

A 11737 Rules (Morelle) Same as S
4481-A SEWARD
Insurance Law
TITLE....Provides enhanced consumer and
provider protections; repealer
06/20/08referred to insurance
06/23/08reported referred to rules

S4481-A SEWARD Same as A 11737
Rules (Morelle)
ON FILE: 06/20/08 Insurance Law
TITLE....Provides enhanced consumer and
provider protections
04/17/07REFERRED TO INSURANCE
01/09/08REFERRED TO INSURANCE
06/20/08AMEND (T) AND RECOMMIT
TO INSURANCE
06/20/08PRINT NUMBER 4481A
06/24/08COMMITTEE DISCHARGED
AND COMMITTED TO RULES
06/24/08ORDERED TO THIRD
READING CAL.2194
06/24/08PASSED SENATE
06/24/08DELIVERED TO ASSEMBLY
06/24/08referred to insurance

RULES COM (Request of Morelle, Bradley)
Amd Ins L, generally; amd SS4406-c, 4408-d, 4906, 4910 & 4914, add S4917, Pub
Health L
Provides enhanced consumer and provider protections limitations on denial of claims for
pre-authorized health care services; relates to grievance procedures; relates to managed
care health insurance contracts; relates to determinations involving urgent care by
utilization review agents.

STATE OF NEW YORK

11737

IN ASSEMBLY

June 20, 2008

Introduced by COMMITTEE ON RULES -- (at request of M. of A.
Morelle) --
read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to prohibiting certain adverse reimbursement change to a contract with a physician; and in relation to grievance procedures and providing access to specialty care

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Subsections (g) and (h) of section 3217-b of the insurance law, subsection (g) as relettered by chapter 586 of the laws of 1998, are relettered subsections (h) and (i) and a new subsection (g) is added to read as follows:

2 (g)(1) No insurer shall implement an adverse reimbursement change to a contract with a physician that is otherwise permitted by the contract, unless, prior to the effective date of the change, the insurer gives the physician 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 physician objects to the change that is the subject of the notice by the insurer, the physician 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.

3 For the purposes of this subsection, the term "adverse reimbursement change" shall mean a proposed change that could reasonably be expected to have the effect of materially reducing the level of payment to a physician. 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 (B) such change is expressly provided for under the terms of the contract by the inclusion of or reference to

24 a specific fee or fee schedule, reimbursement methodology
or payment
25 policy indexing mechanism.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets

[-] is old law to be omitted.

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1 (2) Nothing in this subsection shall create a private right
of action
2 on behalf of a physician against an insurer for
violations of this
3 subsection.

4 § 2. The insurance law is amended by adding a new section
3217-d to

5 read as follows:

6 § 3217-d. Grievance procedure and access to specialty care.

(a) An

7 insurer that issues a comprehensive policy that utilizes a
network of

8 providers and is not a managed care health insurance contract
as defined

9 in subsection (c) of section four thousand eight hundred one
of this

10 chapter shall establish and maintain a grievance procedure
consistent

11 with the requirements of section four thousand eight hundred
two of this

12 chapter.

13 (b) An insurer that issues a comprehensive policy that
utilizes a

14 network of providers and is not a managed care health insurance
contract

15 as defined in subsection (c) of section four thousand eight
hundred one

16 of this chapter and requires that specialty care be provided
pursuant to

17 a referral from a primary care provider shall provide access
to such

18 specialty care consistent with the requirements of subsections
(b), (c)

19 and (d) of section four thousand eight hundred four of this
chapter;

20 provided however, that nothing herein shall be construed to
require that

21 an insurer, or a primary care provider on behalf of the
insurer, make a

22 referral to a provider that is not in the insurer's network.

23 (c) An insurer that issues a comprehensive policy that
utilizes a

24 network of providers and is not a managed care health insurance
contract

25 as defined in subsection (c) of section four thousand eight
hundred one

26 of this chapter shall provide access to transitional care
27 consistent
28 with the requirements of subsections (e) and (f) of section
29 four thou-
30 sand eight hundred four of this chapter.

31 § 3. Paragraph (B) of paragraph 2 of subsection (e) of
32 section 3231 of
33 the insurance law, as added by chapter 501 of the laws of
34 1992, is

35 amended to read as follows:

36 (B) Each calendar year, an insurer shall return, in the form
37 of aggre-

38 gate benefits for each policy form filed pursuant to the
39 alternate

40 procedure set forth in this paragraph at least seventy-five
41 percent of

42 the aggregate premiums collected for the policy form during
43 that calen-

44 dar year. Insurers shall annually report, no later than May
45 first of

46 each year, the loss ratio calculated pursuant to this paragraph
47 for each

48 such policy form for the previous calendar year. In each case
49 where the

50 loss ratio for a policy form fails to comply with the
51 seventy-five

52 percent loss ratio requirement, the insurer shall issue a
53 dividend or

54 credit against future premiums for all policy holders with
55 that policy

56 form in an amount sufficient to assure that the aggregate
57 benefits paid

58 in the previous calendar year plus the amount of the dividends
59 and cred-

60 its shall equal seventy-five percent of the aggregate premiums
61 collected

62 for the policy form in the previous calendar year. The dividend
63 or cred-

64 it shall be issued to each policy which was in effect as of
65 December

66 thirty-first of the applicable year [~~and remains in effect~~
67 ~~as of the~~

68 ~~date the dividend or credit is issued~~]. An insurer shall make a
69 reason-

70 able effort to identify the current address of those policy
71 holders who

72 are no longer policy holders when the dividend or credit is
73 issued. All

74 dividends and credits must be distributed by September
75 thirtieth of the

76 year following the calendar year in which the loss ratio
77 requirements

78 were not satisfied. The annual report required by this
79 paragraph shall

80 include an insurer's calculation of the dividends and credits,
81 as well

55 as an explanation of the insurer's plan to issue dividends or credits.

