

STATE OF NEW YORK

3321

2025-2026 Regular Sessions

IN ASSEMBLY

January 27, 2025

Introduced by M. of A. BLANKENBUSH, BRABENEC, DeSTEFANO, DURSO, HAWLEY, McDONOUGH -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, the penal law and the executive law, in relation to establishing the New York automobile insurance fraud and premium reduction act; and making an appropriation therefor

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

1 Section 1. This act shall be known and may be cited as the "New York
2 automobile insurance fraud and premium reduction act".

3 § 2. The insurance law is amended by adding a new section 5110 to read
4 as follows:

5 § 5110. Certification of managed care organizations. (a)(1) Any indi-
6 vidual or group authorized to provide medical or other health care
7 services in this state may, directly or through an authorized insurer,
8 make written application to the superintendent to become certified to
9 provide managed care to injured covered persons under this article.

10 (2) Certification shall be valid for such period and for such service
11 areas as the superintendent may prescribe, unless sooner revoked,
12 suspended or amended.

13 (3) Each application for certification shall be accompanied by a
14 reasonable fee prescribed by the superintendent and a proposed managed
15 care program detailing its significant features, methods and procedures.

16 (b) Application for certification shall be made in such form and
17 manner, and shall set forth such information regarding the proposed plan
18 of managed care for providing medical and other health care services, as
19 the superintendent may prescribe, including:

20 (1) the names and credentials of all individuals or organizations that
21 will provide services under the managed care program, together with
22 appropriate evidence of compliance with any licensing or certification
23 requirements for such individuals or organizations to practice in this
24 state;

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

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1 (2) a description of the times, places and manner of providing
2 services under the managed care program;

3 (3) a description of the times, places and manner of providing other
4 related optional services the applicant may wish to provide; and

5 (4) a description and representative copies of all remuneration and
6 related arrangements between the managed care organization and individ-
7 ual providers of services under the managed care program.

8 (c) The superintendent shall certify an applicant, if the superinten-
9 dent finds that the managed care program:

10 (1) provides medical and other health care services that meet quality,
11 continuity and other treatment standards prescribed by the superinten-
12 dent or the commissioner of health, in a manner that is timely, effec-
13 tive and convenient for injured persons;

14 (2) includes a sufficient number of each category of provider through-
15 out the proposed service areas to give injured persons adequate flexi-
16 bility to choose an authorized provider from among those health care
17 providers who participate in the managed care program;

18 (3) provides appropriate financial incentives or other approaches to
19 reduce costs and minimize improper utilization without sacrificing qual-
20 ity of service;

21 (4) provides adequate methods of peer review, utilization review, and
22 dispute resolution, including where applicable, access to the external
23 appeal process as provided in article forty-nine of this chapter, in
24 order to: (A) prevent inappropriate or excessive treatment; (B) avoid
25 conflicts of interest; (C) exclude from participation in the program
26 those providers who violate reasonable treatment standards; and (D)
27 provide for the resolution of medical disputes;

28 (5) provides a timely and accurate method of reporting to the super-
29 intendent or the commissioner of health as appropriate, necessary infor-
30 mation regarding medical and health care service cost and utilization to
31 monitor the effectiveness of the managed care program;

32 (6) provides a mechanism for an injured person to obtain treatment
33 outside of the managed care program if the services are not available or
34 accessible within the program;

35 (7) provides for a reasonable and appropriate coordination with another
36 health care provider where the injured person has been receiving
37 treatment from another health care provider for a previously existing
38 condition or injury which has been aggravated by the motor vehicle acci-
39 dent;

40 (8) provides for a mechanism for notification about and transition
41 from emergency care; and

42 (9) complies with any other requirement the superintendent determines
43 is necessary to provide quality medical and other health care services
44 to injured persons.

