1 Section 1. Subdivision (e) of section 41.55 of the mental hygiene law,
2 as amended by section 3 of part C of chapter 111 of the laws of 2010, is
3 amended to read as follows:
4 (e) The amount of community mental health support and workforce rein-
5 vestment funds for the office of mental health shall be determined in
6 the annual budget and shall include the amount of actual state oper-
7 ations general fund appropriation reductions, including personal service
8 savings and other than personal service savings directly attributed to
9 each child and adult non-geriatric inpatient bed closure. For the
10 purposes of this section a bed shall be considered to be closed upon the
11 elimination of funding for such beds in the executive budget. The
12 appropriation reductions as a result of inpatient bed closures shall be
13 no less than [~~seventy~~] **one hundred ten** thousand dollars per bed on a
14 full annual basis, as annually recommended by the commissioner, subject
15 to the approval of the director of the budget, in the executive budget
16 request prior to the fiscal year for which the executive budget is being
17 submitted. The methodologies used to calculate the per bed closure
18 savings shall be developed by the commissioner and the director of the
19 budget. In no event shall the full annual value of community mental
20 health support and workforce reinvestment programs attributable to beds
21 closed as a result of net inpatient census decline exceed the twelve
22 month value of the office of mental health state operations general fund
23 reductions resulting from such census decline. Such reinvestment amount
24 shall be made available in the same proportion by which the office of
25 mental health's state operations general fund appropriations are reduced
26 each year as a result of child and adult non-geriatric inpatient bed
27 closures due to census decline.
28 § 2. Subdivision 2 of section 97-dddd of the state finance law, as
29 added by section 6 of part R2 of chapter 62 of the laws of 2003, is
30 amended to read as follows:
31 2. The commissioner of the office of mental health shall notify the
32 director of the budget when the number of children's psychiatric center
33 beds or adult, non-geriatric psychiatric center beds closed in any one
34 year exceeds the number of beds projected to be closed by the office of
35 mental health in the executive budget request submitted in the year
36 prior to the fiscal year for which the executive budget is being submit-
37 ted. Notwithstanding any other law, rule or regulation to the contrary
38 the director of the budget shall then transfer the amount of actual
39 state operations general fund appropriation reductions, including
40 personal service and nonpersonal service, directly attributed to the
41 closure of such beds, to the state comptroller who shall then credit
42 such appropriation reductions to the community mental health support and
43 workforce reinvestment account. The per bed appropriation reduction
44 shall be no less than [~~seventy~~] **one hundred ten** thousand dollars on a
45 full annual basis.
46 § 3. Section 7 of part R2 of chapter 62 of the laws of 2003, amending
47 the mental hygiene law and the state finance law relating to the commu-
48 nity mental health support and workforce reinvestment program, the
49 membership of subcommittees for mental health of community services
50 boards and the duties of such subcommittees and creating the community
51 mental health and workforce reinvestment account, as amended by section
52 3 of part H of chapter 56 of the laws of 2013, is amended to read as
53 follows:
54 § 7. This act shall take effect immediately and shall expire March 31,
55 [~~2015~~] **2018** when upon such date the provisions of this act shall be
56 deemed repealed.

1 § 4. This act shall take effect immediately; provided that:
2 1. the amendments to subdivision (e) of section 41.55 of the mental
3 hygiene law made by section one of this act shall not affect the repeal
4 of such section and shall be deemed repealed therewith; and
5 2. the amendments to subdivision 2 of section 97-dddd of the state
6 finance law made by section two of this act shall not affect the repeal
7 of such section and shall be deemed repealed therewith.

8 PART H

9 Section 1. Paragraphs 11, 12, 13, 14, 16 and 17 of subsection (a) of
10 section 3217-a of the insurance law, as added by chapter 705 of the laws
11 of 1996, are amended and four new paragraphs 16-a, 18, 19 and 20 are
12 added to read as follows:
13 (11) where applicable, notice that an insured enrolled in a managed
14 care product **or in a comprehensive policy that utilizes a network of**
15 **providers** offered by the insurer may obtain a referral [~~to~~] **or preau-**
16 **thorization for** a health care provider outside of the insurer's network
17 or panel when the insurer does not have a health care provider [~~with~~]
18 **who is geographically accessible to the insured and who has the** appro-
19 priate training and experience in the network or panel to meet the
20 particular health care needs of the insured and the procedure by which
21 the insured can obtain such referral **or preauthorization**;
22 (12) where applicable, notice that an insured enrolled in a managed
23 care product **or a comprehensive policy that utilizes a network of**
24 **providers** offered by the insurer with a condition which requires ongoing
25 care from a specialist may request a standing referral to such a
26 specialist and the procedure for requesting and obtaining such a stand-
27 ing referral;
28 (13) where applicable, notice that an insured enrolled in a managed
29 care product **or a comprehensive policy that utilizes a network of**
30 **providers** offered by the insurer with [~~(i)~~] **(A)** a life-threatening
31 condition or disease, or [~~(ii)~~] **(B)** a degenerative and disabling condi-
32 tion or disease, either of which requires specialized medical care over
33 a prolonged period of time may request a specialist responsible for
34 providing or coordinating the insured's medical care and the procedure
35 for requesting and obtaining such a specialist;
36 (14) where applicable, notice that an insured enrolled in a managed
37 care product **or a comprehensive policy that utilizes a network of**
38 **providers** offered by the insurer with [~~(i)~~] **(A)** a life-threatening
39 condition or disease, or [~~(ii)~~] **(B)** a degenerative and disabling condi-
40 tion or disease, either of which requires specialized medical care over
41 a prolonged period of time, may request access to a specialty care
42 center and the procedure by which such access may be obtained;
43 (16) notice of all appropriate mailing addresses and telephone numbers
44 to be utilized by insureds seeking information or authorization; [~~and~~]
45 **(16-a) where applicable, notice that an insured shall have direct**
46 **access to primary and preventive obstetric and gynecologic services,**
47 **including annual examinations, care resulting from such annual examina-**
48 **tions, and treatment of acute gynecologic conditions, from a qualified**
49 **provider of such services of her choice from within the plan or for any**
50 **care related to a pregnancy;**
51 (17) where applicable, a listing by specialty, which may be in a sepa-
52 rate document that is updated annually, of the name, address, and tele-
53 phone number of all participating providers, including facilities, and
54 in addition, in the case of physicians, board certification[~~.~~]**,**

