

STATE OF NEW YORK

7297--A

Cal. No. 1390

2025-2026 Regular Sessions

IN SENATE

April 9, 2025

Introduced by Sens. HOYLMAN-SIGAL, ADDABBO, CLEARE, COMRIE, FERNANDEZ, GALLIVAN, GONZALEZ, JACKSON, KRUEGER, LIU, MAY, RIVERA, WALCZYK, WEBB -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- reported favorably from said committee, ordered to first and second report, ordered to a third reading, amended and ordered reprinted, retaining its place in the order of third reading

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
17 writing within [~~three business days~~] seventy-two hours of receipt of the
18 necessary information, or for inpatient rehabilitation services follow-
19 ing an inpatient hospital admission provided by a hospital or skilled

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

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

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

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

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

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

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