56 The instructions and format for calculating and reporting loss ratios

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1 and issuing dividends or credits shall be specified by the superinten-
2 dent by regulation. Such regulations shall include provisions for the
3 distribution of a dividend or credit in the event of cancellation or
4 termination by a policy holder.

5 § 4. The insurance law is amended by adding a new section 4306-c to

6 read as follows:

7 §4306-c. Grievance procedure and access to specialty care.

(a) A

8 corporation, including a municipal cooperative health benefits plan

9 certified pursuant to article forty-seven of this chapter, that issues a

10 comprehensive contract that utilizes a network of providers and is not a

11 managed care health insurance contract as defined in subsection (c) of

12 section four thousand eight hundred one of this chapter shall establish

13 and maintain a grievance procedure consistent with the requirements of

14 section four thousand eight hundred two of this chapter.

15 (b) A corporation, including a municipal cooperative health benefits

16 plan certified pursuant to article forty-seven of this chapter, that

17 issues a comprehensive contract that utilizes a network of providers and

18 is not a managed care health insurance contract as defined in subsection

19 (c) of section four thousand eight hundred one of this chapter and

20 requires that specialty care be provided pursuant to a referral from a

21 primary care provider shall provide access to such specialty care

22 consistent with the requirements of subsections (b), (c) and (d) of

23 section four thousand eight hundred four of this chapter; provided

24 however, that nothing herein shall be construed to require that a corpo-

25 ration, or a primary care provider on behalf of the corporation, make a

26 referral to a provider that is not in the corporation's network.

27 (c) A corporation, including a municipal cooperative health benefits

28 plan certified pursuant to article forty-seven of this
29 chapter, that
30 issues a comprehensive contract that utilizes a network of
31 providers and
32 is not a managed care health insurance contract as defined in
33 subsection
34 (c) of section four thousand eight hundred one of this
35 chapter shall
36 provide access to transitional care consistent with the
37 requirements of
38 subsections (e) and (f) of section four thousand eight
39 hundred four of
40 this chapter.

41 § 5. Paragraph 2 of subsection (h) of section 4308 of the
42 insurance
43 law, as added by chapter 504 of the laws of 1995, is amended
44 to read as
45 follows:

46 (2) In each case where the loss ratio for a contract form
47 fails to
48 comply with the eighty-five percent minimum loss ratio
49 requirement for
50 individual direct payment contracts, or the seventy-five
51 percent minimum
52 loss ratio requirement for small group and small group
53 remittance
54 contracts, as set forth in paragraph one of this subsection,
55 the corpo-
56 ration shall issue a dividend or credit against future premiums
57 for all
58 contract holders with that contract form in an amount
59 sufficient to
60 assure that the aggregate benefits incurred in the previous
61 calendar
62 year plus the amount of the dividends and credits shall
63 equal no less
64 than eighty-five percent for individual direct payment
65 contracts, or
66 seventy-five percent for small group and small group
67 remittance
68 contracts, of the aggregate premiums earned for the contract
69 form in the
70 previous calendar year. The dividend or credit shall be issued
71 to each
72 contract that was in effect as of December thirty-first of the
73 applica-
74 ble year [~~and remains in effect as of the date the dividend or~~
75 ~~credit is~~
76 issued]. A corporation shall make a reasonable effort to
77 identify the
78 current address of those contract holders or subscribers
79 who are no
80 longer contract holders or subscribers when the dividend or
81 credit is
82 issued. All dividends and credits must be distributed by
83 September thir-

1 tieth of the year following the calendar year in which the
loss ratio

2 requirements were not satisfied. The annual report required by
paragraph

3 one of this subsection shall include a corporation's
calculation of the

4 dividends and credits, as well as an explanation of the
corporation's

5 plan to issue dividends or credits. The instructions and
format for

6 calculating and reporting loss ratios and issuing dividends
or credits

7 shall be specified by the superintendent by regulation. Such
regulations

8 shall include provisions for the distribution of a dividend or
credit in

9 the event of cancellation or termination by a contract
holder or

10 subscriber.

