§ 3217-b. Prohibitions. (a) No insurer subject to this article shall by contract, written policy or written procedure prohibit or restrict any health care provider from disclosing to any insured, designated representative or, where appropriate, prospective insured, (hereinafter collectively referred to as insured) any information that such provider deems appropriate regarding:

(1) a condition or a course of treatment with an insured including the availability of other therapies, consultations, or tests; or

(2) the provisions, terms, or requirements of the insurer's products as they relate to the insured.

(b) No insurer subject to this article shall by contract, written policy, written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such insurer which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall an insurer subject to this article take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such insurer which may violate this chapter including paragraphs thirty, as added by chapter forty-one of the laws of 2014, thirty-one, thirty-one-a and thirty-five of subsection (i) of section thirty-two hundred sixteen and paragraphs five, six, seven, seven-a and seven-b of subsection (l) of section thirty-two hundred twenty-one of this article.

(c) No insurer subject to this article shall by contract, written policy or written procedure prohibit or restrict any health care provider from advocating to the insurer on behalf of the insured for approval or coverage of a particular course of treatment or for the provision of health care services.

(d) No contract or agreement between an insurer subject to this article and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions or omissions of the insurer as opposed to the health care provider.

(e) Contracts entered into between an insurer and a health care

provider shall include terms which prescribe:

(1) the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

(2) the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

(3) a description of the records or information relied upon to calculate any such payments and adjustments, and a description of how the provider can access a summary of such calculations and adjustments;

(4) the process to be employed to resolve disputed incorrect or incomplete records or information and to adjust any such payments and adjustments which have been calculated by relying on any such incorrect or incomplete records or information so disputed; provided, however, that nothing herein shall be deemed to authorize or require the disclosure of personally identifiable patient information or information related to other individual health care providers or the plan's proprietary data collection systems, software or quality assurance or utilization review methodologies; and

(5) the right of either party to the contract to seek resolution of a dispute arising pursuant to the payment terms of such contracts through a proceeding under article seventy-five of the civil practice law and rules.

(f) No contract entered into between an insurer and a health care provider shall be enforceable if it includes terms which transfer financial risk to providers, in a manner inconsistent with the provisions of paragraph (c) of subdivision one of section forty-four hundred three of the public health law, or penalize providers for unfavorable case mix so as to jeopardize the quality of or insureds' appropriate access to medically necessary services; provided, however, that payment at less than prevailing fee for service rates or capitation shall not be deemed or presumed prima facie to jeopardize quality or access.

(g)(1) No insurer shall implement an adverse reimbursement change to a contract with a health care professional that is otherwise permitted by the contract, unless, prior to the effective date of the change, the insurer gives the health care professional with whom the insurer has

directly contracted and who is impacted by the adverse reimbursement change, at least ninety days written notice of the change. If the contracting health care professional objects to the change that is the subject of the notice by the insurer, the health care professional may, within thirty days of the date of the notice, give written notice to the insurer to terminate his or her contract with the insurer effective upon the implementation date of the adverse reimbursement change. For the purposes of this subsection, the term "adverse reimbursement change" shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional, and the term "health care professional" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law. The notice provisions required by this subsection shall not apply where: (A) such change is otherwise required by law, regulation or applicable regulatory authority, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions; or (B) such change is expressly provided for under the terms of the contract by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

(2) Nothing in this subsection shall create a private right of action on behalf of a health care professional against an insurer for violations of this subsection.

(h) Any contract provision, written policy or written procedure in violation of this section shall be deemed to be void and unenforceable.

* (i) If a contract between an insurer and a hospital is not renewed or is terminated by either party, the parties shall continue to abide by the terms of such contract, including reimbursement terms, for a period of two months from the effective date of termination or, in the case of a non-renewal, from the end of the contract period. Notice shall be provided to all insureds potentially affected by such termination or non-renewal within fifteen days after commencement of the two-month period. The commissioner of health shall have the authority to waive the two-month period upon the request of either party to a contract that is being terminated for cause. This subsection shall not apply where both

parties mutually agree in writing to the termination or non-renewal and the insurer provides notice to the insured at least thirty days in advance of the date of contract termination.

* NB Repealed June 30, 2027

(j) (1) No insurer shall by contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of the public health law for a claim for medically necessary inpatient services, observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not comply with certain administrative requirements of such insurer with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and an insurer from agreeing to certain administrative requirements relating to payment for inpatient services, observation services, or emergency department services, including but not limited to timely notification that medically necessary inpatient services have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely notification; provided, however that: (A) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for services provided on weekends or federal holidays, (B) any agreed to reduction in payment for failure to meet administrative requirements, including timely notification shall not exceed seven and one-half percent of the payment amount otherwise due for the services provided, and (C) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the services were provided.

(3) The provisions of this subsection shall not apply to the denial of a claim: (A) based on a reasonable belief by an insurer of fraud or intentional misconduct resulting in misrepresentation of patient diagnosis or the services provided, or abusive billing; (B) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members; (C) that is a duplicate claim, that is a claim submitted late pursuant to subsection (g) of section thirty-two

hundred twenty-four-a of this article, or is for services for a benefit that is not covered under the insured's policy or for a patient determined to be ineligible for coverage; (D) except in the case of medically necessary inpatient services resulting from an emergency admission, where there is not an existing participating provider agreement between an insurer and a general hospital; or (E) where the hospital has repeatedly and systematically, over the previous twelve month period, failed to seek prior authorization for services for which prior authorization was required.

