

1 (6) This section shall not apply to a general hospital, as defined in
2 subdivision ten of section two thousand eight hundred one of the public
3 health law, or a provider of health services that submitted less than
4 fifty claims in the prior calendar year for health services rendered
5 under this article.

6 § 5. This act shall take effect immediately; provided, however, that
7 sections one and two of this act shall take effect on the sixtieth day
8 after it shall have become a law.

9 PART U

10 Section 1. Paragraphs 11, 12, 13, 14, 16 and 17 of subsection (a) of
11 section 3217-a of the insurance law, as added by chapter 705 of the laws
12 of 1996, are amended and four new paragraphs 16-a, 18, 19 and 20 are
13 added to read as follows:

14 (11) where applicable, notice that an insured enrolled in a managed
15 care product or in a comprehensive policy that utilizes a network of
16 providers offered by the insurer may obtain a referral [to] or preau-
17 thorization for a health care provider outside of the insurer's network
18 or panel when the insurer does not have a health care provider [with]
19 who is geographically accessible to the insured and who has the appro-
20 priate essential level of training and experience in the network or
21 panel to meet the particular health care needs of the insured and the
22 procedure by which the insured can obtain such referral or preauthori-
23 zation;

24 (12) where applicable, notice that an insured enrolled in a managed
25 care product or a comprehensive policy that utilizes a network of
26 providers offered by the insurer with a condition which requires ongoing

1 care from a specialist may request a standing referral to such a
2 specialist and the procedure for requesting and obtaining such a stand-
3 ing referral;

4 (13) where applicable, notice that an insured enrolled in a managed
5 care product or a comprehensive policy that utilizes a network of
6 providers offered by the insurer with [(i)] (A) a life-threatening
7 condition or disease, or [(ii)] (B) a degenerative and disabling condi-
8 tion or disease, either of which requires specialized medical care over
9 a prolonged period of time may request a specialist responsible for
10 providing or coordinating the insured's medical care and the procedure
11 for requesting and obtaining such a specialist;

12 (14) where applicable, notice that an insured enrolled in a managed
13 care product or a comprehensive policy that utilizes a network of
14 providers offered by the insurer with [(i)] (A) a life-threatening
15 condition or disease, or [(ii)] (B) a degenerative and disabling condi-
16 tion or disease, either of which requires specialized medical care over
17 a prolonged period of time, may request access to a specialty care
18 center and the procedure by which such access may be obtained;

19 (16) notice of all appropriate mailing addresses and telephone numbers
20 to be utilized by insureds seeking information or authorization; [and]

21 (16-a) where applicable, notice that an insured shall have direct
22 access to primary and preventive obstetric and gynecologic services,
23 including annual examinations, care resulting from such annual examina-
24 tions, and treatment of acute gynecologic conditions, from a qualified
25 provider of such services of her choice from within the plan or for any
26 care related to a pregnancy;

27 (17) where applicable, a listing by specialty, which may be in a sepa-
28 rate document that is updated annually, of the name, address, and tele-

1 phone number of all participating providers, including facilities, and
2 in addition, in the case of physicians, board certification[.],
3 languages spoken and any affiliations with participating hospitals. The
4 listing shall also be posted on the insurer's website and the insurer
5 shall update the website within fifteen days of the addition or termi-
6 nation of a provider from the insurer's network or a change in a physi-
7 cian's hospital affiliation;

8 (18) a description of the method by which an insured may submit a
9 claim for health care services;

10 (19) where applicable, with respect to out-of-network coverage:

11 (A) a clear description of the methodology used by the insurer to
12 determine reimbursement for out-of-network health care services;

13 (B) a description of the amount that the insurer will reimburse under
14 the methodology for out-of-network health care services set forth as a
15 percentage of the usual and customary cost for out-of-network health
16 care services; and

17 (C) examples of anticipated out-of-pocket costs for frequently billed
18 out-of-network health care services; and

19 (20) information in writing and through an internet website that
20 reasonably permits an insured or prospective insured to determine the
21 anticipated out-of-pocket cost for out-of-network health care services
22 in a geographical area or zip code based upon the difference between
23 what the insurer will reimburse for out-of-network health care services
24 and the usual and customary cost for out-of-network health care
25 services.

26 § 2. Paragraphs 11 and 12 of subsection (b) of section 3217-a of the
27 insurance law, as added by chapter 705 of the laws of 1996, are amended
28 and two new paragraphs 13 and 14 are added to read as follows:

1 (11) where applicable, provide the written application procedures and
2 minimum qualification requirements for health care providers to be
3 considered by the insurer for participation in the insurer's network for
4 a managed care product; [and]

5 (12) disclose such other information as required by the superinten-
6 dent, provided that such requirements are promulgated pursuant to the
7 state administrative procedure act[.];

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

10 (14) where applicable, with respect to out-of-network coverage,
11 disclose the dollar amount that the insurer will pay for a specific
12 out-of-network health care service.