1 languages spoken and any affiliations with participating hospitals. The
2 listing shall also be posted on the insurer's website and the insurer
3 shall update the website within fifteen days of the addition or termi-
4 nation of a provider from the insurer's network or a change in a physi-
5 cian's hospital affiliation;
6 (18) a description of the method by which an insured may submit a
7 claim for health care services;
8 (19) with respect to out-of-network coverage:
9 (A) a clear description of the methodology used by the insurer to
10 determine reimbursement for out-of-network health care services;
11 (B) the amount that the insurer will reimburse under the methodology
12 for out-of-network health care services set forth as a percentage of the
13 usual and customary cost for out-of-network health care services; and
14 (C) examples of anticipated out-of-pocket costs for frequently billed
15 out-of-network health care services; and
16 (20) information in writing and through an internet website that
17 reasonably permits an insured or prospective insured to estimate the
18 anticipated out-of-pocket cost for out-of-network health care services
19 in a geographical area or zip code based upon the difference between
20 what the insurer will reimburse for out-of-network health care services
21 and the usual and customary cost for out-of-network health care
22 services.
23 § 2. Paragraphs 11 and 12 of subsection (b) of section 3217-a of the
24 insurance law, as added by chapter 705 of the laws of 1996, are amended
25 and two new paragraphs 13 and 14 are added to read as follows:
26 (11) where applicable, provide the written application procedures and
27 minimum qualification requirements for health care providers to be
28 considered by the insurer for participation in the insurer's network for
29 a managed care product; [and]
30 (12) disclose such other information as required by the superinten-
31 dent, provided that such requirements are promulgated pursuant to the
32 state administrative procedure act[.];
33 (13) disclose whether a health care provider scheduled to provide a
34 health care service is an in-network provider; and
35 (14) with respect to out-of-network coverage, disclose the approximate
36 dollar amount that the insurer will pay for a specific out-of-network
37 health care service. The insurer shall also inform the insured through
38 such disclosure that such approximation is not binding on the insurer
39 and that the approximate dollar amount that the insurer will pay for a
40 specific out-of-network health care service may change.
41 § 3. Section 3217-a of the insurance law is amended by adding a new
42 subsection (f) to read as follows:
43 (f) For purposes of this section, "usual and customary cost" shall
44 mean the eightieth percentile of all charges for the particular health
45 care service performed by a provider in the same or similar specialty
46 and provided in the same geographical area as reported in a benchmarking
47 database maintained by a nonprofit organization specified by the super-
48 intendent. The nonprofit organization shall not be affiliated with an
49 insurer, a corporation subject to article forty-three of this chapter, a
50 municipal cooperative health benefit plan certified pursuant to article
51 forty-seven of this chapter, or a health maintenance organization certi-
52 fied pursuant to article forty-four of the public health law.
53 § 4. Section 3217-d of the insurance law is amended by adding a new
54 subsection (d) to read as follows:
55 (d) An insurer that issues a comprehensive policy that utilizes a
56 network of providers and is not a managed care health insurance contract

1 as defined in subsection (c) of section four thousand eight hundred one
2 of this chapter, shall provide access to out-of-network services
3 consistent with the requirements of subsection (a) of section four thou-
4 sand eight hundred four of this chapter, subsections (g-6) and (g-7) of
5 section four thousand nine hundred of this chapter, subsections (a-1)
6 and (a-2) of section four thousand nine hundred four of this chapter,
7 paragraphs three and four of subsection (b) of section four thousand
8 nine hundred ten of this chapter, and subparagraphs (C) and (D) of para-
9 graph four of subsection (b) of section four thousand nine hundred four-
10 teen of this chapter.
11 § 5. Section 3224-a of the insurance law is amended by adding a new
12 subsection (j) to read as follows:
13 (j) An insurer or an organization or corporation licensed or certified
14 pursuant to article forty-three or forty-seven of this chapter or arti-
15 cle forty-four of the public health law or a student health plan estab-
16 lished or maintained pursuant to section one thousand one hundred twen-
17 ty-four of this chapter shall accept claims submitted by a policyholder
18 or covered person, in writing, including through the internet, by elec-
19 tronic mail or by facsimile.
20 § 6. The insurance law is amended by adding a new section 3241 to read
21 as follows:
22 § 3241. Network coverage. (a) An insurer, a corporation organized
23 pursuant to article forty-three of this chapter, a municipal cooperative
24 health benefit plan certified pursuant to article forty-seven of this
25 chapter, or a student health plan established or maintained pursuant to
26 section one thousand one hundred twenty-four of this chapter, that
27 issues a health insurance policy or contract with a network of health
28 care providers shall ensure that the network is adequate to meet the
29 health needs of insureds and provide an appropriate choice of providers
30 sufficient to render the services covered under the policy or contract.
31 The superintendent shall review the network of health care providers for
32 adequacy at the time of the superintendent's initial approval of a
33 health insurance policy or contract; at least every three years there-
34 after; and upon application for expansion of any service area associated
35 with the policy or contract in conformance with the standards set forth
36 in subdivision five of section four thousand four hundred three of the
37 public health law. To the extent that the network has been determined
38 by the commissioner of health to meet the standards set forth in subdi-
39 vision five of section four thousand four hundred three of the public
40 health law, such network shall be deemed adequate by the superintendent.
41 (b)(1)(A) An insurer, a corporation organized pursuant to article
42 forty-three of this chapter, a municipal cooperative health benefit plan
43 certified pursuant to article forty-seven of this chapter, a health
44 maintenance organization certified pursuant to article forty-four of the
45 public health law or a student health plan established or maintained
46 pursuant to section one thousand one hundred twenty-four of this chap-
47 ter, that issues a comprehensive group or group remittance health insur-
48 ance policy or contract that covers out-of-network health care services
49 shall make available and, if requested by the policyholder or contract-
50 holder, provide at least one option for coverage for at least eighty
51 percent of the usual and customary cost of each out-of-network health
52 care service after imposition of a deductible or any permissible benefit
53 maximum.
54 (B) If there is no coverage available pursuant to subparagraph (A) of
55 this paragraph in a rating region, then the superintendent may require
56 an insurer, a corporation organized pursuant to article forty-three of

1 this chapter, a municipal cooperative health benefit plan certified
2 pursuant to article forty-seven of this chapter, a health maintenance
3 organization certified pursuant to article forty-four of the public
4 health law, or a student health plan established or maintained pursuant
5 to section one thousand one hundred twenty-four of this chapter issuing
6 a comprehensive group or group remittance health insurance policy or
7 contract in the rating region, to make available and, if requested by
8 the policyholder or contractholder, provide at least one option for
9 coverage of eighty percent of the usual and customary cost of each out-
10 of-network health care service after imposition of any permissible
11 deductible or benefit maximum. The superintendent may, after giving
12 consideration to the public interest, permit an insurer, a corporation,
13 or a health maintenance organization to satisfy the requirements of this
14 paragraph on behalf of another insurer, corporation, or health mainte-
15 nance organization within the same holding company system, as defined in
16 article fifteen of this chapter, including a health maintenance organ-
17 ization operated as a line of business of a health service corporation
18 organized pursuant to article forty-three of this chapter. The super-
19 intendent may, upon written request, waive the requirement for coverage
20 of out-of-network health care services to be made available pursuant to
21 this subparagraph if the superintendent determines that it would pose an
22 undue hardship upon an insurer, a corporation organized pursuant to
23 article forty-three of this chapter, a municipal cooperative health
24 benefit plan certified pursuant to article forty-seven of this chapter,
25 a health maintenance organization certified pursuant to article forty-
26 four of the public health law, or a student health plan established or
27 maintained pursuant to section one thousand one hundred twenty-four of
28 this chapter.
29 (2) For the purposes of this subsection, "usual and customary cost"
30 shall mean the eightieth percentile of all charges for the particular
31 health care service performed by a provider in the same or similar
32 specialty and provided in the same geographical area as reported in a
33 benchmarking database maintained by a nonprofit organization specified
34 by the superintendent. The nonprofit organization shall not be affil-
35 iated with an insurer, a corporation subject to article forty-three of
36 this chapter, a municipal cooperative health benefit plan certified
37 pursuant to article forty-seven of this chapter, a health maintenance
38 organization certified pursuant to article forty-four of the public
39 health law or a student health plan established or maintained pursuant
40 to section one thousand one hundred twenty-four of this chapter.
41 (3) This subsection shall not apply to emergency care services in
42 hospital facilities or prehospital emergency medical services as defined
43 in clause (i) of subparagraph (E) of paragraph twenty-four of subsection
44 (i) of section three thousand two hundred sixteen of this article, or
45 clause (i) of subparagraph (E) of paragraph fifteen of subsection (l) of
46 section three thousand two hundred twenty-one of this chapter, or
47 subparagraph (A) of paragraph five of subsection (aa) of section four
48 thousand three hundred three of this chapter.
49 (4) Nothing in this subsection shall limit the superintendent's
50 authority pursuant to section three thousand two hundred seventeen of
51 this article to establish minimum standards for the form, content and
52 sale of accident and health insurance policies and subscriber contracts,
53 to require additional coverage options for out-of-network services, or
54 to provide for standardization and simplification of coverage.
55 (c) When an insured or enrollee under a contract or policy that
56 provides coverage for emergency services receives the services from a