(4) For purposes of this subsection, an "administrative requirement" shall not include requirements: (A) imposed on an insurer or provider pursuant to federal or state laws, regulations or guidance; or (B) established by the state or federal government applicable to insurers offering benefits under a state or federal government program.

(5) The prohibition on denials set forth in this subsection shall not apply to claims for services for which a request for preauthorization was denied by the insurer prior to delivery of the service.

(k) An insurer shall not require a prior authorization determination for services provided in a neonatal intensive care unit of a general hospital certified pursuant to article twenty-eight of the public health law. Nothing in this subsection shall prohibit an insurer from denying a claim for such services if the services are subsequently determined not medically necessary.

(l) At least sixty days prior to the termination of a contract between a hospital and an insurer, the parties shall utilize a mutually agreed upon mediator to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on the parties.

* (m) A contract between an insurer and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider

directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

* NB Effective until January 1, 2027

* (m) A contract between an insurer and a health care provider shall include a provision that requires the health care provider to have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. For purposes of this subsection, "provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance-related and addictive disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

* NB Effective January 1, 2027

(n) A contract between an insurer and a health care provider shall include a provision that states that the provider shall reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided

with inaccurate network status information by the insurer in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the insurer provides inaccurate network status information to the insured indicating the provider was a participating provider when such provider was not a participating provider, the insurer shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of-network services. Nothing in this subsection shall prohibit a health care provider from requiring in the terms of a contract with an insurer that the insurer remove, at the time of termination of such contract, the provider from the insurer's provider directory or that the insurer bear financial responsibility for providing inaccurate network status information to an insured.

(o) (1) No contract or agreement between a health plan subject to this article and a health care provider, other than a residential health care facility as defined by section two thousand eight hundred one of the public health law, shall include a provision that:

(A) contains a most-favored-nation provision; or

(B) restricts the ability of a health plan, an entity that contracts with a health plan for a provider network, or a health care provider to disclose (i) actual claims costs or (ii) price or quality information required to be disclosed under federal law, including the allowed amount, negotiated rates or discounts, or any other claim-related financial obligations, including, but not limited to, patient cost-sharing covered by the provider contract to any insured, group or other entity receiving health care services pursuant to the contract, or to any public compilation of reimbursement data such as the New York all payer database required by law or regulation, provided that no disclosure shall include protected health information or other information covered by statutory or other privilege.

(2) For purposes of this subsection, the term "health plan" shall include (A) an insurer licensed pursuant to the insurance law or a health maintenance organization certified pursuant to article forty-four of the public health law and (B) a third-party administrator, affiliated with an insurer or health maintenance organization, who administers a health benefit plan.

(p)(1) An insurer may pay a claim for reimbursement made by a provider using a credit card, virtual credit card, or electronic funds transfer payment method that imposes on the provider a specifically identified fee or similar dedicated charge to process the payment if in advance of using such reimbursement method:

(A) The insurer notifies the provider of the potential fees or other charges associated with the use of the credit card, virtual credit card, or electronic funds transfer payment;

(B) The insurer offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(C) The provider or a designee of the provider elects to accept payment of the claim using the credit card, virtual credit card, or electronic funds transfer payment method. Such payment type election shall be made by the provider within thirty days of receipt of the notice from the insurer. If the provider fails to make any payment type election within thirty days, the insurer shall pay the provider using the alternative payment method offered in the notice unless the insurer is unable to pay the provider using that alternative method due to the insurer lacking information necessary to make the alternative payment. In that instance, the insurer may use another fee-free method of payment in order to meet the timeframes established in section three thousand two hundred twenty-four-a of this article.

(2) A decision pursuant to paragraph one of this subsection shall remain in effect until the provider notifies the insurer, in writing, of a change in the designated payment type.

(3) If an insurer contracts with a vendor to process payments of providers' claims, the insurer shall require the vendor to comply with the provisions of paragraph one of this subsection. This paragraph shall not apply to a vendor used by the provider in order to receive payments from an insurer.

(4) No contract between an insurer and provider issued, renewed, modified, altered or amended after the effective date of this subsection shall contain provisions allowing for waiver of the notice requirements contained in this subsection.

(5) For any contract that is in effect on or before the effective date of this subsection or that is entered into, amended or renewed on or after the effective date of this subsection, an insurer that initiates a

payment to a provider using, or changes the payment method to, a health care electronic funds transfers and remittance advice transaction shall not charge a fee solely to transmit the payment to the provider unless the provider elects to accept payment in accordance with subparagraph (C) of paragraph one of this subsection.

(6) For purposes of this subsection, the following terms shall have the following meanings:

(A) "Provider" shall mean a health care professional or a group of health care professionals licensed pursuant to title eight of the education law that has a participating provider contract with an insurer to provide health care services to an insured.

(B) "Virtual credit card" shall mean a single-use series of numbers linked to a fixed dollar amount and provided by an insurer to a provider for the purpose of paying a claim for health care services performed by the provider.