13 § 3. Section 3217-a of the insurance law is amended by adding a new
14 subsection (f) to read as follows:

15 (f) For purposes of this section, "usual and customary cost" shall
16 mean the eightieth percentile of all charges for the particular health
17 care service performed by a provider in the same or similar specialty
18 and provided in the same geographical area as reported in a benchmarking
19 database maintained by a nonprofit organization specified by the super-
20 intendent. The nonprofit organization shall not be affiliated with an
21 insurer, a corporation subject to article forty-three of this chapter, a
22 municipal cooperative health benefit plan certified pursuant to article
23 forty-seven of this chapter, or a health maintenance organization certi-
24 fied pursuant to article forty-four of the public health law.

25 § 4. Section 3217-d of the insurance law is amended by adding a new
26 subsection (d) to read as follows:

27 (d) An insurer that issues a comprehensive policy that utilizes a
28 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

1 health needs of insureds and provide an appropriate choice of providers
2 sufficient to render the services covered under the policy or contract.
3 The superintendent shall review the network of health care providers for
4 adequacy at the time of the superintendent's initial approval of a
5 health insurance policy or contract; at least every three years there-
6 after; and upon application for expansion of any service area associated
7 with the policy or contract in conformance with the standards set forth
8 in subdivision five of section four thousand four hundred three of the
9 public health law. To the extent that the network has been determined
10 by the commissioner of health to meet the standards set forth in subdi-
11 vision five of section four thousand four hundred three of the public
12 health law, such network shall be deemed adequate by the superintendent.

13 (b)(1) An insurer, a corporation organized pursuant to article forty-
14 three of this chapter, a municipal cooperative health benefit plan
15 certified pursuant to article forty-seven of this chapter, a health
16 maintenance organization certified pursuant to article forty-four of the
17 public health law or a student health plan established or maintained
18 pursuant to section one thousand one hundred twenty-four of this chap-
19 ter, that issues a comprehensive group or group remittance health insur-
20 ance policy or contract that covers out-of-network health care services
21 shall make available and, if requested by the policyholder or contract-
22 holder, provide coverage for at least seventy percent of the usual and
23 customary cost of each out-of-network health care service after imposi-
24 tion of a deductible or any permissible benefit maximum.

25 (2) For the purposes of this subsection, "usual and customary cost"
26 shall mean the eightieth percentile of all charges for the particular
27 health care service performed by a provider in the same or similar
28 specialty and provided in the same geographical area as reported in a

1 benchmarking database maintained by a nonprofit organization specified
2 by the superintendent. The nonprofit organization shall not be affil-
3 iated with an insurer, a corporation subject to article forty-three of
4 this chapter, a municipal cooperative health benefit plan certified
5 pursuant to article forty-seven of this chapter, a health maintenance
6 organization certified pursuant to article forty-four of the public
7 health law or a student health plan established or maintained pursuant
8 to section one thousand one hundred twenty-four of this chapter.

9 (3) This subsection shall not apply to emergency care services in
10 hospital facilities or prehospital emergency medical services as defined
11 in clause (i) of subparagraph (E) of paragraph twenty-four of subsection
12 (i) of section three thousand two hundred sixteen of this article, or
13 clause (i) of subparagraph (E) of paragraph fifteen of subsection (1) of
14 section three thousand two hundred twenty-one of this chapter, or
15 subparagraph (A) of paragraph five of subsection (aa) of section four
16 thousand three hundred three of this chapter.

17 (4) Nothing in this subsection shall limit the superintendent's
18 authority pursuant to section three thousand two hundred seventeen of
19 this article to establish minimum standards for the form, content and
20 sale of accident and health insurance policies and subscriber contracts,
21 to require additional coverage options for out-of-network services, or
22 to provide for standardization and simplification of coverage.

23 (c) When an insured or enrollee under a contract or policy that
24 provides coverage for emergency services receives the services from a
25 health care provider that does not participate in the provider network
26 of an insurer, a corporation organized pursuant to article forty-three
27 of this chapter, a municipal cooperative health benefit plan certified
28 pursuant to article forty-seven of this chapter, a health maintenance

1 organization certified pursuant to article forty-four of the public
2 health law, or a student health plan established or maintained pursuant
3 to section one thousand one hundred twenty-four of this chapter ("health
4 care plan"), the health care plan shall ensure that the insured or
5 enrollee shall incur no greater out-of-pocket costs for the emergency
6 services than the insured or enrollee would have incurred with a health
7 care provider that participates in the health care plan's provider
8 network. For the purpose of this section, "emergency services" shall
9 have the meaning set forth in subparagraph (D) of paragraph nine of
10 subsection (i) of section three thousand two hundred sixteen of this
11 article, subparagraph (D) of paragraph four of subsection (k) of section
12 three thousand two hundred twenty-one of this article, and subparagraph
13 (D) of paragraph two of subsection (a) of section four thousand three
14 hundred three of this chapter.