1 health care provider that does not participate in the provider network
2 of an insurer, a corporation organized pursuant to article forty-three
3 of this chapter, a municipal cooperative health benefit plan certified
4 pursuant to article forty-seven of this chapter, a health maintenance
5 organization certified pursuant to article forty-four of the public
6 health law, or a student health plan established or maintained pursuant
7 to section one thousand one hundred twenty-four of this chapter ("health
8 care plan"), the health care plan shall ensure that the insured or
9 enrollee shall incur no greater out-of-pocket costs for the emergency
10 services than the insured or enrollee would have incurred with a health
11 care provider that participates in the health care plan's provider
12 network. For the purpose of this section, "emergency services" shall
13 have the meaning set forth in subparagraph (D) of paragraph nine of
14 subsection (i) of section three thousand two hundred sixteen of this
15 article, subparagraph (D) of paragraph four of subsection (k) of section
16 three thousand two hundred twenty-one of this article, and subparagraph
17 (D) of paragraph two of subsection (a) of section four thousand three
18 hundred three of this chapter.
19 § 7. Section 4306-c of the insurance law is amended by adding a new
20 subsection (d) to read as follows:
21 (d) A corporation, including a municipal cooperative health benefit
22 plan certified pursuant to article forty-seven of this chapter and a
23 student health plan established or maintained pursuant to section one
24 thousand one hundred twenty-four of this chapter, that issues a compre-
25 hensive policy that utilizes a network of providers and is not a managed
26 care health insurance contract as defined in subsection (c) of section
27 four thousand eight hundred one of this chapter, shall provide access to
28 out-of-network services consistent with the requirements of subsection
29 (a) of section four thousand eight hundred four of this chapter,
30 subsections (g-6) and (g-7) of section four thousand nine hundred of
31 this chapter, subsections (a-1) and (a-2) of section four thousand nine
32 hundred four of this chapter, paragraphs three and four of subsection
33 (b) of section four thousand nine hundred ten of this chapter, and
34 subparagraphs (C) and (D) of paragraph four of subsection (b) of section
35 four thousand nine hundred fourteen of this chapter.
36 § 8. Paragraphs 11, 12, 13, 14, 16-a, 17, and 18 of subsection (a) of
37 section 4324 of the insurance law, paragraphs 11, 12, 13, 14, 17 and 18
38 as added by chapter 705 of the laws of 1996, paragraph 16-a as added by
39 chapter 554 of the laws of 2002, are amended and three new paragraphs
40 19, 20 and 21 are added to read as follows:
41 (11) where applicable, notice that a subscriber enrolled in a managed
42 care product or in a comprehensive contract that utilizes a network of
43 providers offered by the corporation may obtain a referral [~~to~~] or
44 preauthorization for a health care provider outside of the corporation's
45 network or panel when the corporation does not have a health care
46 provider [~~with~~] who is geographically accessible to the insured and who
47 has the appropriate training and experience in the network or panel to
48 meet the particular health care needs of the subscriber and the proce-
49 dure by which the subscriber can obtain such referral or preauthori-
50 zation;
51 (12) where applicable, notice that a subscriber enrolled in a managed
52 care product or a comprehensive contract that utilizes a network of
53 providers offered by the corporation with a condition which requires
54 ongoing care from a specialist may request a standing referral to such a
55 specialist and the procedure for requesting and obtaining such a stand-
56 ing referral;

1 (13) where applicable, notice that a subscriber enrolled in a managed
2 care product **or a comprehensive contract that utilizes a network of**
3 **providers** offered by the corporation with (i) a life-threatening condi-
4 tion or disease, or (ii) a degenerative and disabling condition or
5 disease, either of which requires specialized medical care over a
6 prolonged period of time may request a specialist responsible for
7 providing or coordinating the subscriber's medical care and the proce-
8 dure for requesting and obtaining such a specialist;
9 (14) where applicable, notice that a subscriber enrolled in a managed
10 care product **or a comprehensive contract that utilizes a network of**
11 **providers** offered by the corporation with [~~(i)~~] **(A)** a life-threatening
12 condition or disease, or [~~(ii)~~] **(B)** a degenerative and disabling condi-
13 tion or disease, either of which requires specialized medical care over
14 a prolonged period of time may request access to a specialty care center
15 and the procedure by which such access may be obtained;
16 (16-a) where applicable, notice that an enrollee shall have direct
17 access to primary and preventive obstetric and gynecologic services**,**
18 **including annual examinations, care resulting from such annual examina-**
19 **tions, and treatment of acute gynecologic conditions,** from a qualified
20 provider of such services of her choice from within the plan [~~for no~~
21 ~~fewer than two examinations annually for such services~~] or [~~to~~] **for** any
22 care related to **a** pregnancy [~~and that additionally, the enrollee shall~~
23 ~~have direct access to primary and preventive obstetric and gynecologic~~
24 ~~services required as a result of such annual examinations or as a result~~
25 ~~of an acute gynecologic condition~~];
26 (17) where applicable, a listing by specialty, which may be in a sepa-
27 rate document that is updated annually, of the name, address, and tele-
28 phone number of all participating providers, including facilities, and
29 in addition, in the case of physicians, board certification[~~, and~~]**,**
30 **languages spoken and any affiliations with participating hospitals. The**
31 **listing shall also be posted on the corporation's website and the corpo-**
32 **ration shall update the website within fifteen days of the addition or**
33 **termination of a provider from the corporation's network or a change in**
34 **a physician's hospital affiliation;**
35 (18) a description of the mechanisms by which subscribers may partic-
36 ipate in the development of the policies of the corporation[~~.~~]**;**
37 **(19) the method by which a subscriber may submit a claim for health**
38 **care services;**
39 **(20) with respect to out-of-network coverage:**
40 **(A) a clear description of the methodology used by the corporation to**
41 **determine reimbursement for out-of-network health care services;**
42 **(B) a description of the amount that the corporation will reimburse**
43 **under the methodology for out-of-network health care services set forth**
44 **as a percentage of the usual and customary cost for out-of-network**
45 **health care services; and**
46 **(C) examples of anticipated out-of-pocket costs for frequently billed**
47 **out-of-network health care services; and**
48 **(21) information in writing and through an internet website that**
49 **reasonably permits a subscriber or prospective subscriber to estimate**
50 **the anticipated out-of-pocket cost for out-of-network health care**
51 **services in a geographical area or zip code based upon the difference**
52 **between what the corporation will reimburse for out-of-network health**
53 **care services and the usual and customary cost for out-of-network health**
54 **care services.**