45 (d) The superintendent may certify a health maintenance organization
46 issued a certificate of authority under article forty-four of the public
47 health law or licensed under article forty-three of this chapter, if it
48 meets the requirements of this section. The superintendent may also
49 certify an accident and health insurer, including a corporation organ-
50 ized under article forty-three of this chapter, which has a participat-
51 ing or preferred network of providers if such insurer meets the require-
52 ments of this section. To the extent a managed care organization has
53 been reviewed, approved or certified by another state agency as to
54 accessibility, quality or continuity of care or for any of the other
55 matters within the superintendent's review, the superintendent shall
56 consider the review, approval or certification of another state agency

1 so as not to duplicate those reviews, approvals or certifications.
2 However, nothing in this subsection shall be deemed to limit the super-
3 intendent's authority to impose and review additional requirements or
4 standards above and beyond those imposed by another state agency to the
5 extent those requirements or standards are necessary or appropriate for
6 implementation of this section.

7 (e) The superintendent shall refuse to certify, or may revoke, or
8 suspend or amend the certification of, any managed care organization, if
9 the superintendent finds that:

10 (1) the managed care program for providing services fails to meet the
11 requirements of this section; or

12 (2) service under the managed care program is not being provided in
13 accordance with its terms as described in the application for certif-
14 ication.

15 (f) For purposes of this section, the superintendent may consider
16 whether providers utilized by a managed care organization or otherwise
17 authorized to provide services under the contract are authorized to
18 render medical care in accordance with section thirteen-b of the work-
19 ers' compensation law.

20 (g) Utilization review, quality assurance and peer review activities
21 pursuant to this section shall be subject to review by the superinten-
22 dent and the commissioner of health. Findings by the commissioner of
23 health of professional misconduct, or disciplinary actions in relation
24 thereto, shall be reported to the appropriate licensing boards and the
25 superintendent.

26 (h) Data generated by or received in connection with these activities,
27 including written reports, notes or records of any such activities or of
28 the review thereof, shall be confidential and shall not be disclosed,
29 except to the extent determined to be necessary by the superintendent or
30 the commissioner of health. No data generated by utilization review,
31 quality assurance or peer review activities pursuant to this section, or
32 the review thereof, shall be used in any action, suit or proceeding,
33 except to the extent determined to be necessary by the superintendent or
34 the commissioner.

35 (i) A person participating in utilization review, quality assurance,
36 or peer review activities pursuant to this section shall not be examined
37 as to any communication made in the course of such activities or the
38 findings thereof, nor shall any such person be subject to a civil action
39 for actions taken or statements made in good faith.

40 (j) Provided that there is compliance with standards governing managed
41 care established by the superintendent, no person who participates in
42 forming any network, collectively negotiating fees, or otherwise solici-
43 ts or enters into contracts in a good faith effort, to provide medical
44 or other health care services on a managed care basis in accordance with
45 the provisions of this section, shall be subject to antitrust liability
46 regarding such participation.

47 (k) The provisions of this section shall not affect the confidentiali-
48 ty or admission in evidence of a claimant's medical treatment records.

49 (l) The superintendent, in consultation with the commissioner of
50 health, shall adopt such rules as may be necessary to carry out the
51 provisions of this section.

52 § 3. Paragraph 1 of subsection (a) of section 5102 of the insurance
53 law, as amended by chapter 601 of the laws of 2022, is amended to read
54 as follows:

55 (1) All necessary expenses incurred for: (i) medical, hospital
56 (including services rendered in compliance with article forty-one of the

