§ 4406-c. Prohibitions. 1. For purposes of this section, "health care plan" shall mean a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article or an independent practice association certified or recognized pursuant to this article or a medical group.

2. No health care plan shall by contract or written policy or written procedure prohibit or restrict any health care provider from disclosing to any subscriber, enrollee, patient, designated representative or, where appropriate, prospective enrollee, (hereinafter collectively referred to as enrollee) any information that such provider deems appropriate regarding:

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

(b) the provisions, terms, or requirements of the health care plan's products as they relate to the enrollee, where applicable.

3. No health care plan 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 health care plan which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall a health care plan 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 health care plan which may violate this chapter or the insurance law including subsection (g), (k), (l), (l-1) or (1-2) of section forty-three hundred three of the insurance law.

4. No health care plan shall by contract, written policy or written procedure prohibit or restrict any health care provider from advocating to the health care plan on behalf of the enrollee for approval or coverage of a particular course of treatment or for the provision of health care services.

5. No contract or agreement between a health care plan and a health care provider shall contain any clause purporting to transfer to the health care provider, other than a medical group, by indemnification or otherwise any liability relating to activities, actions or omissions of the health care plan as opposed to those of the health care provider.

5-a. Contracts entered into between a plan and a health care provider shall include terms which prescribe:

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

(b) 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;

(c) 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;

(d) the process to be employed to resolved 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 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

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

5-b. No contract entered into with health care providers 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 this article, or penalize providers for unfavorable case mix so as to jeopardize the quality of or enrollees' 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.

5-c. (a) No health care plan 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 health care plan gives the health care professional with whom the health care plan 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 health care plan, the health care professional may, within thirty days of the date of the notice, give written notice to the health care plan to terminate his or her contract with the health care plan effective upon the implementation date of the adverse reimbursement change. For the purposes of this subdivision, 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 subdivision shall not apply where: (i) 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 (ii) 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.

(b) Nothing in this subdivision shall create a private right of action on behalf of a health care professional against a health care plan for violations of this subdivision.

* 5-d. If a contract between a plan 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 enrollees potentially affected by such termination or non-renewal within fifteen days after commencement of the two-month period. The commissioner 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 subdivision shall not apply where both parties mutually agree in writing to the termination or non-renewal and the plan provides notice to the enrollee at least thirty days in advance of the date of contract termination.

* NB Repealed June 30, 2027

5-e. At least sixty days prior to the termination of a contract between a hospital and a health care plan, 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.

6. No health care plan which provides coverage for prescription drugs shall require, or enter into a contract which permits, a copayment which exceeds the usual and customary cost of such prescribed drug.

* 7. No health maintenance organization which provides coverage for prescription drugs and for which cost-sharing, deductibles or co-insurance obligations are determined by category of prescription drugs shall impose cost-sharing, deductibles or co-insurance obligations for any prescription drug that exceeds the dollar amount of cost-sharing, deductibles or co-insurance obligations for non-preferred brand drugs or its equivalent (or brand drugs if there is no non-preferred brand drug category).

* NB There are 2 sub 7's

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

* NB There are 2 sub 7's

8. (a) No health care plan 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 this chapter 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 health care plan with respect to those services.

(b) Nothing in this subdivision shall preclude a general hospital and a health care plan 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: (i) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for services provided on weekends or federal holidays, (ii) 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 service provided, and (iii) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's coverage could not be determined by the hospital after reasonable efforts at the time the services were provided.

(c) The provisions of this subdivision shall not apply to the denial of a claim: (i) based on a reasonable belief of a health care plan of fraud or intentional misconduct resulting in a misrepresentation of patient diagnosis or the services provided, or abusive billing; (ii) 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; (iii) that is a duplicate claim, is a claim submitted late pursuant to subsection (g) of section thirty-two hundred twenty-four-a of the insurance law, or is for services for a benefit that is not covered under the insured's contract or for a patient determined to be ineligible for coverage; (iv) except in the case of medically necessary inpatient services resulting from an

emergency admission, where there is not an existing participating provider agreement between a health care plan and a general hospital; or (v) 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.

(d) For purposes of this subdivision, an "administrative requirement" shall not include requirements: (i) imposed on a health care plan or provider pursuant to federal or state laws, regulations or guidance; or (ii) established by the state or federal government applicable to health care plans offering benefits under a state or federal government program.

(e) The prohibition on denials set forth in this subdivision shall not apply to claims for services for which a request for preauthorization was denied by the health care plan prior to delivery of the service.

9. A health care plan 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 this chapter. Nothing in this subdivision shall prohibit a health care plan from denying a claim for such services if the services are subsequently determined not medically necessary.