11 § 6. Subsections (g) and (h) of section 4325 of the
insurance law,

12 subsection (g) as relettered by chapter 586 of the laws of
1998, are

13 relettered subsections (h) and (i) and a new subsection (g) is
added to

14 read as follows:

15 (g)(1) No insurer shall implement an adverse reimbursement
change to a

16 contract with a physician that is otherwise permitted by the
contract,

17 unless, prior to the effective date of the change, the insurer
gives the

18 physician with whom the insurer has directly contracted
and who is

19 impacted by the adverse reimbursement change, at least ninety
days writ-

20 ten notice of the change. If the contracting physician objects
to the

21 change that is the subject of the notice by the insurer, the
physician

22 may, within thirty days of the date of the notice, give
written notice

23 to the insurer to terminate his or her contract with the
insurer effec-

24 tive upon the implementation date of the adverse reimbursement
change.

25 For the purposes of this subsection, the term "adverse
reimbursement

26 change" shall mean a proposed change that could reasonably be
expected

27 to have the effect of materially reducing the level of
payment to a

28 physician. The notice provisions required by this subsection
shall not

29 apply where: (A) such change is otherwise required by law,
regulation or

30 applicable regulatory authority, or is required as a result
of changes
31 in fee schedules, reimbursement methodology or payment
policies estab-
32 lished by a government agency; or (B) such change is expressly
provided
33 for under the terms of the contract by the inclusion of or
reference to
34 a specific fee or fee schedule, reimbursement methodology
or payment
35 policy indexing mechanism.
36 (2) Nothing in this subsection shall create a private right
of action
37 on behalf of a physician against an insurer for
violations of this
38 subsection.

39 § 7. Subsection (a) of section 4803 of the insurance law, as
amended
40 by chapter 551 of the laws of 2006, is amended to read as
follows:

41 (a) (1) An insurer which offers a managed care product
shall, upon
42 request, make available and disclose to health care
professionals writ-
43 ten application procedures and minimum qualification
requirements which
44 a health care professional must meet in order to be considered
by the
45 insurer for participation in the in-network benefits
portion of the
46 insurer's network for the managed care product. The
insurer shall
47 consult with appropriately qualified health care professionals
in devel-
48 oping its qualification requirements for participation in the
in-network
49 benefits portion of the insurer's network for the managed care
product.
50 An insurer shall complete review of the health care
professional's
51 application to participate in the in-network portion of the
insurer's
52 network and, within ninety days of receiving a health care
profes-
53 sional's completed application to participate in the insurer's
network,
54 will notify the health care professional as to [~~(i)~~]: (A)
whether he or
55 she is credentialed; or [~~(ii)~~] (B) whether additional time is
necessary
56 to make a determination in spite of the insurer's best
efforts or

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1 because of a failure of a third party to provide necessary
documenta-

2 tion, or non-routine or unusual circumstances require
additional time
3 for review. In such instances where additional time is
necessary
4 because of a lack of necessary documentation, an insurer
shall make
5 every effort to obtain such information as soon as possible.
6 (2) If the complete application of a newly-licensed
physician or a
7 physician that has recently relocated to this state from
another state
8 and has not previously practiced in this state, who joins a
group prac-
9 tice of physicians each of whom participates in the in-
network portion
10 of an insurer's network, is not approved or declined within
ninety days
11 pursuant to paragraph one of this subsection, such physician
shall be
12 deemed "provisionally credentialed" and may participate in the
in-net-
13 work portion of an insurer's network; provided, however,
that such
14 physician may not be designated as an insured's primary care
physician
15 until such time as the physician has been fully
credentialed. The
16 network participation for the provisionally credentialed
physician shall
17 begin on the day following the ninetieth day of receipt of the
completed
18 application and shall last until the final credentialing
determination
19 is made by the insurer. A physician shall only be eligible
for provi-
20 sional credentialing if the group practice of physicians
agrees that,
21 should the application ultimately be denied, the physician or
the group
22 practice: (A) shall refund any payments made by the insurer for
in-net-
23 work services provided by the provisionally credentialed
physician that
24 exceed any out-of-network benefits payable under the insured's
contract
25 with the insurer; and (B) shall not pursue reimbursement
from the
26 insured, except to collect the copayment or coinsurance that
otherwise
27 would have been payable had the insured received services from
a physi-
28 cian participating in the in-network portion of an insurer's
network.
29 Interest and penalties pursuant to section three thousand
two hundred
30 twenty-four-a of this chapter shall not be assessed based on
the denial

31 of a claim submitted during the period when the physician
was provi-
32 sionally credentialed; provided, however, that nothing
herein shall
33 prevent an insurer from paying a claim from a physician who
is provi-
34 sionally credentialed upon submission of such claim. An
insurer shall
35 not deny, after appeal, a claim for services provided by a
provisionally
36 credentialed physician solely on the ground that the claim was
not time-
37 ly filed.

38 § 8. Section 4906 of the insurance law, as amended by
chapter 586 of
39 the laws of 1998, is amended to read as follows:
40 § 4906. Waiver. (a) Any agreement which purports to
waive, limit,
41 disclaim, or in any way diminish the rights set forth in this
article,
42 except as provided pursuant to section four thousand nine
hundred ten of
43 this article shall be void as contrary to public policy.
44 (b) Notwithstanding subsection (a) of this section, in lieu
of the
45 external appeal process as set forth in this article, a health
care plan
46 and a facility licensed pursuant to article twenty-eight of
the public
47 health law may mutually agree to an alternative dispute
resolution mech-
48 anism to resolve disputes otherwise subject to this article.