1 public health law, whether or not such services are rendered directly by
2 a hospital), surgical, nursing, dental, ambulance, x-ray, prescription
3 drug and prosthetic services; (ii) psychiatric, physical therapy
4 (provided that treatment is rendered pursuant to a referral) and occupa-
5 tional therapy and rehabilitation (provided that treatment is rendered
6 pursuant to a referral); (iii) any non-medical remedial care and treat-
7 ment rendered in accordance with a religious method of healing recog-
8 nized by the laws of this state; and (iv) any other professional health
9 services; all without limitation as to time, provided that within one
10 year after the date of the accident causing the injury it is ascertaina-
11 ble that further expenses may be incurred as a result of the injury. For
12 the purpose of determining basic economic loss, the expenses incurred
13 under this paragraph shall be in accordance with the limitations of
14 section five thousand one hundred eight of this article Medical treat-
15 ments, diagnostic tests and services provided by the policy shall be
16 rendered in accordance with commonly accepted protocols and professional
17 standards and practices which are commonly accepted as being beneficial
18 for the treatment of the covered injury. Protocols and professional
19 standards and practices which are deemed to be commonly accepted pursu-
20 ant to this section shall be those recognized by national standard
21 setting organizations, national or state professional organizations of
22 the same discipline as the treating provider or those designated or
23 approved by the superintendent in consultation with professional licens-
24 ing boards in the department of health and the department of education.
25 The superintendent, in consultation with the commissioners of health and
26 education, may reject the use of protocols, standards and practices or
27 lists of diagnostic tests set by any organization deemed not to have
28 standing or general recognition by the provider community or applicable
29 licensing boards. Protocols shall be deemed to establish guidelines as
30 to standard appropriate treatment and diagnostic tests for injuries
31 sustained in automobile accidents, but the establishment of standard
32 treatment protocols or protocols for the administration of diagnostic
33 tests shall not be interpreted in such a manner as to preclude variance
34 when warranted by reason of medical necessity. The policy form may
35 provide for pre-certification of certain procedures, treatments, diag-
36 nostic tests or other services or for the purchase of durable medical
37 goods or equipment, except that no pre-certification requirement shall
38 apply within ten days of the accident giving rise to the injury.

39 § 4. Subsection (d) of section 5103 of the insurance law is amended to
40 read as follows:

41 (d) Insurance policy forms for insurance to satisfy the requirements
42 of subsection (a) [~~hereof~~] of this section shall be subject to approval
43 pursuant to article twenty-three of this chapter. Minimum benefit stand-
44 ards for such policies and for self-insurers, and rights of subrogation,
45 examination and other such matters, shall be established by regulation
46 pursuant to section three hundred one of this chapter, provided, howev-
47 er, that effective immediately such regulation shall be deemed to
48 include new provisions applicable to injuries which occur on or after
49 the effective date of the chapter of the laws of two thousand twenty-
50 five that amended this subsection and established the New York automo-
51 bile insurance fraud and premium reduction act. Such regulation shall
52 provide that the initial filing of a notice of the existence of a claim
53 or claims for first party benefits by a covered person shall be made
54 within thirty days of sustaining an injury for which such claim or
55 claims may be made, but which permit the filing of such initial notice
56 of the existence of a claim or claims as soon as reasonably practicable

1 after the expiration of such thirty day period where the nature of the
2 injury results in a reasonably justifiable delay in filing the initial
3 notice during such thirty day period.

4 § 5. Section 5108 of the insurance law is amended by adding a new
5 subsection (d) to read as follows:

6 (d) Proof of the fact and cost of a medical or health service or
7 treatment which is needed for a covered person to receive payment or
8 reimbursement for that portion of a claim or claims attributable to such
9 service or treatment, whether such proof is submitted to a first party
10 or additional first party benefits insurer by the covered person or
11 directly by a medical professional or health services provider on behalf
12 of such covered person, for a service rendered by the medical or health
13 services provider to the covered person shall be submitted within
14 forty-five days from the date the service was rendered to the covered
15 person. At the option of the insurer, in any case where multiple or
16 continuing medical or health treatments or services are required, such
17 time limit may be waived and the claims of one or more such medical or
18 health service providers may be bundled.