10. (a) Any contract or other arrangement entered into by a health care plan for the provision and administration of pharmacy benefit management services on behalf of individuals enrolled in a managed care provider, as defined in section three hundred sixty-four-j of the social services law, shall be based on a pass-through pricing model and include the following requirements:

(i) Payment to the pharmacy benefit manager for pharmacy benefit management services shall be limited to the actual ingredient costs, dispensing fees paid to pharmacies, and an administrative fee that covers the cost of providing pharmacy benefit management services pursuant to a contract described in this paragraph. The department may establish a maximum administrative fee;

(ii) The pharmacy benefit manager shall identify all sources and amounts of income, payments, and financial benefits to the pharmacy benefit manager related to the provision and administration of pharmacy

benefit management services on behalf of the health care plan, including, but not limited to, any pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other benefits and shall ensure that any portion of such income, payments, and financial benefits is passed through to the health care plan in full to reduce the reportable ingredient cost;

(iii) The pharmacy benefit manager shall fully disclose to the department and to the health care plan the sources and amounts of all income, payments, and financial benefits referred to in subparagraph (ii) of this paragraph received by the pharmacy benefit manager;

(iv) The pharmacy benefit manager shall identify all ingredient costs and dispensing fees or similar payments made by the pharmacy benefit manager to any pharmacy in connection with the contract or other arrangement;

(v) The pharmacy benefit manager shall not utilize any form of spread pricing in any contract or other arrangement with health care plans. For purposes of this subdivision "spread pricing" means any amount charged or claimed by the pharmacy benefit manager in excess of the amount paid to pharmacies on behalf of the health care plan less an administrative fee as described in this paragraph. Any such excess amount shall be remitted to the health care plan on a quarterly basis;

(vi) Pharmacy benefit managers shall make their payment model for administrative fees available to the health care plan and to the department. The health care plan shall, if so directed by the department, make changes to the payment model and resubmit an amended contract or contracts to the department for review and approval.

(b) Any changes to premiums resulting from such contracts shall be subject to certification by the state's actuary as actuarially appropriate.

(c) Contracts or other arrangements subject to this subdivision shall be submitted to the department for review and approval as required by and in accordance with state law and the regulations of the department. Contracts or other arrangements subject to this subdivision existing and in force at the time of enactment of this subdivision shall be submitted to the department for review and approval on or before July first, two thousand nineteen.

11. A contract between a health care plan 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 health care plan. A health care provider shall submit such provider directory information to a health care plan, at a minimum, when a provider begins or terminates a network agreement with a health care plan, when there are material changes to the content of the provider directory information of such health care provider, and at any other time, including upon the health care plan'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.

12. A contract between a health care plan and a health care provider shall include a provision that states that the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the commissioner in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the enrollee is provided with inaccurate network status information by the health care plan 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 health care plan provides inaccurate network status information to the enrollee indicating the provider was a participating provider when such provider was not a participating provider, the health care plan shall reimburse the provider for the out-of-network services regardless of whether the enrollee's coverage includes out-of-network services. Nothing in this

subdivision shall prohibit a health care provider from requiring in the terms of a contract with a health care plan that the health care plan remove, at the time of termination of such contract, the provider from the health care plan's provider directory or that the health care plan bear financial responsibility for providing inaccurate network status information to an enrollee.

13. (a) 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 twenty-eight hundred one of this chapter, shall include a provision that:

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

(ii) restricts the ability of a health plan, an entity that contracts with a health care plan for a provider network, or a health care provider to disclose: (A) actual claims costs; or (B) 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 subscriber, enrollee, 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.

(b) For purposes of this subdivision, the term "health plan" shall include:

(i) an insurer licensed pursuant to the insurance law or a health maintenance organization certified pursuant to this article; and

(ii) a third-party administrator, affiliated with an insurer or health maintenance organization, who administers a health benefit plan.

14. (a) A health care plan 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:

(i) The health care plan 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;

(ii) The health care plan offers the provider an alternative payment method that does not impose fees or similar charges on the provider; and

(iii) 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 the insurance law.

(b) A decision pursuant to paragraph (a) of this subdivision shall remain in effect until the provider notifies the health care plan, in writing, of a change to the designated payment type.

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

(d) No contract between a health care plan and provider issued, renewed, modified, altered or amended after the effective date of this subdivision shall contain provisions allowing for waiver of the notice requirements contained in this subdivision.

(e) For any contract that is in effect on or before the effective date of this subdivision or that is entered into, amended or renewed on or after the effective date of this subdivision, a health care plan 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 (iii) of paragraph (a) of this subdivision.

(f) For purposes of this subdivision, the following definitions shall

apply:

(i) "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 a health care plan to provide health care services to an enrollee.

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