49 § 9. The opening paragraph of subsection (b) of section 4910
of the
50 insurance law, as added by chapter 586 of the laws of 1998,
is amended
51 to read as follows:

52 An insured, the insured's designee and, in connection with
concurrent
53 and retrospective adverse determinations, an insured's
health care
54 provider, shall have the right to request an external appeal
when:

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1 § 10. Paragraphs 2 and 3 of subsection (b) of section 4914
of the
2 insurance law, as added by chapter 586 of the laws of 1998,
are amended
3 to read as follows:
4 (2) The external appeal agent shall make a determination
with regard
5 to the appeal within thirty days of the receipt of the
[insured's]
6 request therefor, submitted in accordance with the
superintendent's

7 instructions. The external appeal agent shall have the
opportunity to
8 request additional information from the insured, the
insured's health
9 care provider and the insured's health care plan within such
thirty-day
10 period, in which case the agent shall have up to five
additional busi-
11 ness days if necessary to make such determination. The
external appeal
12 agent shall notify the insured, where appropriate the
insured's health
13 care provider, and the health care plan, in writing, of
the appeal
14 determination within two business days of the rendering of such
determi-
15 nation.

16 (3) Notwithstanding the provisions of paragraphs one and
two of this
17 subsection, if the insured's attending physician states that a
delay in
18 providing the health care service would pose an imminent
or serious
19 threat to the health of the insured, the external appeal
shall be
20 completed within three days of the request therefor and the
external
21 appeal agent shall make every reasonable attempt to
immediately notify
22 the insured, where appropriate, the insured's health care
provider, and
23 the health plan of its determination by telephone or facsimile,
followed
24 immediately by written notification of such determination.

25 § 11. Subsection (d) of section 4914 of the insurance law, as
added by
26 chapter 586 of the laws of 1998, is amended to read as follows:
27 (d) [~~Payment~~] (1) Except as provided in paragraphs two and
three of

28 this subsection, payment for an external appeal shall be the
responsi-
29 bility of the health care plan. The health care plan shall make
payment
30 to the external appeal agent within forty-five days, from the
date the
31 appeal determination is received by the health care plan, and
the health
32 care plan shall be obligated to pay such amount together with
interest
33 thereon calculated at a rate which is the greater of the rate
set by the
34 commissioner of taxation and finance for corporate taxes
pursuant to
35 paragraph one of subsection (e) of section one thousand
ninety-six of
36 the tax law or twelve percent per annum, to be computed from
the date

37 the bill was required to be paid, in the event that payment is
not made

38 within such forty-five days.

39 (2) If an insured's health care provider requests an
external appeal
40 of a concurrent adverse determination and the external
appeal agent
41 upholds the health care plan's determination in whole,
payment for the
42 external appeal shall be made by the health care provider in
the manner
43 and subject to the timeframes and requirements set forth in
paragraph
44 one of this subsection.

45 (3) If an insured's health care provider requests an
external appeal
46 of a concurrent adverse determination and the external
appeal agent
47 upholds the health care plan's determination in part, payment
for the
48 external appeal shall be evenly split between the health care
plan and
49 the insured's health care provider who requested the external
appeal and
50 shall be made by the health care plan and the insured's
health care
51 provider in the manner and subject to the timeframes and
requirements
52 set forth in paragraph one of this subsection for one year
from the
53 effective date of this subsection. After one year from the
effective

54 date of this subsection, the superintendent shall evaluate
whether
55 health care plans or health care providers are experiencing a
substan-
56 tial hardship as a result of payment for the external appeal
when the

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1 external appeal agent upholds the health care plan's
determination in
2 part. The superintendent, in consultation with the
commissioner of
3 health, may promulgate a regulation to specify payment
responsibilities
4 of providers and health care plans when the external
appeal agent
5 upholds the health care plan's determination in part which
shall super-
6 sede the requirements of this paragraph.
7 (4) If an insured's health care provider was acting as the
insured's
8 designee, payment for the external appeal shall be made by
the health
9 care plan. The external appeal and any designation shall be
submitted

10 on a standard form developed by the superintendent in
11 consultation with
12 the commissioner of health pursuant to subsection (e) of this
13 section.
14 The superintendent shall have the authority upon receipt of an
15 external
16 appeal to confirm the designation or request other information
17 as neces-
18 sary. The superintendent shall make at least two written
19 requests to the
20 insured to confirm the designation. The insured shall have two
21 weeks to
22 respond to each such request. If the insured fails to respond
23 to the
24 superintendent within the specified timeframe, the
25 superintendent shall
26 pend the external appeal and make two written requests to
27 the health
28 care provider to file an external appeal on his or her own
29 behalf. The
30 health care provider shall have two weeks to respond to
31 each such
32 request. If the health care provider does not respond to the
33 superinten-
34 dent's requests within the specified timeframe, the
35 superintendent shall
36 reject the appeal.

24 § 12. The insurance law is amended by adding a new
section 4917 to

25 read as follows:

26 § 4917. Hold harmless. A health care provider requesting an
27 external
28 appeal of a concurrent adverse determination, including when
29 the health
30 care provider requests an external appeal as the insured's
31 designee,
32 shall not pursue reimbursement from the insured except to
33 collect a
34 copayment, coinsurance or deductible for services
35 determined not
36 medically necessary by the external appeal agent.