19 § 6. Section 5106 of the insurance law, subsection (b) as amended by
20 chapter 452 of the laws of 2005, subsection (d) as amended by section 8
21 of part AAA of chapter 59 of the laws of 2017, paragraph 2 of subsection
22 (d) as amended by chapter 129 of the laws of 2022 and subsection (e) as
23 added by chapter 766 of the laws of 2023, is amended to read as follows:

24 § 5106. Fair claims settlement. (a) Payments of first party benefits
25 and additional first party benefits shall be made as the loss is
26 incurred. Such benefits are overdue if not paid within [~~thirty~~ forty-
27 five days after the claimant supplies proof of the fact and amount of
28 loss sustained. If proof is not supplied as to the entire claim, the
29 amount which is supported by proof is overdue if not paid within [~~thir-~~
30 ~~ty~~] forty-five days after such proof is supplied. All overdue payments
31 shall bear interest at the rate of two percent per month. If a valid
32 claim or portion was overdue, the claimant shall also be entitled to
33 recover [~~his~~] such claimant's attorney's reasonable fee, for services
34 necessarily performed in connection with securing payment of the overdue
35 claim, subject to limitations promulgated by the superintendent in regu-
36 lations. The failure to issue a denial of a claim within the forty-five
37 day period provided for in this subsection shall not preclude the insur-
38 er from raising a defense to the claim where the insurer has made a
39 report to the insurance frauds bureau pursuant to section four hundred
40 five of this chapter. An insurer will also not be precluded from estab-
41 lishing that the claimant has failed to meet its prima facie burden of
42 proof.

43 (b) Every insurer shall [~~provide~~] notify a claimant [~~with the option~~
44 ~~of submitting~~] that any dispute involving the insurer's liability to pay
45 first party benefits, or additional first party benefits, the amount
46 thereof or any other matter which may arise pursuant to subsection (a)
47 of this section [~~to~~] must be settled by arbitration pursuant to simpli-
48 fied procedures to be promulgated or approved by the superintendent.
49 Such simplified procedures shall include an expedited eligibility hear-
50 ing option, when required, to designate the insurer for first party
51 benefits pursuant to subsection (d) of this section. The expedited
52 eligibility hearing option shall be a forum for eligibility disputes
53 only, and shall not include the submission of any particular bill,
54 payment or claim for any specific benefit for adjudication, nor shall it
55 consider any other defense to payment.

1 (c) An award by an arbitrator shall be binding except where vacated or
2 modified by a master arbitrator in accordance with simplified procedures
3 to be promulgated or approved by the superintendent. The grounds for
4 vacating or modifying an arbitrator's award by a master arbitrator shall
5 not be limited to those grounds for review set forth in article seven-
6 ty-five of the civil practice law and rules. The award of a master arbi-
7 trator shall be binding except for the grounds for review set forth in
8 article seventy-five of the civil practice law and rules[~~, and provided
9 further that where the amount of such master arbitrator's award is five
10 thousand dollars or greater, exclusive of interest and attorney's fees,
11 the insurer or the claimant may institute a court action to adjudicate
12 the dispute de novo~~].

13 (d) (1) Except as provided in paragraph two of this subsection, where
14 there is reasonable belief more than one insurer would be the source of
15 first party benefits, the insurers may agree among themselves, if there
16 is a valid basis therefor, that one of them will accept and pay the
17 claim initially. If there is no such agreement, then the first insurer
18 to whom notice of claim is given shall be responsible for payment. Any
19 such dispute shall be resolved in accordance with the arbitration proce-
20 dures established pursuant to section five thousand one hundred five of
21 this article and regulations as promulgated by the superintendent, and
22 any insurer paying first-party benefits shall be reimbursed by other
23 insurers for their proportionate share of the costs of the claim and the
24 allocated expenses of processing the claim, in accordance with the
25 provisions entitled "other coverage" contained in regulation and the
26 provisions entitled "other sources of first-party benefits" contained in
27 regulation. If there is no such insurer and the motor vehicle accident
28 occurs in this state, then an applicant who is a qualified person as
29 defined in article fifty-two of this chapter shall institute the claim
30 against the motor vehicle accident indemnification corporation.

31 (2) A group policy issued pursuant to section three thousand four
32 hundred fifty-five or three thousand four hundred fifty-eight of this
33 chapter shall provide first party benefits when a dispute exists as to
34 whether a driver was using or operating a motor vehicle in connection
35 with a transportation network company or peer-to-peer car sharing
36 program when loss, damage, injury, or death occurs. A transportation
37 network company or peer-to-peer car sharing program administrator shall
38 notify the insurer that issued the owner's policy of liability insurance
39 of the dispute within ten business days of becoming aware that the
40 dispute exists. When there is a dispute, the group insurer liable for
41 the payment of first party benefits under a group policy shall have the
42 right to recover the amount paid from the driver's insurer or in the
43 case of a peer-to-peer car sharing program, the shared vehicle owner's
44 insurer to the extent that the driver would have been liable to pay
45 damages in an action at law.

