

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:

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, within twenty-four hours of the receipt of neces-
19 sary information if the request is for an enrollee with a medical condi-
20 tion that places the health of the insured in serious jeopardy without
21 the health care services recommended by the enrollee's health care
22 professional, or for inpatient rehabilitation services following an
23 inpatient hospital admission provided by a hospital or skilled nursing
24 facility, within one business day of receipt of the necessary informa-
25 tion. The notification shall identify[+]: (i) whether the services are
26 considered in-network or out-of-network; (ii) and whether the enrollee
27 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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1 payment, other than any applicable co-payment or co-insurance; (iii) as
2 applicable, the dollar amount the health care plan will pay if the
3 service is out-of-network; and (iv) as applicable, information explain-
4 ing how an enrollee may determine the anticipated out-of-pocket cost for
5 out-of-network health care services in a geographical area or zip code
6 based upon the difference between what the health care plan will reim-
7 burse for out-of-network health care services and the usual and custom-
8 ary cost for out-of-network health care services. An approval for a
9 request for pre-authorization shall be valid for (1) the duration of the
10 prescription, including any authorized refills and (2) the duration of
11 treatment for a specific condition as requested by the enrollee's health
12 care provider.

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

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

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

25 (1) A utilization review agent shall make a utilization review deter-
26 mination involving health care services which require pre-authorization
27 and provide notice of a determination to the insured or insured's desig-
28 nee and the insured's health care provider by telephone and in writing
29 within [~~three business days~~] seventy-two hours of receipt of the neces-
30 sary information, within twenty-four hours of receipt of necessary
31 information if the request is for an insured with a medical condition
32 that places the health of the insured in serious jeopardy without the
33 health care services recommended by the insured's health care provider,
34 or for inpatient rehabilitation services following an inpatient hospital
35 admission provided by a hospital or skilled nursing facility, within one
36 business day of receipt of the necessary information. The notification
37 shall identify: (i) whether the services are considered in-network or
38 out-of-network; (ii) whether the insured will be held harmless for the
39 services and not be responsible for any payment, other than any applica-
40 ble co-payment, co-insurance or deductible; (iii) as applicable, the
41 dollar amount the health care plan will pay if the service is out-of-
42 network; and (iv) as applicable, information explaining how an insured
43 may determine the anticipated out-of-pocket cost for out-of-network
44 health care services in a geographical area or zip code based upon the
45 difference between what the health care plan will reimburse for out-of-
46 network health care services and the usual and customary cost for out-
47 of-network health care services. An approval of request for pre-authorized
48 request for pre-authorization shall be valid for (1) the duration of the prescription,
49 including any authorized refills and (2) the duration of treatment for a
50 specific condition requested for pre-authorization.

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