32 § 13. Subdivision 5-c of section 4406-c of the public
health law is
33 relettered subdivision 5-d and a new subdivision 5-c is added
to read as
34 follows:

35 5-c. (a) No health care plan shall implement an adverse
36 reimbursement
37 change to a contract with a physician that is otherwise
38 permitted by the
39 contract, unless, prior to the effective date of the change,
40 the health
41 care plan gives the physician with whom the health care plan
42 has direct-
43 ly contracted and who is impacted by the adverse reimbursement
44 change,

40 at least ninety days written notice of the change. If the
41 contracting
42 physician objects to the change that is the subject of the
43 notice by the
44 health care plan, the physician may, within thirty days of the
45 date of
46 the notice, give written notice to the health care plan to
47 terminate his
48 or her contract with the health care plan effective upon the
49 implementa-
50 tion date of the adverse reimbursement change. For the
51 purposes of this
52 subdivision, the term "adverse reimbursement change" shall
53 mean a
54 proposed change that could reasonably be expected to have the
55 effect of
56 materially reducing the level of payment to a physician.
The notice
49 provisions required by this subdivision shall not apply where:
(i) such
50 change is otherwise required by law, regulation or applicable
51 regulatory
52 authority, or is required as a result of changes in fee
53 schedules,
54 reimbursement methodology or payment policies established by
55 a govern-
56 ment agency; or (ii) such change is expressly provided for
under the
54 terms of the contract by the inclusion of or reference to a
55 specific fee
56 or fee schedule, reimbursement methodology or payment policy
indexing
56 mechanism.

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1 (b) Nothing in this subdivision shall create a private right
2 of action
3 on behalf of a physician against an insurer for violations
4 of this
5 subdivision.

4 § 14. Subdivision 1 of section 4406-d of the public
health law, as
5 amended by chapter 551 of the laws of 2006, is amended to
read as

6 follows:
7 1. (a) A health care plan shall, upon request, make
available and
8 disclose to health care professionals written application
procedures and
9 minimum qualification requirements which a health care
professional must
10 meet in order to be considered by the health care plan. The
plan shall
11 consult with appropriately qualified health care professionals
in devel-
12 oping its qualification requirements. A health care plan shall
complete

13 review of the health care professional's application to
participate in
14 the in-network portion of the health care plan's network
and shall,
15 within ninety days of receiving a health care professional's
completed
16 application to participate in the health care plan's network,
notify the
17 health care professional as to ~~[(a)]~~: (i) whether he or she
is creden-
18 tialled; or ~~[(b)]~~ (ii) whether additional time is necessary to
make a
19 determination in spite of the health care plan's best efforts
or because
20 of a failure of a third party to provide necessary
documentation, or
21 non-routine or unusual circumstances require additional time
for review.
22 In such instances where additional time is necessary because of
a lack
23 of necessary documentation, a health plan shall make every
effort to
24 obtain such information as soon as possible.
25 (b) If the complete application of a newly-licensed
physician or a
26 physician that has recently relocated to this state from
another state
27 and has not previously practiced in this state, who joins a
group prac-
28 tice of physicians each of whom participates in the in-
network portion
29 of a health care plan's network, is not approved or
declined within
30 ninety days pursuant to paragraph (a) of this subdivision, the
physician
31 shall be deemed "provisionally credentialed" and may
participate in the
32 in-network portion of the health care plan's network; provided,
however,
33 that such physician may not be designated as an enrollee's
primary care
34 physician until such time as the physician has been fully
credentialed.
35 The network participation for the provisionally credentialed
physician
36 shall begin on the day following the ninetieth day of
receipt of the
37 completed application and shall last until the final
credentialing
38 determination is made by the health care plan. A physician
shall only be
39 eligible for provisional credentialing if the group practice
of physi-
40 cians agrees that, should the application ultimately be
denied, the
41 physician or the group practice: (i) shall refund any
payments made by

42 the health care plan for in-network services provided by
43 the provi-
44 sionally credentialed physician that exceed any out-of-network
45 benefits
46 payable under the enrollee's contract with the health care
47 plan; and
48 (ii) shall not pursue reimbursement from the enrollee, except
49 to collect
50 the copayment that otherwise would have been payable had the
51 enrollee
52 received services from a physician participating in the
53 in-network
54 portion of a health care plan's network. Interest and penalties
55 pursuant
56 to section three thousand two hundred twenty-four-a of the
57 insurance law
58 shall not be assessed based on the denial of a claim
59 submitted during
60 the period when the physician was provisionally credentialed;
61 provided,
62 however, that nothing herein shall prevent a health care
63 plan from
64 paying a claim from a physician who is provisionally
65 credentialed upon
66 submission of such claim. A health care plan shall not
67 deny, after
68 appeal, a claim for services provided by a provisionally
69 credentialed
70 physician solely on the ground that the claim was not timely
71 filed.

