding any contrary provision of subparagraph (i) of this paragraph, a health care plan may deny an automatic preauthorization approval:

(A) if the health care professional does not have the approval at the time of the relevant evaluation period; and

(B) the health care plan provides the health care professional with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the health care professional does not meet the criteria for an automatic preauthorization approval pursuant to subparagraph (i) of this paragraph for the particular health care service;

(ix) after a final determination or review affirming the rescission or denial of an automatic preauthorization approval for a specific health care service under this paragraph, a health care professional shall be eligible for consideration of such approval for the same health care service after the evaluation period following the evaluation period which formed the basis of the rescission or denial of such approval;

(x) the health care plan shall, not later than five business days after determining that a health care professional qualifies for an auto-

matic preauthorization approval pursuant to subparagraph (i) of this paragraph, provide to a health care professional a notice that shall include:

(A) a statement that the health care professional qualifies for an automatic preauthorization approval pursuant to this paragraph;

(B) a description of the health care services to which such automatic preauthorization approval applies; and

(C) a statement of the duration that such automatic approval shall remain in effect;

(xi) when the health care professional submits a preauthorization request for a health care service for which the health care professional qualifies for an automatic preauthorization approval under subparagraph (i) of this paragraph, the health care plan shall promptly issue an automatic preauthorization approval for such health care service;

(xii) nothing in this paragraph shall be construed to:

(A) authorize a health care professional to provide a health care service outside the scope of such health care professional's applicable license; or

(B) prohibit a health care plan from performing a retrospective review of the health care service pursuant to section forty-nine hundred three of this title;

(xiii) when a health care professional provides a health care service covered by the health care professional's automatic preauthorization approval, the service is deemed medically necessary by virtue of the automatic preauthorization approval. For every claim submitted by a health care professional for such service, each health care plan shall promptly pay the full payment to the health care professional. A health care plan is prohibited from denying, withholding, or reducing payment to a health care professional for such health care service. A health care plan may not retroactively deny, reduce, or recoup payment from a health care professional for such health care service for reasons related to medical necessity or appropriateness of care;

(xiv) a health care plan may not retroactively deny, reduce, or recoup payment from a health care professional for a health care service for which the health care professional has qualified for an automatic preauthorization approval under subparagraph (i) of this paragraph unless the health care plan has proven that the health care professional:

(A) knowingly and materially misrepresented the health care service in a request for preauthorization or payment submitted to the health care plan with the specific intent to deceive and obtain an unlawful payment from the health care plan; or

(B) failed to substantially perform the health care service;

(xv) a health care plan may not retroactively deny, reduce or recoup payment from a health care professional for a health care service for which the health care professional has qualified for an automatic preauthorization approval solely on the basis of the rescission of the health care professional's automatic preauthorization approval. Nothing herein shall limit a health care professional's ability to file a complaint with the department;

(xvi) the health care plan shall make available and submit to the commissioner, at the commissioner's request, documentation that describes the health care plan's process for:

(A) determining the specific health care service or services for which an individual health care professional is granted an automatic preauthorization approval; and

(B) any other activity, policy, decision, or determination related to automatic preauthorization approvals; and

(xvii) the commissioner, in consultation with the superintendent, shall promulgate regulations to implement the requirements of this section and establish additional minimum standards as appropriate.

§ 3. This act shall take effect on the one hundred eightieth day after it shall have become a law.