STATE OF NEW YORK

9651

IN SENATE

March 31, 2026

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

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:

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

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

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

(a) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within [~~three business days~~] **seventy-two hours** of receipt of the necessary information, **within twenty-four hours of the receipt of necessary information if the request is for an enrollee with a medical condition that places the health of the insured in serious jeopardy without the health care services recommended by the enrollee's health care professional,** or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. The notification shall identify[~~,~~]**:** (i) whether the services are considered in-network or out-of-network; (ii) and whether the enrollee will be held harmless for the services and not be responsible for any

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

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payment, other than any applicable co-payment or co-insurance; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an enrollee may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services. **An approval for a request for pre-authorization shall be valid for (1) the duration of the prescription, including any authorized refills and (2) the duration of treatment for a specific condition as requested by the enrollee's health care provider.**

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

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

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

(1) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within [~~three business days~~] **seventy-two hours** of receipt of the necessary information, **within twenty-four hours of receipt of necessary information if the request is for an insured with a medical condition that places the health of the insured in serious jeopardy without the health care services recommended by the insured's health care provider,** or for inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, within one business day of receipt of the necessary information. The notification shall identify: (i) whether the services are considered in-network or out-of-network; (ii) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (iii) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (iv) as applicable, information explaining how an insured may determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services. **An approval of request for pre-authorization shall be valid for (1) the duration of the prescription, including any authorized refills and (2) the duration of treatment for a specific condition requested for pre-authorization.**

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