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1 § 15. Section 4906 of the public health law, as amended by
2 chapter 586
3 of the laws of 1998, is amended to read as follows:
4 § 4906. Waiver. 1. Any agreement which purports to
5 waive, limit,
6 disclaim, or in any way diminish the rights set forth in this
7 article,
8 except as provided pursuant to section four thousand nine
9 hundred ten of
10 this article shall be void as contrary to public policy.
11 2. Notwithstanding subdivision one of this section, in
12 lieu of the
13 external appeal process as set forth in this article, a health
14 care plan
15 and a facility licensed pursuant to article twenty-eight of
16 this chapter
17 may mutually agree to an alternative dispute resolution
18 mechanism to
19 resolve disputes otherwise subject to this article.
20 § 16. The opening paragraph of subdivision 2 of section
21 4910 of the
22 public health law, as added by chapter 586 of the laws of
23 1998, is
24 amended to read as follows:

15 An enrollee, the enrollee's designee and, in connection
with concur-
16 rent and retrospective adverse determinations, an enrollee's
health care
17 provider, shall have the right to request an external appeal
when:

18 § 17. Paragraphs (b) and (c) of subdivision 2 of section 4914
of the
19 public health law, as added by chapter 586 of the laws of
1998, are
20 amended to read as follows:

21 (b) The external appeal agent shall make a determination with
respect

22 to the appeal within thirty days of the receipt of the
[enrollee's]

23 request therefor, submitted in accordance with the
commissioner's

24 instructions. The external appeal agent shall have the
opportunity to

25 request additional information from the enrollee, the
enrollee's health

26 care provider and the enrollee's health care plan within such
thirty-day

27 period, in which case the agent shall have up to five
additional busi-

28 ness days if necessary to make such determination. The
external appeal

29 agent shall notify the enrollee, where appropriate, the
enrollee's

30 health care provider, and the health care plan, in writing,
of the

31 appeal determination within two business days of the
rendering of such

32 determination.

33 (c) Notwithstanding the provisions of paragraphs (a) and (b)
of this

34 subdivision, if the enrollee's attending physician states
that a delay

35 in providing the health care service would pose an imminent or
serious

36 threat to the health of the enrollee, the external appeal
shall be

37 completed within three days of the request therefor and the
external

38 appeal agent shall make every reasonable attempt to
immediately notify

39 the enrollee, where appropriate, the enrollee's health care
provider,

40 and the health plan of its determination by telephone or
facsimile,

41 followed immediately by written notification of such
determination.

42 § 18. Subdivision 4 of section 4914 of the public health law,
as added

43 by chapter 586 of the laws of 1998, is amended to read as
follows:

44 4. [Payment] (a) Except as provided in paragraphs (b) and (c)
of this
45 subdivision, payment for an external appeal shall be the
responsibility
46 of the health care plan. The health care plan shall make
payment to the
47 external appeal agent within forty-five days from the date
the appeal
48 determination is received by the health care plan, and the
health care
49 plan shall be obligated to pay such amount together with
interest there-
50 on calculated at a rate which is the greater of the rate
set by the
51 commissioner of taxation and finance for corporate taxes
pursuant to
52 paragraph one of subsection (e) of section one thousand
ninety-six of
53 the tax law or twelve percent per annum, to be computed from
the date
54 the bill was required to be paid, in the event that payment is
not made
55 within such forty-five days.
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1 (b) If an enrollee's health care provider requests an
external appeal
2 of a concurrent adverse determination and the external
appeal agent
3 upholds the health care plan's determination in whole, payment
for the
4 external appeal shall be made by the health care provider in
the manner
5 and subject to the timeframes and requirements set forth in
paragraph
6 (a) of this subdivision.
7 (c) If an enrollee's health care provider requests an
external appeal
8 of a concurrent adverse determination and the external
appeal agent
9 upholds the health care plan's determination in part, payment
for the
10 external appeal shall be evenly split between the health care
plan and
11 the enrollee's health care provider who requested the
external appeal
12 and shall be made by the health care plan and the enrollee's
health care
13 provider in the manner and subject to the timeframes and
requirements
14 set forth in paragraph (a) of this subdivision. After one year
from the
15 effective date of this subdivision, the superintendent of
insurance
16 shall evaluate whether health care plans or health care
providers are

17 experiencing a substantial hardship as a result of
18 payment for the
19 external appeal when the external appeal agent upholds the
20 health care
21 plan's determination in part. The commissioner, in consultation
22 with the
23 superintendent of insurance, may promulgate a regulation
24 to specify
25 payment responsibilities of providers and health care plans
26 when the
27 external appeal agent upholds the health care plan's
28 determination in
29 part which shall supersede the requirements of this paragraph.
30 (d) If an enrollee's health care provider was acting as the
31 enrollee's
32 designee, payment for the external appeal shall be made by
33 the health
34 care plan. The external appeal and any designation shall be
35 submitted
36 on a standard form developed by the commissioner in
37 consultation with
38 the superintendent of insurance pursuant to subdivision
39 five of this
40 section. The superintendent of insurance shall have the
41 authority upon
42 receipt of an external appeal to confirm the designation
43 or request
44 other information as necessary. The superintendent of
45 insurance shall
46 make at least two written requests to the enrollee to confirm
47 the desig-
48 nation. The enrollee shall have two weeks to respond to
49 each such
50 request. If the enrollee fails to respond to the
51 superintendent of
52 insurance within the specified time frame, the superintendent
53 of insur-
54 ance shall pend the external appeal and make two written
55 requests to the
56 health care provider to file an external appeal on his or
57 her own
58 behalf. The health care provider shall have two weeks to
59 respond to each
60 such request. If the health care provider does not respond to
61 the super-
62 intendent of insurance requests within the specified
63 timeframe, the
64 superintendent of insurance shall reject the appeal.
65 § 19. The public health law is amended by adding a new
section 4917 to
66 read as follows:
67 § 4917. Hold harmless. A health care provider requesting an
68 external
69 appeal of a concurrent adverse determination, including when
70 the health
71 care provider requests an external appeal as the enrollee's
72 designee,

