§ 4408. Disclosure of information. 1. Each subscriber, and upon request each prospective subscriber prior to enrollment, shall be supplied with written disclosure information which may be incorporated into the member handbook or the subscriber contract or certificate containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

(a) a description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(b) a description of all prior authorization or other requirements for treatments and services;

(c) a description of utilization review policies and procedures used by the health maintenance organization, including:

(i) the circumstances under which utilization review will be undertaken;

(ii) the toll-free telephone number of the utilization review agent;

(iii) the timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions;

(iv) the right to reconsideration;

(v) the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(vi) the right to designate a representative;

(vii) a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision;

(viii) a notice of the right to an external appeal together with a description, jointly promulgated by the commissioner and the superintendent of financial services as required pursuant to subdivision five of section forty-nine hundred fourteen of this chapter, of the external appeal process established pursuant to title two of article forty-nine of this chapter and the timeframes for such appeals; and

(ix) further appeal rights, if any;

(d) a description prepared annually of the types of methodologies the

health maintenance organization uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a health maintenance organization and a health care provider;

(e) an explanation of a subscriber's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a subscriber's financial responsibility, caps on payments for covered services and financial responsibility for non-covered health care procedures, treatments or services provided within the health maintenance organization;

(f) an explanation of a subscriber's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization or by any provider without required authorization or when a procedure, treatment or service is not a covered health care benefit;

(g) a description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including: the right to file a grievance regarding any dispute between an enrollee and a health maintenance organization; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which enrollees may use to file an oral grievance; the timeframes and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the timeframes and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

(h) a description of the procedure for providing care and coverage twenty-four hours a day for emergency services. Such description shall include a definition of emergency services; notice that emergency services are not subject to prior approval; and shall describe the enrollee's financial and other responsibilities regarding obtaining such

services including when such services are received outside the health maintenance organization's service area;

(i) a description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(j) a description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(k) notice that an enrollee may obtain a referral to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider who is geographically accessible to the enrollee and who has appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral;

(l) notice that an enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(m) notice that an enrollee with (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the enrollee's medical care and the procedure for requesting and obtaining such a specialist;

(n) notice that an enrollee with a (i) a life-threatening condition or disease or (ii) a degenerative and disabling condition or disease either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(o) a description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(p) a description of how the health maintenance organization addresses the needs of non-English speaking enrollees;

(p-1) notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual

examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy;

(q) notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address, telephone number, and digital contact information of all participating providers, including facilities, and: (i) whether the provider is accepting new patients; (ii) in the case of mental health or 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 (iii) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance organization's website and the health maintenance organization shall update the website within fifteen days of the addition or termination of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation;

(s) where applicable, a description of the method by which an enrollee may submit a claim for health care services;

(t) with respect to out-of-network coverage:

(i) a clear description of the methodology used by the health maintenance organization to determine reimbursement for out-of-network health care services;

(ii) the amount that the health maintenance organization will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services;

(iii) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

(u) information in writing and through an internet website that reasonably permits an enrollee or prospective enrollee to estimate 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 maintenance organization will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services; and

(v) the most recent comparative analysis performed by the health maintenance organization to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j) and any amendments to, and federal guidance and regulations issued under, those Acts.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee:

(a) provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the health maintenance organization;

(b) provide a copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(c) provide a copy of the most recent individual, direct pay subscriber contracts;

(d) provide information relating to consumer complaints compiled pursuant to section two hundred ten of the insurance law;

(e) provide the procedures for protecting the confidentiality of medical records and other enrollee information;

(f) allow enrollees and prospective enrollees to inspect drug formularies used by such health maintenance organization; and provided further, that the health maintenance organization shall also disclose whether individual drugs are included or excluded from coverage to an enrollee or prospective enrollee who requests this information;

(g) provide a written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(h) provide a description of the procedures followed by the health maintenance organization in making decisions about the experimental or

investigational nature of individual drugs, medical devices or treatments in clinical trials;

(i) provide individual health practitioner affiliations with participating hospitals, if any;

(j) upon written request, provide specific written clinical review criteria relating to a particular condition or disease including clinical review criteria relating to a step therapy protocol override determination pursuant to subdivisions three-a, three-b and three-c of section forty-nine hundred three of this chapter, and, where appropriate, other clinical information which the organization might consider in its utilization review and the organization may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the organization, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the organization. Such clinical review criteria, and other clinical information shall also be made available to a health care professional as defined in subdivision six of section forty-nine hundred of this chapter, on behalf of an enrollee and upon written request;

(k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization;

(l) disclose other information as required by the commissioner, provided that such requirements are promulgated pursuant to the state administrative procedure act;

(m) disclose whether a health care provider scheduled to provide a health care service is an in-network provider; and

(n) with respect to out-of-network coverage, disclose the approximate dollar amount that the health maintenance organization will pay for a specific out-of-network health care service. The health maintenance organization shall also inform an enrollee through such disclosure that such approximation is not binding on the health maintenance organization and that the approximate dollar amount that the health maintenance organization will pay for a specific out-of-network health care service may change.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

4. If a primary care provider ceases participation in the health maintenance organization, the organization shall provide written notice within fifteen days from the date that the organization becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and the health maintenance organization is aware of such ongoing course of treatment, the health maintenance organization shall provide written notice within fifteen days from the date that the health maintenance organization becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care pursuant to paragraphs (e) and (f) of subdivision six of section four thousand four hundred three of this article and for choosing an alternative provider.

5. Every health maintenance organization shall annually on or before April first, file a report with the commissioner and superintendent of financial services showing its financial condition as of the last day of the preceding calendar year, in such form and providing such information as the commissioner shall prescribe.