46 (e) With respect to an action for serious personal injury permissible
47 under section five thousand one hundred four of this article, an award
48 or decision of an arbitrator or master arbitrator or that is court
49 rendered pursuant to subsection (c) of this section seeking no-fault
50 reimbursement by or for medical providers, shall not be given collateral
51 estoppel effect in any action or proceeding arising out of the same
52 occurrence and shall not be admissible in any action or proceeding in
53 actions seeking damages for bodily injuries, pain suffering, medical
54 care and loss of wages as evidence of any facts.

55 § 7. Subsection (c) of section 5303 of the insurance law is amended to
56 read as follows:

1 (c) Such plan shall provide for the method of classifying risks,
2 establishing territories and making rates applicable thereto. Such
3 rates[~~, except with respect to rates for the minimum limits of insurance~~
4 ~~required by article six or seven of the vehicle and traffic law,~~] shall
5 be based upon loss and expense experience of the risks insured pursuant
6 to the plan.

7 § 8. The insurance law is amended by adding a new section 405-a to
8 read as follows:

9 § 405-a. Compensation for report of insurance fraud to law enforce-
10 ment authorities. (a) Any person, other than persons described in
11 subsection (a) of section four hundred five of this article, who has
12 reason to believe that a fraudulent insurance act prohibited pursuant to
13 article one hundred seventy-six of the penal law has been committed or
14 that an insurance transaction may be fraudulent, or has knowledge that a
15 fraudulent insurance transaction is about to take place, or has taken
16 place may report such act or transaction and any additional information
17 relative to the factual circumstances of the transaction and the parties
18 involved to the attorney general, district attorney or insurance frauds
19 bureau.

20 (b) If the insurance frauds bureau recommends to the attorney general
21 or district attorney to commence an action or if the attorney general or
22 district attorney commences an action based on information provided by a
23 person pursuant to subsection (a) of this section, then such person
24 shall be entitled to receive an award of at least fifteen percent, but
25 not more than twenty-five percent of the proceeds of the action or
26 settlement of the claim up to a maximum of twenty-five thousand dollars.
27 The attorney general or district attorney shall recommend to the court
28 when a settlement is entered the amount of such award. The court shall
29 base such award decision on the extent to which the person substantially
30 contributed to the prosecution of the action.

31 § 9. Section 176.00 of the penal law is amended by adding three new
32 subdivisions 6, 7 and 8 to read as follows:

33 6. "Provider" means an attorney, a health care professional, an owner
34 or operator of a health care practice or facility, any person who
35 creates the impression that they, or their practice can provide legal or
36 health care services, or any person employed or acting on behalf of any
37 such person.

38 7. "Public media" means telephone directories, professional directo-
39 ries, newspapers and other periodicals, radio and television, bill-
40 boards, and mailed or electronically transmitted written communications
41 that do not involve in-person contact with a specific prospective
42 client, patient, or customer.

43 8. "Runner" means a person who, for a pecuniary benefit, procures or
44 attempts to procure a client, patient or customer at the direction of,
45 request of or in cooperation with a provider when such person knows or
46 has reason to know that the purpose of such provider is to seek to
47 falsely or fraudulently: obtain benefits under a contract of insurance;
48 or assert a claim against an insured or an insurance carrier for provid-
49 ing services to the client, patient or customer. Such term shall not
50 include a person who procures or attempts to procure clients, patients
51 or customers for a provider through public media or a person who refers
52 clients, patients or customers as authorized by law. Nothing in this
53 article shall be deemed to prohibit an agent, broker or employee of a
54 health maintenance organization from seeking to sell health maintenance
55 organization coverage or health insurance coverage to an individual or
56 group.