47 shall not pursue reimbursement from the enrollee except to
48 collect a
49 copayment for services determined not medically necessary
50 by the
51 external appeal agent.

52 § 20. This act shall take effect January 1, 2009; provided,
however,

53 that:

54 1. sections seven and fourteen of this act shall take effect
October

55 1, 2008, and shall apply to applications submitted after that
date, and

56 shall not apply to applications submitted prior to such date
if such

57 application is resubmitted in substantially similar form on
or after

58 October 1, 2008;

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11

60 2. the amendments to subsection (a) of section 3217-d of the
insurance

61 law made by section two of this act and subsection (a) of
section 4306-c

62 of the insurance law made by section four of this act shall
take effect

63 January 1, 2010 or the date uniform standards for a grievance
procedure

64 are adopted to be consistent with federal requirements,
whichever is

65 6 later;

66 3. provided, further, that the amendments to subsection (i)
of section

67 3217-b of the insurance law made by section one of this act
shall not

68 affect the repeal of such subsection and shall be deemed
repealed there-

69 10 with;

70 4. provided, further, that the amendments to subsection (i)
of section

71 4325 of the insurance law made by section six of this act
shall not

72 affect the repeal of such subsection and shall be deemed
repealed there-

73 14 with; and

74 5. provided, further, that the amendments made to subdivision
5-d of

75 section 4406-c of the public health law made by section
thirteen of this

76 act shall not affect the repeal of such subdivision and shall
be deemed

77 18 repealed therewith.

BILL NUMBER: A11737

SPONSOR: Rules|(Morelle)|||||

TITLE OF BILL: An act to amend the insurance law and the public health law, in relation to prohibiting certain adverse reimbursement change to a contract with a physician; and in relation to grievance procedures and providing access to specialty care

PURPOSE OR GENERAL IDEA OF BILL: This bill enhances consumer and provider protections by requiring insurers to extend protections regarding referrals to specialists and grievance procedures; removing the limitation that a member's contract must be in effect as of the date a dividend or credit is issued in the event a loss ratio requirement is not met; offering protections to providers against an adverse reimbursement change to a contract; permitting newly licensed physicians and physicians moving to New York to be provisionally credentialed until the final credentialing determination is made by the insurer or health care plan; and extending to providers the right to pursue an external appeal of a concurrent adverse determination.

SUMMARY OF SPECIFIC PROVISIONS: Section 1 of the bill amends Section 3217-b of the Insurance Law to prohibit an insurer from implementing an adverse reimbursement change to a contract with a physician unless the insurer gives the physician ninety days written notice of the change and allows the physician, within thirty days of the date of the notice, to terminate his or her contract with the insurer effective upon the implementation date of such adverse reimbursement change.

Section 2 of the bill amends the Insurance Law by adding a new Section 3217-d to require that insurers offering a comprehensive policy to conform grievance procedures and access to care requirements to those in Article 48 of the Insurance Law.

Section 3 of the bill amends Section 3231 of the Insurance Law to remove the limitation that a member's contract must be in effect as of the date a dividend or credit is issued in the event a loss ratio requirement is not met.

Section 4 of the bill amends the Insurance Law by adding a new Section 4306-c to require that Article 43 corporations and municipal cooperative health benefits plans organized pursuant to Article 47 of the Insurance Law offering a comprehensive policy to conform grievance procedures and access to care requirements to those in Article 48 of the Insurance Law.

Section 5 of the bill amends Section 4308 of the Insurance Law to remove the limitation that a member's contract must be in effect as of the date a dividend or credit is issued in the event a loss ratio requirement is not met.

Section 6 of the bill amends Section 4325 of the Insurance Law to prohibit an insurer from implementing an adverse reimbursement change to a contract with a physician unless the insurer gives the physician ninety days written notice of the change and allows the physician, within thirty days of the date of the notice, terminate his or her contract with the insurer effective upon the implementation date of such adverse reimbursement change.

Section 7 of the bill amends Section 4803 of the Insurance Law to require that if a newly-licensed physician or a physician moving to New York from another state joins a group practice of physicians that participates in the in-network portion of an health care plan's network, but the physician is not credentialed by the insurer within ninety days, the physician shall be deemed "provisionally credentialed" and shall participate in the in-network portion of an health care plan's network until the final credentialing determination is made by the health care plan.