15 § 7. Section 4306-c of the insurance law is amended by adding a new
16 subsection (d) to read as follows:

17 (d) A corporation, including a municipal cooperative health benefit
18 plan certified pursuant to article forty-seven of this chapter and a
19 student health plan established or maintained pursuant to section one
20 thousand one hundred twenty-four of this chapter, that issues a compre-
21 hensive policy that utilizes a network of providers and is not a managed
22 care health insurance contract as defined in subsection (c) of section
23 four thousand eight hundred one of this chapter, shall provide access to
24 out-of-network services consistent with the requirements of subsection
25 (a) of section four thousand eight hundred four of this chapter,
26 subsections (g-6) and (g-7) of section four thousand nine hundred of
27 this chapter, subsections (a-1) and (a-2) of section four thousand nine
28 hundred four of this chapter, paragraphs three and four of subsection

1 (b) of section four thousand nine hundred ten of this chapter, and
2 subparagraphs (C) and (D) of paragraph four of subsection (b) of section
3 four thousand nine hundred fourteen of this chapter.

4 § 8. Paragraphs 11, 12, 13, 14, 16-a, 17, and 18 of subsection (a) of
5 section 4324 of the insurance law, paragraphs 11, 12, 13, 14, 17 and 18
6 as added by chapter 705 of the laws of 1996, paragraph 16-a as added by
7 chapter 554 of the laws of 2002, are amended and three new paragraphs
8 19, 20 and 21 are added to read as follows:

9 (11) where applicable, notice that a subscriber enrolled in a managed
10 care product or in a comprehensive contract that utilizes a network of
11 providers offered by the corporation may obtain a referral [to] or
12 preauthorization for a health care provider outside of the corporation's
13 network or panel when the corporation does not have a health care
14 provider [with] who is geographically accessible to the insured and who
15 has the appropriate essential level of training and experience in the
16 network or panel to meet the particular health care needs of the
17 subscriber and the procedure by which the subscriber can obtain such
18 referral or preauthorization;

19 (12) where applicable, notice that a subscriber enrolled in a managed
20 care product or a comprehensive contract that utilizes a network of
21 providers offered by the corporation with a condition which requires
22 ongoing care from a specialist may request a standing referral to such a
23 specialist and the procedure for requesting and obtaining such a stand-
24 ing referral;

25 (13) where applicable, notice that a subscriber enrolled in a managed
26 care product or a comprehensive contract that utilizes a network of
27 providers offered by the corporation with (i) a life-threatening condi-
28 tion or disease, or (ii) a degenerative and disabling condition or

1 disease, either of which requires specialized medical care over a
2 prolonged period of time may request a specialist responsible for
3 providing or coordinating the subscriber's medical care and the proce-
4 dure for requesting and obtaining such a specialist;

5 (14) where applicable, notice that a subscriber enrolled in a managed
6 care product or a comprehensive contract that utilizes a network of
7 providers offered by the corporation with [(i)] (A) a life-threatening
8 condition or disease, or [(ii)] (B) a degenerative and disabling condi-
9 tion or disease, either of which requires specialized medical care over
10 a prolonged period of time may request access to a specialty care center
11 and the procedure by which such access may be obtained;

12 (16-a) where applicable, notice that an enrollee shall have direct
13 access to primary and preventive obstetric and gynecologic services,
14 including annual examinations, care resulting from such annual examina-
15 tions, and treatment of acute gynecologic conditions, from a qualified
16 provider of such services of her choice from within the plan [for no
17 fewer than two examinations annually for such services] or [to] for any
18 care related to a pregnancy [and that additionally, the enrollee shall
19 have direct access to primary and preventive obstetric and gynecologic
20 services required as a result of such annual examinations or as a result
21 of an acute gynecologic condition];

22 (17) where applicable, a listing by specialty, which may be in a sepa-
23 rate document that is updated annually, of the name, address, and tele-
24 phone number of all participating providers, including facilities, and
25 in addition, in the case of physicians, board certification[; and],
26 languages spoken and any affiliations with participating hospitals. The
27 listing shall also be posted on the corporation's website and the corpo-
28 ration shall update the website within fifteen days of the addition or

1 termination of a provider from the corporation's network or a change in
2 a physician's hospital affiliation;

3 (18) a description of the mechanisms by which subscribers may partic-
4 ipate in the development of the policies of the corporation[.];