1 § 9. Paragraphs 11 and 12 of subsection (b) of section 4324 of the
2 insurance law, as added by chapter 705 of the laws of 1996, are amended
3 and two new paragraphs 13 and 14 are added to read as follows:
4 (11) where applicable, provide the written application procedures and
5 minimum qualification requirements for health care providers to be
6 considered by the corporation for participation in the corporation's
7 network for a managed care product; [and]
8 (12) disclose such other information as required by the superinten-
9 dent, provided that such requirements are promulgated pursuant to the
10 state administrative procedure act[.];
11 (13) disclose whether a health care provider scheduled to provide a
12 health care service is an in-network provider; and
13 (14) with respect to out-of-network coverage, disclose the approximate
14 dollar amount that the corporation will pay for a specific out-of-net-
15 work health care service. The corporation shall also inform the insured
16 through such disclosure that such approximation is not binding on the
17 corporation and that the approximate dollar amount that the corporation
18 will pay for a specific out-of-network health care service may change.
19 § 10. Section 4324 of the insurance law is amended by adding a new
20 subsection (f) to read as follows:
21 (f) For purposes of this section, "usual and customary cost" shall
22 mean the eightieth percentile of all charges for the particular health
23 care service performed by a provider in the same or similar specialty
24 and provided in the same geographical area as reported in a benchmarking
25 database maintained by a nonprofit organization specified by the super-
26 intendent. The nonprofit organization shall not be affiliated with an
27 insurer, a corporation subject to this article, a municipal cooperative
28 health benefit plan certified pursuant to article forty-seven of this
29 chapter, or a health maintenance organization certified pursuant to
30 article forty-four of the public health law.
31 § 11. Section 4900 of the insurance law is amended by adding a new
32 subsection (g-6-a) to read as follows:
33 (g-6-a) "Out-of-network referral denial" means a denial under a
34 managed care product as defined in subsection (c) of section four thou-
35 sand eight hundred one of this chapter of a request for an authorization
36 or referral to an out-of-network provider on the basis that the health
37 care plan has a health care provider in the in-network benefits portion
38 of its network with appropriate training and experience to meet the
39 particular health care needs of an insured, and who is able to provide
40 the requested health service. The notice of an out-of-network referral
41 denial provided to an insured shall include information explaining what
42 information the insured must submit in order to appeal the out-of-net-
43 work referral denial pursuant to subsection (a-2) of section four thou-
44 sand nine hundred four of this article. An out-of-network referral
45 denial under this subsection does not constitute an adverse determi-
46 nation as defined in this article. An out-of-network referral denial
47 shall not be construed to include an out-of-network denial as defined in
48 subsection (g-6) of this section.
49 § 12. Subsection (b) of section 4903 of the insurance law, as amended
50 by chapter 514 of the laws of 2013, is amended to read as follows:
51 (b) A utilization review agent shall make a utilization review deter-
52 mination involving health care services which require pre-authorization
53 and provide notice of a determination to the insured or insured's desig-
54 nee and the insured's health care provider by telephone and in writing
55 within three business days of receipt of the necessary information. To
56 the extent practicable, such written notification to the enrollee's

health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. **The notification shall identify: (1) whether the services are considered in-network or out-of-network; (2) whether the insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible; (3) as applicable, the dollar amount the health care plan will pay if the service is out-of-network; and (4) as applicable, information explaining how an insured may determine 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 care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.**

§ 13. Section 4904 of the insurance law is amended by adding a new subsection (a-2) to read as follows:

(a-2) An insured or the insured's designee may appeal an out-of-network referral denial by a health care plan by submitting a written statement from the insured's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, provided that: (1) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the insured for the health service; and (2) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the requested health service.

§ 14. Subsection (b) of section 4910 of the insurance law is amended by adding a new paragraph 4 to read as follows:

(4)(A) The insured has had an out-of-network referral denied on the grounds that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

(B) The insured's attending physician, who shall be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the insured for the health service sought, certifies that the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of an insured, and recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service.

§ 15. Paragraph 4 of subsection (b) of section 4914 of the insurance law is amended by adding a new subparagraph (D) to read as follows:

(D) For external appeals requested pursuant to paragraph four of subsection (b) of section four thousand nine hundred ten of this title relating to an out-of-network referral denial, the external appeal agent shall review the utilization review agent's final adverse determination and, in accordance with the provisions of this title, shall make a determination as to whether the out-of-network referral shall be covered by the health plan; provided that such determination shall:

(i) be conducted only by one or a greater odd number of clinical peer reviewers;

(ii) be accompanied by a written statement:

1 (I) that the out-of-network referral shall be covered by the health
2 care plan either when the reviewer or a majority of the panel of review-
3 ers determines, upon review of the training and experience of the
4 in-network health care provider or providers proposed by the plan, the
5 training and experience of the requested out-of-network provider, the
6 clinical standards of the plan, the information provided concerning the
7 insured, the attending physician's recommendation, the insured's medical
8 record, and any other pertinent information, that the health plan does
9 not have a provider with the appropriate training and experience to meet
10 the particular health care needs of an insured who is able to provide
11 the requested health service, and that the out-of-network provider has
12 the appropriate training and experience to meet the particular health
13 care needs of an insured, is able to provide the requested health
14 service, and is likely to produce a more clinically beneficial outcome;
15 or
16 (II) upholding the health plan's denial of coverage;
17 (iii) be subject to the terms and conditions generally applicable to
18 benefits under the evidence of coverage under the health care plan;
19 (iv) be binding on the plan and the insured; and
20 (v) be admissible in any court proceeding.
21 § 16. The public health law is amended by adding a new section 23 to
22 read as follows:
23 § 23. Claim forms. A non-participating physician shall include a
24 claim form for a third-party payor with a patient bill for health care
25 services, other than a bill for the patient's co-payment, coinsurance or
26 deductible.
27 § 17. The public health law is amended by adding a new section 24 to
28 read as follows:
29 § 24. Disclosure. 1. A health care professional, or a group practice
30 of health care professionals, a diagnostic and treatment center or a
31 health center defined under 42 U.S.C. § 254b on behalf of health care
32 professionals rendering services at the group practice, diagnostic and
33 treatment center or health center, shall disclose to patients or
34 prospective patients in writing or through an internet website the
35 health care plans in which the health care professional, group practice,
36 diagnostic and treatment center or health center, is a participating
37 provider and the hospitals with which the health care professional is
38 affiliated prior to the provision of non-emergency services and verbally
39 at the time an appointment is scheduled.
40 2. If a health care professional, or a group practice of health care
41 professionals, a diagnostic and treatment center or a health center
42 defined under 42 U.S.C. § 254b on behalf of health care professionals
43 rendering services at the group practice, diagnostic and treatment
44 center or health center, does not participate in the network of a
45 patient's or prospective patient's health care plan, the health care
46 professional, group practice, diagnostic and treatment center or health
47 center, shall: (a) prior to the provision of non-emergency services,
48 inform a patient or prospective patient that the amount or estimated
49 amount the health care professional will bill the patient for health
50 care services is available upon request; and (b) upon receipt of a
51 request from a patient or prospective patient, disclose to the patient
52 or prospective patient in writing the amount or estimated amount or,
53 with respect to a health center, a schedule of fees provided under 42
54 U.S.C. § 254b(k)(3)(G)(i), that the health care professional, group
55 practice, diagnostic and treatment center or health center, will bill
56 the patient or prospective patient for health care services provided or