Section 8 of the bill amends Section 4906 of the Insurance Law to provide that a hospital and a health care plan may utilize a mutually agreed to alternative dispute resolution mechanism in lieu of the external appeal process in Article 49 of the Insurance Law.

Section 9 of the bill amends Section 4910 of the Insurance Law to allow providers to appeal a concurrent adverse determination through the external appeal process.

Section 10 of the bill amends Section 4914 of the Insurance Law to require the external appeal agent to notify providers, where appropriate, of the external appeal determination.

Section 11 of the bill amends Section 4914 of the Insurance Law to require the provider to pay the cost of the external appeal of a concurrent adverse determination if the health care plan's denial is upheld, to require that the health care plan and provider split the cost of the external appeal of a concurrent adverse determination if the denial is upheld in part, to require the Superintendent of Insurance to study the effects of the split fee, to allow the Superintendent of Insurance to promulgate regulations related to the fee if necessary, and to allow the Superintendent of Insurance to confirm a patient's designation of a provider to bring an external appeal on his or her behalf.

Section 12 of the bill amends the Insurance Law to add a new Section

4917 to require that when a health care provider's external appeal of a concurrent adverse determination, including when the health care provider is the insured's designee, is upheld by the external appeal agent, that the health care provider shall not pursue reimbursement from the insured, except for any applicable cost sharing mechanisms under the insured's health insurance contract.

Section 13 of the bill amends Section 4406-c of the Public Health Law to prohibit a health care plan from implementing an adverse reimbursement change to a contract with a physician unless the health care plan gives the physician ninety days written notice of the change and allows the physician, within thirty days of the date of the notice, terminate his or her contract with the health care plan effective upon the implementation date of such adverse reimbursement change.

Section 14 of the bill amends Section 4406-d of the Public Health Law to require that if a newly-licensed physician or a physician moving to New York from another state joins a group practice of physicians that participates in the in-network portion of an health care plan's network, but the physician is not credentialed by the insurer within ninety days, the physician shall be deemed "provisionally credentialed" and shall participate in the in-network portion of an health care plan's network until the final credentialing determination is made by the health care plan.

Section 15 of the bill amends Section 4906 of the Public Health Law to provide that a hospital and a health care plan may utilize a mutually agreed to alternative dispute resolution mechanism in lieu of the external appeal process in Article 49 of the Public Health Law.

Section 16 of the bill amends Section 4910 of the Public Health Law to allow providers to appeal a concurrent adverse determination through the external appeal process.

Section 17 of the bill amends Section 4914 of the Public Health Law to require the external appeal agent to notify providers, where appropriate, of the external appeal determination.

Section 18 of the bill amends Section 4914 of the Public Health Law to require the provider to pay the cost of the external appeal of a concurrent adverse determination if the health care plan's denial is upheld, to require that the health care plan and provider split the cost of the external appeal of a concurrent adverse determination if the denial is upheld in part, to require the Superintendent of Insurance to study the effects of the split fee, to allow the Commissioner of Health to promulgate regulations related to the fee if necessary, and to allow the Superintendent of Insurance to confirm a patient's designation of a provider to bring an external appeal on his or her behalf.

Section 19 of the bill amends the Public Health Law to add a new Section 4917 to require that when a health care provider's external appeal of a concurrent adverse determination is upheld by the external appeal agent, including when the health care provider is the enrollee's designee, that the health care provider shall not pursue reimbursement from the enrollee, except for any applicable cost sharing mechanisms under the enrollee's health care plan.

JUSTIFICATION: In 1996, the managed care bill of rights was enacted and was followed by the external appeal law in 1998. In 2007, additional consumer protections were added with respect to imposing limitations on when pre-authorized services may be denied, permitting external appeal of out-of-network denials when a health insurance plan is proposing an alternative in-network treatment, enhancing protections when a provider leaves a network, requiring the collection and dissemination of preferred provider organization data, and establishing timeframes for submission of claims to managed care providers and family health insurance plans.

This bill builds upon the legislative changes made last year to further ensure that consumers and providers are meaningfully protected. It provides enhanced consumer protections by extending existing grievance and access to specialty care protections to members of insurance products subject to Article 32, 43 or 47 of the Insurance Law. This bill also allows for enhanced provider protections by allowing the provisional credentialing of new physicians and prohibiting insurers from implementing an adverse reimbursement change to a contract with a physician without prior notification. This bill also expands the right of health care providers to allow them to pursue an external appeal of a concurrent adverse determination. It requires providers to pay the external appeal agent fee if a health plan's concurrent adverse determination is upheld (or split the cost if upheld in part).

PRIOR LEGISLATIVE HISTORY: This is a new bill.

FISCAL IMPLICATIONS: None.

EFFECTIVE DATE: This act shall take effect January 1, 2009; provided, however, that: sections seven and fourteen of this act shall take effect on October 1, 2008, and shall apply to applications submitted after that date, and shall not apply to applications submitted prior to such date if such application is resubmitted in substantially similar form on or after October 1, 2008; and subsection (a) of section 3217-d of the Insurance Law and subsection (a) of section 4306-c of the Insurance Law

shall not be effective until the later of January 1, 2010 or the date
uniform standards for a grievance procedure are adopted to be
consistent
with federal requirements.

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