6. Every health maintenance organization offering to indemnify enrollees pursuant to subdivision nine of section forty-four hundred five and subdivision two of section forty-four hundred six of this article shall on a quarterly basis file a report with the commissioner and the superintendent of financial services showing the percentage utilization for the preceding quarter of non-participating provider services in such form and providing such other information as the commissioner shall prescribe.

7. For purposes of this section, "usual and customary cost" shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and

provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of financial services. The nonprofit organization shall not be affiliated with an insurer, a corporation subject to article forty-three of the insurance law, a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law, or a health maintenance organization certified pursuant to this article.

* 8. Every contract delivered or issued for delivery in this state which provides major medical or similar comprehensive-type coverage shall provide space on any enrollment, renewal or initial online portal process setup forms required of a subscriber or applicant for coverage, excepting forms issued by the NY State of Health, the official Health Plan Marketplace, other than those specifically referenced in subparagraph (iv) of paragraph (a) of subdivision five of section forty-three hundred ten and paragraph (v) of subdivision one of section two hundred six of this chapter, so that the subscriber or applicant for coverage shall register or decline registration in the donate life registry for organ, eye and tissue donations under this section of the enrollment or renewal form and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

* NB There are 2 sb 8's

* 8. (a) As used in this subdivision:

(i) "Pharmacy benefit manager" shall have the meaning set forth in section two hundred eighty-a of this chapter.

(ii) "Cost-sharing information" means the amount a subscriber is required to pay to receive a drug that is covered under the subscriber's insurance contract.

(iii) "Covered/coverage" means those health care services to which a subscriber is entitled under the terms of the subscriber contract.

(iv) "Electronic health record" means a digital version of a patient's paper chart and medical history that makes information available instantly and securely to authorized users.

(v) "Electronic prescribing system" means a system that enables prescribers to enter prescription information into a computer

prescription device and securely transmit the prescription to pharmacies using a special software program and connectivity to a transmission network.

(vi) "Electronic prescription" shall have the meaning set forth in section thirty-three hundred two of this chapter.

(vii) "Prescriber" means a health care provider licensed to prescribe medication or medical devices in this state.

(viii) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (1) is capable of integrating with prescribers' electronic prescribing system and, if feasible, electronic health record systems; and (2) complies with the technical standards adopted by an American National Standards Institute (ANSI) accredited standards development organization.

(ix) "Authorized third party" shall include a third party legally authorized under state or federal law subject to a Health Insurance Portability and Accountability Act (HIPAA) business associate agreement.

(b) The provisions of this section shall not apply to any health plan that exclusively serves individuals enrolled pursuant to a federal or state insurance affordability program, including the medical assistance program under title eleven of article five of the social services law, child health plus under section twenty-five hundred eleven of this chapter, the basic health program under section three hundred sixty-nine-gg of the social services law, or a plan providing services under title XVIII of the federal social security act.

(c) A health maintenance organization or pharmacy benefit manager shall, upon request of the subscriber, the subscriber's health care provider, or an authorized third party on the subscriber's behalf, made to the health maintenance organization or pharmacy benefit manager, furnish the cost, benefit, and coverage data required by this subdivision to the subscriber, the subscriber's health care provider, or the authorized third party and shall ensure that such data is: (i) current no later than one business day after any change to the cost, benefit, or coverage data is made; (ii) provided through a RTBT when the request is made by the subscriber's health care provider; and (iii) in a format that is easily accessible to the requestor.

(d) When providing the data required by paragraph (c) of this subdivision, the health maintenance organization or pharmacy benefit

manager shall use established industry content and transport standards published by:

(i) a standards developing organization accredited by the American National Standards Institute (ANSI), including, the National Council for Prescription Drug Programs (NCPDP), ASC X12, Health Level 7; or

(ii) a relevant federal or state governing body, including the Center for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology.

(iii) another format deemed acceptable to the department which provides the data prescribed in paragraph (c) of this subdivision and in the same timeliness as required by this section.

(e) A facsimile shall not be considered an acceptable electronic format pursuant to this subdivision.

(f) Upon a request made pursuant to paragraph (c) of this subdivision, the health maintenance organization or pharmacy benefit manager shall provide the following data for any drug covered under the subscriber's subscriber contract:

(i) subscriber-specific eligibility information;

(ii) subscriber-specific prescription cost and benefit data, such as applicable formulary, benefit, coverage, and cost-sharing data for the prescribed drug and clinically-appropriate alternatives, when appropriate;

(iii) subscriber-specific cost-sharing information that describes variance in cost-sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the insured's benefit; and

(iv) applicable utilization management requirements.

(g) A health maintenance organization or pharmacy benefit manager shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code or descriptive term. A health maintenance organization or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

(h) A health maintenance organization and pharmacy benefit manager shall not, except as may be required or authorized by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required; nor shall a health maintenance organization or pharmacy benefit manager penalize a health care provider for disclosing

such information to a subscriber or legally prescribing, administering, or ordering a lower cost, clinically appropriate alternative.

(i) Nothing in this subdivision shall be construed to limit access to the most up-to-date subscriber-specific eligibility or subscriber-specific prescription cost and benefit data by the health maintenance organization or pharmacy benefit manager.

(j) Nothing in this subdivision shall interfere with subscriber choice and a health care provider's ability to convey the full range of prescription drug cost options to a subscriber. Health maintenance organizations and pharmacy benefit managers shall not restrict a health care provider from communicating to the subscriber prescription cost options.

* NB There are 2 sb 8's