1 anticipated to be provided to the patient or prospective patient absent
2 unforeseen medical circumstances that may arise when the health care
3 services are provided.
4 3. A health care professional who is a physician shall provide a
5 patient or prospective patient with the name, practice name, mailing
6 address, and telephone number of any health care provider scheduled to
7 perform anesthesiology, laboratory, pathology, radiology or assistant
8 surgeon services in connection with care to be provided in the physi-
9 cian's office for the patient or coordinated or referred by the physi-
10 cian for the patient at the time of referral to or coordination of
11 services with such provider.
12 4. A health care professional who is a physician shall, for a
13 patient's scheduled hospital admission or scheduled outpatient hospital
14 services, provide a patient and the hospital with the name, practice
15 name, mailing address and telephone number of any other physician whose
16 services will be arranged by the physician and are scheduled at the time
17 of the pre-admission testing, registration or admission at the time
18 non-emergency services are scheduled; and information as to how to
19 determine the healthcare plans in which the physician participates.
20 5. A hospital shall establish, update and make public through posting
21 on the hospital's website, to the extent required by federal guidelines,
22 a list of the hospital's standard charges for items and services
23 provided by the hospital, including for diagnosis-related groups estab-
24 lished under section 1886(d)(4) of the federal social security act.
25 6. A hospital shall post on the hospital's website: (a) the health
26 care plans in which the hospital is a participating provider; (b) a
27 statement that (i) physician services provided in the hospital are not
28 included in the hospital's charges; (ii) physicians who provide services
29 in the hospital may or may not participate with the same health care
30 plans as the hospital, and; (iii) the prospective patient should check
31 with the physician arranging for the hospital services to determine the
32 health care plans in which the physician participates; (c) as applica-
33 ble, the name, mailing address and telephone number of the physician
34 groups that the hospital has contracted with to provide services includ-
35 ing anesthesiology, pathology or radiology, and instructions how to
36 contact these groups to determine the health care plan participation of
37 the physicians in these groups; and (d) as applicable, the name, mailing
38 address, and telephone number of physicians employed by the hospital and
39 whose services may be provided at the hospital, and the health care
40 plans in which they participate.
41 7. In registration or admission materials provided in advance of non-
42 emergency hospital services, a hospital shall: (a) advise the patient or
43 prospective patient to check with the physician arranging the hospital
44 services to determine: (i) the name, practice name, mailing address and
45 telephone number of any other physician whose services will be arranged
46 by the physician; and (ii) whether the services of physicians who are
47 employed or contracted by the hospital to provide services including
48 anesthesiology, pathology and/or radiology are reasonably anticipated to
49 be provided to the patient; and (b) provide patients or prospective
50 patients with information as to how to timely determine the health care
51 plans participated in by physicians who are reasonably anticipated to
52 provide services to the patient at the hospital, as determined by the
53 physician arranging the patient's hospital services, and who are employ-
54 ees of the hospital or contracted by the hospital to provide services
55 including anesthesiology, radiology and/or pathology.
56 8. For purposes of this section:

(a) "Health care plan" means a health insurer including an insurer licensed to write accident and health insurance subject to article thirty-two of the insurance law; a corporation organized pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of this chapter; a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law or a self-funded employee welfare benefit plan.

(b) "Health care professional" means an appropriately licensed, registered or certified health care professional pursuant to title eight of the education law.

(c) "Hospital" means a general hospital as defined in subdivision ten of section two thousand eight hundred one of this chapter.

§ 18. Paragraphs (k), (p-1), (q) and (r) of subdivision 1 of section 4408 of the public health law, paragraphs (k), (q) and (r) as added by chapter 705 of the laws of 1996, and paragraph (p-1) as added by chapter 554 of the laws of 2002, are amended and three new paragraphs (s), (t) and (u) are added to read as follows:

(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 [~~with~~] 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;

(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 [~~for no fewer than two examinations annually for such services~~] or [~~to~~] for any care related to a pregnancy [~~and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition~~];

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

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, 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

1 forth as a percentage of the usual and customary cost for out-of-network
2 health care services;
3 (iii) examples of anticipated out-of-pocket costs for frequently
4 billed out-of-network health care services; and
5 (u) information in writing and through an internet website that
6 reasonably permits an enrollee or prospective enrollee to estimate the
7 anticipated out-of-pocket cost for out-of-network health care services
8 in a geographical area or zip code based upon the difference between
9 what the health maintenance organization will reimburse for out-of-net-
10 work health care services and the usual and customary cost for out-of-
11 network health care services.
12 § 19. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the
13 public health law, as added by chapter 705 of the laws of 1996, are
14 amended and two new paragraphs (m) and (n) are added to read as follows:
15 (k) provide the written application procedures and minimum qualifica-
16 tion requirements for health care providers to be considered by the
17 health maintenance organization; [~~and~~]
18 (l) disclose other information as required by the commissioner,
19 provided that such requirements are promulgated pursuant to the state
20 administrative procedure act[~~.~~];
21 (m) disclose whether a health care provider scheduled to provide a
22 health care service is an in-network provider; and
23 (n) with respect to out-of-network coverage, disclose the approximate
24 dollar amount that the health maintenance organization will pay for a
25 specific out-of-network health care service. The health maintenance
26 organization shall also inform an enrollee through such disclosure that
27 such approximation is not binding on the health maintenance organization
28 and that the approximate dollar amount that the health maintenance
29 organization will pay for a specific out-of-network health care service
30 may change.
31 § 20. Section 4408 of the public health law is amended by adding a new
32 subdivision 7 to read as follows:
33 7. For purposes of this section, "usual and customary cost" shall
34 mean the eightieth percentile of all charges for the particular health
35 care service performed by a provider in the same or similar specialty
36 and provided in the same geographical area as reported in a benchmarking
37 database maintained by a nonprofit organization specified by the super-
38 intendent of financial services. The nonprofit organization shall not be
39 affiliated with an insurer, a corporation subject to article forty-three
40 of the insurance law, a municipal cooperative health benefit plan certi-
41 fied pursuant to article forty-seven of the insurance law, or a health
42 maintenance organization certified pursuant to this article.
43 § 21. Section 4900 of the public health law is amended by adding a new
44 subdivision 7-f-1 to read as follows:
45 7-f-1. "Out-of-network referral denial" means a denial of a request
46 for an authorization or referral to an out-of-network provider on the
47 basis that the health care plan has a health care provider in the
48 in-network benefits portion of its network with appropriate training and
49 experience to meet the particular health care needs of an enrollee, and
50 who is able to provide the requested health service. The notice of an
51 out-of-network referral denial provided to an enrollee shall include
52 information explaining what information the enrollee must submit in
53 order to appeal the out-of-network referral denial pursuant to subdivi-
54 sion one-b of section four thousand nine hundred four of this article.
55 An out-of-network referral denial under this subdivision does not
56 constitute an adverse determination as defined in this article. An out-