1 § 10. Subdivision 1 of section 176.05 of the penal law, as amended by
2 chapter 211 of the laws of 2011, is amended to read as follows:

3 1. any written statement as part of, or in support of, an application
4 for the issuance of, or the rating of a policy insuring against losses
5 or liabilities arising out of the ownership, operation, or use of a
6 motor vehicle, a commercial insurance policy, or certificate or evidence
7 of self insurance for commercial insurance or commercial self insurance,
8 or a claim for payment or other benefit pursuant to an insurance policy
9 or self insurance program for commercial or personal insurance that [~~he~~
10 ~~or she~~] such person knows to:

11 (a) contain materially false information concerning any fact material
12 thereto; or

13 (b) conceal, for the purpose of misleading, information concerning any
14 fact material thereto; or

15 § 11. The penal law is amended by adding a new section 176.66 to read
16 as follows:

17 § 176.66 Unlawful procurement of clients, patients or customers.

18 A person is guilty of unlawful procurement of clients, patients or
19 customers when, such person knowingly:

20 1. acts as a runner; or

21 2. uses, solicits, directs, hires or employs another person to act as
22 a runner.

23 Unlawful procurement of clients, patients or customers is a class E
24 felony.

25 § 12. Section 176.15 of the penal law, as amended by chapter 515 of
26 the laws of 1986, is amended to read as follows:

27 § 176.15 Insurance fraud in the fourth degree.

28 A person is guilty of insurance fraud in the fourth degree when [~~he~~]
29 such person commits a fraudulent insurance act and thereby wrongfully
30 takes, obtains or withholds, or attempts to wrongfully take, obtain or
31 withhold property with a value in excess of [~~one-thousand~~] five hundred
32 dollars.

33 Insurance fraud in the fourth degree is a class E felony.

34 § 13. Section 176.20 of the penal law, as amended by chapter 515 of
35 the laws of 1986, is amended to read as follows:

36 § 176.20 Insurance fraud in the third degree.

37 A person is guilty of insurance fraud in the third degree when [~~he~~]
38 such person commits a fraudulent insurance act and thereby wrongfully
39 takes, obtains or withholds, or attempts to wrongfully take, obtain or
40 withhold property with a value in excess of [~~three~~] one thousand five
41 hundred dollars.

42 Insurance fraud in the third degree is a class D felony.

43 § 14. Section 176.25 of the penal law, as added by chapter 515 of the
44 laws of 1986, is amended to read as follows:

45 § 176.25 Insurance fraud in the second degree.

46 A person is guilty of insurance fraud in the second degree when [~~he~~]
47 such person commits a fraudulent insurance act and thereby wrongfully
48 takes, obtains or withholds, or attempts to wrongfully take, obtain or
49 withhold property with a value in excess of [~~fifty~~] twenty-five thousand
50 dollars.

51 Insurance fraud in the second degree is a class C felony.

52 § 15. Section 176.30 of the penal law, as added by chapter 515 of the
53 laws of 1986, is amended to read as follows:

54 § 176.30 Insurance fraud in the first degree.

55 A person is guilty of insurance fraud in the first degree when [~~he~~]
56 such person commits a fraudulent insurance act and thereby wrongfully

1 takes, obtains or withholds, or attempts to wrongfully take, obtain or
2 withhold property with a value in excess of [~~one million~~] five hundred
3 thousand dollars.

4 Insurance fraud in the first degree is a class B felony.

5 § 16. Section 176.35 of the penal law, as added by chapter 635 of the
6 laws of 1996, is amended to read as follows:

7 § 176.35 Aggravated insurance fraud in the third degree.

8 A person is guilty of aggravated insurance fraud in the [~~fourth~~] third
9 degree when [~~he~~] such person commits [~~a fraudulent insurance act~~] the
10 offense of insurance fraud in the fifth degree, and has been previously
11 convicted within the preceding five years of any offense, an essential
12 element of which is the commission of a fraudulent insurance act.

