

STATE OF NEW YORK

3789--A

2025-2026 Regular Sessions

IN ASSEMBLY

January 30, 2025

Introduced by M. of A. WEPRIN, WOERNER, TAYLOR, SANTABARBARA, COLTON, LUPARDO, STIRPE, EPSTEIN, PAULIN, SEAWRIGHT, SIMON, LAVINE, STECK, TANNOUSIS, ROSENTHAL, MEEKS, DAVILA, WILLIAMS, LUNSFORD, BORES, PIROZZOLO, KELLES, R. CARROLL, SIMPSON, BENDETT, REYES, ANGELINO, SAYEGH, LEVENBERG, RAMOS, DiPIETRO, GALLAHAN, RAGA, HEVESI, CLARK, SHRESTHA, CUNNINGHAM, McMAHON, BARRETT, BRABENEC, KASSAY, MAGNARELLI, BUTTENSCHON, KAY, BLANKENBUSH, WIEDER, CRUZ -- read once and referred to the Committee on Insurance -- reported and referred to the Committee on Rules -- Rules Committee discharged, bill amended, ordered reprinted as amended and recommitted to the Committee on Rules

AN ACT to amend the public health law and the insurance law, in relation to utilization review program standards and pre-authorization of health care services

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

1 Section 1. Paragraph (c) of subdivision 1 of section 4902 of the
2 public health law, as added by chapter 705 of the laws of 1996, is
3 amended to read as follows:

4 (c) Utilization of written clinical review criteria developed pursuant
5 to a utilization review plan. Such clinical review criteria shall
6 utilize recognized evidence-based and peer reviewed clinical review
7 criteria that take into account the needs of a typical patient popu-
8 lations and diagnoses;

9 § 2. Paragraph (a) of subdivision 2 of section 4903 of the public
10 health law, as separately amended by section 13 of part YY and section 3
11 of part KKK of chapter 56 of the laws of 2020, is amended to read as
12 follows:

13 (a) A utilization review agent shall make a utilization review deter-
14 mination involving health care services which require pre-authorization
15 and provide notice of a determination to the enrollee or enrollee's
16 designee and the enrollee's health care provider by telephone and in

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

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1 writing within [~~three business days~~] seventy-two hours of receipt of the
2 necessary information, or for inpatient rehabilitation services follow-
3 ing an inpatient hospital admission provided by a hospital or skilled
4 nursing facility, within one business day of receipt of the necessary
5 information. The notification shall identify^[+]: (i) whether the
6 services are considered in-network or out-of-network; (ii) and whether
7 the enrollee will be held harmless for the services and not be responsi-
8 ble for any payment, other than any applicable co-payment or co-insu-
9 rance; (iii) as applicable, the dollar amount the health care plan will
10 pay if the service is out-of-network; and (iv) as applicable, informa-
11 tion explaining how an enrollee may determine the anticipated out-of-
12 pocket cost for out-of-network health care services in a geographical
13 area or zip code based upon the difference between what the health care
14 plan will reimburse for out-of-network health care services and the
15 usual and customary cost for out-of-network health care services. An
16 approval for a request for pre-authorization shall be valid for (1) the
17 duration of the prescription, including any authorized refills and (2)
18 the duration of treatment for a specific condition as requested by the
19 enrollee's health care provider.

20 § 3. Paragraph 3 of subsection (a) of section 4902 of the insurance
21 law, as added by chapter 705 of the laws of 1996, is amended to read as
22 follows:

23 (3) Utilization of written clinical review criteria developed pursuant
24 to a utilization review plan. Such clinical review criteria shall
25 utilize recognized evidence-based and peer reviewed clinical review
26 criteria that take into account the needs of a typical patient popu-
27 lations and diagnoses;

28 § 4. Paragraph 1 of subsection (b) of section 4903 of the insurance
29 law, as separately amended by section 16 of part YY and section 7 of
30 part KKK of chapter 56 of the laws of 2020, is amended to read as
31 follows:

32 (1) A utilization review agent shall make a utilization review deter-
33 mination involving health care services which require pre-authorization
34 and provide notice of a determination to the insured or insured's desig-
35 nee and the insured's health care provider by telephone and in writing
36 within [~~three business days~~] seventy-two hours of receipt of the neces-
37 sary information, or for inpatient rehabilitation services following an
38 inpatient hospital admission provided by a hospital or skilled nursing
39 facility, within one business day of receipt of the necessary informa-
40 tion. The notification shall identify: (i) whether the services are
41 considered in-network or out-of-network; (ii) whether the insured will
42 be held harmless for the services and not be responsible for any
43 payment, other than any applicable co-payment, co-insurance or deduct-
44 ible; (iii) as applicable, the dollar amount the health care plan will
45 pay if the service is out-of-network; and (iv) as applicable, informa-
46 tion explaining how an insured may determine the anticipated out-of-
47 pocket cost for out-of-network health care services in a geographical
48 area or zip code based upon the difference between what the health care
49 plan will reimburse for out-of-network health care services and the
50 usual and customary cost for out-of-network health care services. An
51 approval of request for pre-authorization shall be valid for (1) the
52 duration of the prescription, including any authorized refills and (2)
53 the duration of treatment for a specific condition requested for pre-au-
54 thorization.

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