1 of-network referral denial shall not be construed to include an out-of-
2 network denial as defined in subdivision seven-f of this section.
3 § 22. Subdivision 2 of section 4903 of the public health law, as
4 amended by chapter 514 of the laws of 2013, is amended to read as
5 follows:
6 2. A utilization review agent shall make a utilization review determi-
7 nation involving health care services which require pre-authorization
8 and provide notice of a determination to the enrollee or enrollee's
9 designee and the enrollee's health care provider by telephone and in
10 writing within three business days of receipt of the necessary informa-
11 tion. To the extent practicable, such written notification to the
12 enrollee's health care provider shall be transmitted electronically, in
13 a manner and in a form agreed upon by the parties. The notification
14 shall identify; (a) whether the services are considered in-network or
15 out-of-network; (b) and whether the enrollee will be held harmless for
16 the services and not be responsible for any payment, other than any
17 applicable co-payment or co-insurance; (c) as applicable, the dollar
18 amount the health care plan will pay if the service is out-of-network;
19 and (d) as applicable, information explaining how an enrollee may deter-
20 mine the anticipated out-of-pocket cost for out-of-network health care
21 services in a geographical area or zip code based upon the difference
22 between what the health care plan will reimburse for out-of-network
23 health care services and the usual and customary cost for out-of-network
24 health care services.
25 § 23. Section 4904 of the public health law is amended by adding a new
26 subdivision 1-b to read as follows:
27 1-b. An enrollee or the enrollee's designee may appeal a denial of an
28 out-of-network referral by a health care plan by submitting a written
29 statement from the enrollee's attending physician, who must be a
30 licensed, board certified or board eligible physician qualified to prac-
31 tice in the specialty area of practice appropriate to treat the enrollee
32 for the health service sought, provided that: (a) the in-network health
33 care provider or providers recommended by the health care plan do not
34 have the appropriate training and experience to meet the particular
35 health care needs of the enrollee for the health service; and (b) recom-
36 mends an out-of-network provider with the appropriate training and expe-
37 rience to meet the particular health care needs of the enrollee, and who
38 is able to provide the requested health service.
39 § 24. Subdivision 2 of section 4910 of the public health law is
40 amended by adding a new paragraph (d) to read as follows:
41 (d)(i) The enrollee has had an out-of-network referral denied on the
42 grounds that the health care plan has a health care provider in the
43 in-network benefits portion of its network with appropriate training and
44 experience to meet the particular health care needs of an enrollee, and
45 who is able to provide the requested health service.
46 (ii) The enrollee's attending physician, who shall be a licensed,
47 board certified or board eligible physician qualified to practice in the
48 specialty area of practice appropriate to treat the enrollee for the
49 health service sought, certifies that the in-network health care provid-
50 er or providers recommended by the health care plan do not have the
51 appropriate training and experience to meet the particular health care
52 needs of an enrollee, and recommends an out-of-network provider with the
53 appropriate training and experience to meet the particular health care
54 needs of an enrollee, and who is able to provide the requested health
55 service.

1 § 25. Paragraph (d) of subdivision 2 of section 4914 of the public
2 health law is amended by adding a new subparagraph (D) to read as
3 follows:
4 (D) For external appeals requested pursuant to paragraph (d) of subdi-
5 vision two of section four thousand nine hundred ten of this title
6 relating to an out-of-network referral denial, the external appeal agent
7 shall review the utilization review agent's final adverse determination
8 and, in accordance with the provisions of this title, shall make a
9 determination as to whether the out-of-network referral shall be covered
10 by the health plan; provided that such determination shall:
11 (i) be conducted only by one or a greater odd number of clinical peer
12 reviewers;
13 (ii) be accompanied by a written statement:
14 (1) that the out-of-network referral shall be covered by the health
15 care plan either when the reviewer or a majority of the panel of review-
16 ers determines, upon review of the training and experience of the
17 in-network health care provider or providers proposed by the plan, the
18 training and experience of the requested out-of-network provider, the
19 clinical standards of the plan, the information provided concerning the
20 enrollee, the attending physician's recommendation, the enrollee's
21 medical record, and any other pertinent information, that the health
22 plan does not have a provider with the appropriate training and experi-
23 ence to meet the particular health care needs of an enrollee who is able
24 to provide the requested health service, and that the out-of-network
25 provider has the appropriate training and experience to meet the partic-
26 ular health care needs of an enrollee, is able to provide the requested
27 health service, and is likely to produce a more clinically beneficial
28 outcome; or
29 (2) upholding the health plan's denial of coverage;
30 (iii) be subject to the terms and conditions generally applicable to
31 benefits under the evidence of coverage under the health care plan;
32 (iv) be binding on the plan and the enrollee; and
33 (v) be admissible in any court proceeding.
34 § 26. The financial services law is amended by adding a new article 6
35 to read as follows:
36 ARTICLE 6
37 EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS
38 Section 601. Dispute resolution process established.
39 602. Applicability.
40 603. Definitions.
41 604. Criteria for determining a reasonable fee.
42 605. Dispute resolution for emergency services.
43 606. Hold harmless and assignment of benefits for surprise bills
44 for insureds.
45 607. Dispute resolution for surprise bills.
46 608. Payment for independent dispute resolution entity.
47 § 601. Dispute resolution process established. The superintendent
48 shall establish a dispute resolution process by which a dispute for a
49 bill for emergency services or a surprise bill may be resolved. The
50 superintendent shall have the power to grant and revoke certifications
51 of independent dispute resolution entities to conduct the dispute resol-
52 ution process. The superintendent shall promulgate regulations estab-
53 lishing standards for the dispute resolution process, including a proc-
54 ess for certifying and selecting independent dispute resolution
55 entities. An independent dispute resolution entity shall use licensed
56 physicians in active practice in the same or similar specialty as the

1 physician providing the service that is subject to the dispute resol-
2 ution process of this article. To the extent practicable, the physician
3 shall be licensed in this state.
4 § 602. Applicability. (a) This article shall not apply to health care
5 services, including emergency services, where physician fees are subject
6 to schedules or other monetary limitations under any other law, includ-
7 ing the workers' compensation law and article fifty-one of the insurance
8 law, and shall not preempt any such law.
9 (b)(1) With regard to emergency services billed under American medical
10 association current procedural terminology (CPT) codes 99281 through
11 99285, 99288, 99291 through 99292, 99217 through 99220, 99224 through
12 99226, and 99234 through 99236, the dispute resolution process estab-
13 lished in this article shall not apply when:
14 (A) the amount billed for any such CPT code meets the requirements set
15 forth in paragraph three of this subsection, after any applicable co-in-
16 surance, co-payment and deductible; and
17 (B) the amount billed for any such CPT code does not exceed one
18 hundred twenty percent of the usual and customary cost for such CPT
19 code.
20 (2) The health care plan shall ensure that an insured shall not incur
21 any greater out-of-pocket costs for emergency services billed under a
22 CPT code as set forth in this subsection than the insured would have
23 incurred if such emergency services were provided by a participating
24 physician.
25 (3) Beginning January first, two thousand fifteen and each January
26 first thereafter, the superintendent shall publish on a website main-
27 tained by the department of financial services, and provide in writing
28 to each health care plan, a dollar amount for which bills for the proce-
29 dure codes identified in this subsection shall be exempt from the
30 dispute resolution process established in this article. Such amount
31 shall equal the amount from the prior year, beginning with six hundred
32 dollars in two thousand fourteen, adjusted by the average of the annual
33 average inflation rates for the medical care commodities and medical
34 care services components of the consumer price index. In no event shall
35 an amount exceeding one thousand two hundred dollars for a specific CPT
36 code billed be exempt from the dispute resolution process established in
37 this article.
38 § 603. Definitions. For the purposes of this article:
39 (a) "Emergency condition" means a medical or behavioral condition that
40 manifests itself by acute symptoms of sufficient severity, including
41 severe pain, such that a prudent layperson, possessing an average know-
42 ledge of medicine and health, could reasonably expect the absence of
43 immediate medical attention to result in : (1) placing the health of the
44 person afflicted with such condition in serious jeopardy, or in the case
45 of a behavioral condition placing the health of such person or others in
46 serious jeopardy; (2) serious impairment to such person's bodily func-
47 tions; (3) serious dysfunction of any bodily organ or part of such
48 person; (4) serious disfigurement of such person; or (5) a condition
49 described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the
50 social security act 42 U.S.C. § 1395dd.
51 (b) "Emergency services" means, with respect to an emergency condi-
52 tion: (1) a medical screening examination as required under section 1867
53 of the social security act, 42 U.S.C. § 1395dd, which is within the
54 capability of the emergency department of a hospital, including ancil-
55 lary services routinely available to the emergency department to evalu-
56 ate such emergency medical condition; and (2) within the capabilities of