13 Aggravated insurance fraud in the [~~fourth~~] third degree is a class D
14 felony.

15 § 17. The penal law is amended by adding two new sections 176.36 and
16 176.37 to read as follows:

17 § 176.36 Aggravated insurance fraud in the second degree.

18 A person is guilty of aggravated insurance fraud in the second degree
19 when such person commits the offense of insurance fraud in the fourth
20 degree, and has been previously convicted within the preceding five
21 years of any offense, an essential element of which is the commission of
22 a fraudulent insurance act.

23 Aggravated insurance fraud in the second degree is a class C felony.

24 § 176.37 Aggravated insurance fraud in the first degree.

25 A person is guilty of aggravated insurance fraud in the first degree
26 when such person commits the offense of insurance fraud in the third
27 degree, and has been previously convicted within the preceding five
28 years of any offense, an essential element of which is the commission of
29 a fraudulent insurance act.

30 Aggravated insurance fraud in the first degree is a class B felony.

31 § 18. Paragraph (a) of subdivision 2 of section 846-m of the executive
32 law, as amended by section 6 of part T of chapter 57 of the laws of
33 2000, is amended to read as follows:

34 (a) The moneys received by the fund shall be expended in a manner that
35 is consistent with the plan of operation, pursuant to appropriation,
36 only to reimburse costs incurred by provider agencies for pilot program
37 activities relating to the detection, prevention or reduction of motor
38 vehicle theft and motor vehicle insurance fraud, provided, however, that
39 beginning January first, two thousand twenty-six, additional monies
40 received by the fund pursuant to an appropriation made by a chapter of
41 the laws of two thousand twenty-five establishing the New York automo-
42 bile insurance fraud and premium reduction act shall be used exclusively
43 to support efforts undertaken by district attorneys to detect, identify
44 and prosecute fraud pertaining to article fifty-one of the insurance
45 law.

46 § 19. No later than eighteen months after the effective date of this
47 act, the superintendent of financial services shall study, evaluate and
48 report to the governor and legislature on the impact and effect of this
49 act on private passenger automobile insurance costs, by rating territo-
50 ry, in New York state. The superintendent of financial services shall
51 recommend for each insurer, by rating territory, a one-time premium
52 reduction for the insurance required pursuant to article 51 of the
53 insurance law that reflects the reduced cost of this type of coverage as
54 a result of the provisions enacted pursuant to this act. Notwithstanding
55 the provisions of article 23 of the insurance law, any such recommended
56 reduction shall be binding unless demonstrated by an insurer, based on

1 sound underwriting and actuarial principles reasonably related to actual
2 or anticipated loss experience, that such reduction would result in
3 underwriting losses for policies issued in such rating territory.

4 § 20. The sum of three million one hundred thousand dollars
5 (\$3,100,000), or so much thereof as may be necessary, is hereby appro-
6 priated to the department of transportation out of any moneys in the
7 state treasury in the general fund to the credit of the motor vehicle
8 theft and insurance fraud prevention fund, not otherwise appropriated,
9 and made immediately available, for the purpose of carrying out the
10 provisions of paragraph (a) of subdivision 2 of section 846-m of the
11 executive law, as amended pursuant to section eighteen of this act.
12 Such moneys shall be payable on the audit and warrant of the comptroller
13 on vouchers certified or approved by the commissioner of transportation
14 in the manner prescribed by law.

15 § 21. Severability clause. If any clause, sentence, paragraph, subdi-
16 vision, section or part contained in any part of this act shall be
17 adjudged by any court of competent jurisdiction to be invalid, such
18 judgment shall not affect, impair, or invalidate the remainder thereof,
19 but shall be confined in its operation to the clause, sentence, para-
20 graph, subdivision, section or part of this act contained in any part
21 thereof directly involved in the controversy in which such judgment
22 shall have been rendered. It is hereby declared to be the intent of the
23 legislature that this act would have been enacted even if such invalid
24 provisions had not been included herein.

25 § 22. This act shall take effect on the ninetieth day after it shall
26 have become a law.