1 the staff and facilities available at the hospital, such further medical
2 examination and treatment as are required under section 1867 of the
3 social security act, 42 U.S.C. § 1395dd, to stabilize the patient.
4 (c) "Health care plan" means an insurer licensed to write accident and
5 health insurance pursuant to article thirty-two of the insurance law; a
6 corporation organized pursuant to article forty-three of the insurance
7 law; a municipal cooperative health benefit plan certified pursuant to
8 article forty-seven of the insurance law; a health maintenance organiza-
9 tion certified pursuant to article forty-four of the public health law;
10 or a student health plan established or maintained pursuant to section
11 one thousand one hundred twenty-four of the insurance law.
12 (d) "Insured" means a patient covered under a health care plan's poli-
13 cy or contract.
14 (e) "Non-participating" means not having a contract with a health care
15 plan to provide health care services to an insured.
16 (f) "Participating" means having a contract with a health care plan to
17 provide health care services to an insured.
18 (g) "Patient" means a person who receives health care services,
19 including emergency services, in this state.
20 (h) "Surprise bill" means a bill for health care services, other than
21 emergency services, received by:
22 (1) an insured for services rendered by a non-participating physician
23 at a participating hospital or ambulatory surgical center, where a
24 participating physician is unavailable or a non-participating physician
25 renders services without the insured's knowledge, or unforeseen medical
26 services arise at the time the health care services are rendered;
27 provided, however, that a surprise bill shall not mean a bill received
28 for health care services when a participating physician is available and
29 the insured has elected to obtain services from a non-participating
30 physician;
31 (2) an insured for services rendered by a non-participating provider,
32 where the services were referred by a participating physician to a non-
33 participating provider without explicit written consent of the insured
34 acknowledging that the participating physician is referring the insured
35 to a non-participating provider and that the referral may result in
36 costs not covered by the health care plan; or
37 (3) a patient who is not an insured for services rendered by a physi-
38 cian at a hospital or ambulatory surgical center, where the patient has
39 not timely received all of the disclosures required pursuant to section
40 twenty-four of the public health law.
41 (i) "Usual and customary cost" means the eightieth percentile of all
42 charges for the particular health care service performed by a provider
43 in the same or similar specialty and provided in the same geographical
44 area as reported in a benchmarking database maintained by a nonprofit
45 organization specified by the superintendent. The nonprofit organization
46 shall not be affiliated with an insurer, a corporation subject to arti-
47 cle forty-three of the insurance law, a municipal cooperative health
48 benefit plan certified pursuant to article forty-seven of the insurance
49 law, or a health maintenance organization certified pursuant to article
50 forty-four of the public health law.
51 § 604. Criteria for determining a reasonable fee. In determining the
52 appropriate amount to pay for a health care service, an independent
53 dispute resolution entity shall consider all relevant factors, includ-
54 ing:
55 (a) whether there is a gross disparity between the fee charged by the
56 physician for services rendered as compared to:

1 (1) fees paid to the involved physician for the same services rendered
2 by the physician to other patients in health care plans in which the
3 physician is not participating, and
4 (2) in the case of a dispute involving a health care plan, fees paid
5 by the health care plan to reimburse similarly qualified physicians for
6 the same services in the same region who are not participating with the
7 health care plan;
8 (b) the level of training, education and experience of the physician;
9 (c) the physician's usual charge for comparable services with regard
10 to patients in health care plans in which the physician is not partic-
11 ipating;
12 (d) the circumstances and complexity of the particular case, including
13 time and place of the service;
14 (e) individual patient characteristics; and
15 (f) the usual and customary cost of the service.
16 § 605. Dispute resolution for emergency services. (a) Emergency
17 services for an insured. (1) When a health care plan receives a bill for
18 emergency services from a non-participating physician, the health care
19 plan shall pay an amount that it determines is reasonable for the emer-
20 gency services rendered by the non-participating physician, in accord-
21 ance with section three thousand two hundred twenty-four-a of the insur-
22 ance law, except for the insured's co-payment, coinsurance or
23 deductible, if any, and shall ensure that the insured shall incur no
24 greater out-of-pocket costs for the emergency services than the insured
25 would have incurred with a participating physician pursuant to
26 subsection (c) of section three thousand two hundred forty-one of the
27 insurance law.
28 (2) A non-participating physician or a health care plan may submit a
29 dispute regarding a fee or payment for emergency services for review to
30 an independent dispute resolution entity.
31 (3) The independent dispute resolution entity shall make a determi-
32 nation within thirty days of receipt of the dispute for review.
33 (4) In determining a reasonable fee for the services rendered, an
34 independent dispute resolution entity shall select either the health
35 care plan's payment or the non-participating physician's fee. The inde-
36 pendent dispute resolution entity shall determine which amount to select
37 based upon the conditions and factors set forth in section six hundred
38 four of this article. If an independent dispute resolution entity
39 determines, based on the health care plan's payment and the non-partici-
40 pating physician's fee, that a settlement between the health care plan
41 and non-participating physician is reasonably likely, or that both the
42 health care plan's payment and the non-participating physician's fee
43 represent unreasonable extremes, then the independent dispute resolution
44 entity may direct both parties to attempt a good faith negotiation for
45 settlement. The health care plan and non-participating physician may be
46 granted up to ten business days for this negotiation, which shall run
47 concurrently with the thirty day period for dispute resolution.
48 (b) Emergency services for a patient that is not an insured. (1) A
49 patient that is not an insured or the patient's physician may submit a
50 dispute regarding a fee for emergency services for review to an inde-
51 pendent dispute resolution entity upon approval of the superintendent.
52 (2) An independent dispute resolution entity shall determine a reason-
53 able fee for the services based upon the same conditions and factors set
54 forth in section six hundred four of this article.

1 (3) A patient that is not an insured shall not be required to pay the
2 physician's fee in order to be eligible to submit the dispute for review
3 to an independent dispute resolution entity.
4 (c) The determination of an independent dispute resolution entity
5 shall be binding on the health care plan, physician and patient, and
6 shall be admissible in any court proceeding between the health care
7 plan, physician or patient, or in any administrative proceeding between
8 this state and the physician.
9 § 606. Hold harmless and assignment of benefits for surprise bills for
10 insureds. When an insured assigns benefits for a surprise bill in writ-
11 ing to a non-participating physician that knows the insured is insured
12 under a health care plan, the non-participating physician shall not bill
13 the insured except for any applicable copayment, coinsurance or deduct-
14 ible that would be owed if the insured utilized a participating physi-
15 cian.
16 § 607. Dispute resolution for surprise bills. (a) Surprise bill
17 received by an insured who assigns benefits. (1) If an insured assigns
18 benefits to a non-participating physician, the health care plan shall
19 pay the non-participating physician in accordance with paragraphs two
20 and three of this subsection.
21 (2) The non-participating physician may bill the health care plan for
22 the health care services rendered, and the health care plan shall pay
23 the non-participating physician the billed amount or attempt to negoti-
24 ate reimbursement with the non-participating physician.
25 (3) If the health care plan's attempts to negotiate reimbursement for
26 health care services provided by a non-participating physician does not
27 result in a resolution of the payment dispute between the non-partici-
28 pating physician and the health care plan, the health care plan shall
29 pay the non-participating physician an amount the health care plan
30 determines is reasonable for the health care services rendered, except
31 for the insured's copayment, coinsurance or deductible, in accordance
32 with section three thousand two hundred twenty-four-a of the insurance
33 law.
34 (4) Either the health care plan or the non-participating physician may
35 submit the dispute regarding the surprise bill for review to an inde-
36 pendent dispute resolution entity, provided however, the health care
37 plan may not submit the dispute unless it has complied with the require-
38 ments of paragraphs one, two and three of this subsection.
39 (5) The independent dispute resolution entity shall make a determi-
40 nation within thirty days of receipt of the dispute for review.
41 (6) When determining a reasonable fee for the services rendered, the
42 independent dispute resolution entity shall select either the health
43 care plan's payment or the non-participating physician's fee. An inde-
44 pendent dispute resolution entity shall determine which amount to select
45 based upon the conditions and factors set forth in section six hundred
46 four of this article. If an independent dispute resolution entity
47 determines, based on the health care plan's payment and the non-partici-
48 pating physician's fee, that a settlement between the health care plan
49 and non-participating physician is reasonably likely, or that both the
50 health care plan's payment and the non-participating physician's fee
51 represent unreasonable extremes, then the independent dispute resolution
52 entity may direct both parties to attempt a good faith negotiation for
53 settlement. The health care plan and non-participating physician may be
54 granted up to ten business days for this negotiation, which shall run
55 concurrently with the thirty day period for dispute resolution.

1 (b) Surprise bill received by an insured who does not assign benefits
2 or by a patient who is not an insured. (1) An insured who does not
3 assign benefits in accordance with subsection (a) of this section or a
4 patient who is not an insured and who receives a surprise bill may
5 submit a dispute regarding the surprise bill for review to an independ-
6 ent dispute resolution entity.
7 (2) The independent dispute resolution entity shall determine a
8 reasonable fee for the services rendered based upon the conditions and
9 factors set forth in section six hundred four of this article.
10 (3) A patient or insured who does not assign benefits in accordance
11 with subsection (a) of this section shall not be required to pay the
12 physician's fee to be eligible to submit the dispute for review to the
13 independent dispute entity.
14 (c) The determination of an independent dispute resolution entity
15 shall be binding on the patient, physician and health care plan, and
16 shall be admissible in any court proceeding between the patient or
17 insured, physician or health care plan, or in any administrative
18 proceeding between this state and the physician.
19 § 608. Payment for independent dispute resolution entity. (a) For
20 disputes involving an insured, when the independent dispute resolution
21 entity determines the health care plan's payment is reasonable, payment
22 for the dispute resolution process shall be the responsibility of the
23 non-participating physician. When the independent dispute resolution
24 entity determines the non-participating physician's fee is reasonable,
25 payment for the dispute resolution process shall be the responsibility
26 of the health care plan. When a good faith negotiation directed by the
27 independent dispute resolution entity pursuant to paragraph four of
28 subsection (a) of section six hundred five of this article, or paragraph
29 six of subsection (a) of section six hundred seven of this article
30 results in a settlement between the health care plan and non-participat-
31 ing physician, the health care plan and the non-participating physician
32 shall evenly divide and share the prorated cost for dispute resolution.
33 (b) For disputes involving a patient that is not an insured, when the
34 independent dispute resolution entity determines the physician's fee is
35 reasonable, payment for the dispute resolution process shall be the
36 responsibility of the patient unless payment for the dispute resolution
37 process would pose a hardship to the patient. The superintendent shall
38 promulgate a regulation to determine payment for the dispute resolution
39 process in cases of hardship. When the independent dispute resolution
40 entity determines the physician's fee is unreasonable, payment for the
41 dispute resolution process shall be the responsibility of the physician.
42 § 27. Paragraphs 5 and 6 of subsection (a) of section 2601 of the
43 insurance law, paragraph 5 as amended by chapter 547 of the laws of 1997
44 and paragraph 6 as amended by chapter 388 of the laws of 2008, are
45 amended and a new paragraph 7 is added to read as follows:
46 (5) compelling policyholders to institute suits to recover amounts due
47 under its policies by offering substantially less than the amounts ulti-
48 mately recovered in suits brought by them; [~~or~~]
49 (6) failing to promptly disclose coverage pursuant to subsection (d)
50 or subparagraph (A) of paragraph two of subsection (f) of section three
51 thousand four hundred twenty of this chapter[~~.~~]; or
52 (7) submitting reasonably rendered claims to the independent dispute
53 resolution process established under article six of the financial
54 services law.
55 § 28. 1. An out-of-network reimbursement rate workgroup shall be
56 convened and shall consist of 9 members appointed by the governor. Two

1 members shall be appointed on the recommendation of the speaker of the
2 assembly and two members shall be appointed on the recommendation of the
3 temporary president of the senate and shall consist of two physicians,
4 two representatives of health plans, and three consumers and shall be
5 co-chaired by the superintendent of the department of financial services
6 and the commissioner of the department of health. Such representatives
7 of the workgroup must represent different regions of the state. The
8 members shall receive no compensation for their services, but shall be
9 allowed their actual and necessary expenses incurred in the performance
10 of their duties.
11 2. The workgroup shall review the current out-of-network reimbursement
12 rates used by health insurers licensed under the insurance law and
13 health maintenance organizations certified under the public health law
14 and the rate methodology as required under the laws of 2014 and make
15 recommendations regarding an alternative rate methodology taking into
16 consideration the following factors:
17 a. current physician charges for out-of-network services;
18 b. trends in medical care and the actual costs of medical care;
19 c. regional differences regarding medical costs and trends;
20 d. the current methodologies and levels of reimbursement for out-of-
21 network services currently paid by health plans, including insurers,
22 HMOs, Medicare, and Medicaid;
23 e. the current in-network rates paid by health plans, including insur-
24 ers, HMOs, Medicare and Medicaid for the same service and by the same
25 provider;
26 f. the impact different rate methodologies would have on out-of-pocket
27 costs for consumers who access out-of-network services;
28 g. the impact different rate methodologies would have on premium costs
29 in different regions of the state;
30 h. reimbursement data from all health plans both public and private as
31 well as charge data from medical professionals and hospitals available
32 through the All Payer Database as developed and maintained by the
33 department of health including data provided in the annual report
34 published pursuant to section 2816 of the public health law; and
35 i. other issues deemed appropriate by either the superintendent of the
36 department of financial services or the commissioner of the department
37 of health.
38 3. The workgroup shall review out-of-network coverage in the individ-
39 ual and small group markets and make recommendations regarding the
40 availability and adequacy of the coverage, taking into consideration the
41 following factors:
42 a. the extent to which out-of-network coverage is available in each
43 rating region in this state;
44 b. the extent to which a significant level of out-of-network benefits
45 is available in every rating region in this state, including the preva-
46 lence of coverage based on the usual and customary cost as well as
47 coverage based on other set reimbursement methodologies, such as Medi-
48 care; and
49 c. other issues deemed appropriate by either the superintendent of the
50 department of financial services or the commissioner of the department
51 of health.
52 4. The workgroup shall report its findings and make recommendations
53 for legislation and regulations to the governor, the speaker of the
54 assembly, the senate majority leader, the chairs of the insurance and
55 health committees in both the assembly and the senate, and the super-