5 (19) a description of the method by which a subscriber may submit a
6 claim for health care services;

7 (20) where applicable, with respect to out-of-network coverage:

8 (A) a clear description of the methodology used by the corporation to
9 determine reimbursement for out-of-network health care services;

10 (B) a description of the amount that the corporation will reimburse
11 under the methodology for out-of-network health care services set forth
12 as a percentage of the usual and customary cost for out-of-network
13 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 (21) information in writing and through an internet website that
17 reasonably permits a subscriber or prospective subscriber to determine
18 the anticipated out-of-pocket cost for out-of-network health care
19 services in a geographical area or zip code based upon the difference
20 between what the corporation will reimburse for out-of-network health
21 care services and the usual and customary cost for out-of-network health
22 care services.

23 § 9. Paragraphs 11 and 12 of subsection (b) of section 4324 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

1 considered by the corporation for participation in the corporation's
2 network for a managed care product; [and]

3 (12) disclose such other information as required by the superinten-
4 dent, provided that such requirements are promulgated pursuant to the
5 state administrative procedure act[.];

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

8 (14) where applicable, with respect to out-of-network coverage,
9 disclose the dollar amount that the corporation will pay for a specific
10 out-of-network health care service.

11 § 10. Section 4324 of the insurance law is amended by adding a new
12 subsection (f) to read as follows:

13 (f) For purposes of this section, "usual and customary cost" shall
14 mean the eightieth percentile of all charges for the particular health
15 care service performed by a provider in the same or similar specialty
16 and provided in the same geographical area as reported in a benchmarking
17 database maintained by a nonprofit organization specified by the super-
18 intendent. The nonprofit organization shall not be affiliated with an
19 insurer, a corporation subject to this article, a municipal cooperative
20 health benefit plan certified pursuant to article forty-seven of this
21 chapter, or a health maintenance organization certified pursuant to
22 article forty-four of the public health law.

23 § 10-a. Subsection (a) of section 4804 of the insurance law, as added
24 by chapter 705 of the laws of 1996, is amended to read as follows:

25 (a) If an insurer offering a managed care product determines that it
26 does not have a health care provider in the in-network benefits portion
27 of its network with appropriate training and experience to meet the
28 particular health care needs of an insured, the insurer shall make a

1 referral to an appropriate provider, pursuant to a treatment plan
2 approved by the insurer in consultation with the primary care provider,
3 the non-participating provider and the insured or the insured's desig-
4 nee, at no additional cost to the insured beyond what the insured would
5 otherwise pay for services received within the network. Nothing in this
6 subsection shall be construed to entitle an insured to a referral to the
7 insured's preferred provider, where that provider is out-of-network.
8 The provisions of this subsection shall only apply if there is no
9 in-network provider geographically accessible to the insured who has the
10 appropriate essential level of training and experience to meet the
11 particular needs of the insured.

12 § 11. Subsection (g-7) of section 4900 of the insurance law is redes-
13 igned subsection (g-8) and a new subsection (g-7) is added to read as
14 follows:

15 (g-7) "Out-of-network referral denial" means a denial under a managed
16 care product as defined in subsection (c) of section four thousand eight
17 hundred one of this chapter of a request for an authorization or refer-
18 ral to an out-of-network provider on the basis that the health care plan
19 has a health care provider in the in-network benefits portion of its
20 network with appropriate training and experience to meet the particular
21 health care needs of an insured, and who is able to provide the
22 requested health service. The notice of an out-of-network referral
23 denial provided to an insured shall include information explaining what
24 information the insured must submit in order to appeal the out-of-net-
25 work referral denial pursuant to subsection (a-2) of section four thou-
26 sand nine hundred four of this article. An out-of-network referral
27 denial under this subsection does not constitute an adverse determi-
28 nation as defined in this article. An out-of-network referral denial

1 shall not be construed to include an out-of-network denial as defined in
2 subsection (g-6) of this section.

3 § 12. Subsection (b) of section 4903 of the insurance law, as amended
4 by chapter 514 of the laws of 2013, is amended to read as follows:

5 (b) A utilization review agent shall make a utilization review deter-
6 mination involving health care services which require pre-authorization
7 and provide notice of a determination to the insured or insured's desig-
8 nee and the insured's health care provider by telephone and in writing
9 within three business days of receipt of the necessary information. To
10 the extent practicable, such written notification to the enrollee's
11 health care provider shall be transmitted electronically, in a manner
12 and in a form agreed upon by the parties. The notification shall iden-
13 tify: (1) whether the services are considered in-network or out-of-net-
14 work; (2) whether the insured will be held harmless for the services and
15 not be responsible for any payment, other than any applicable co-pay-
16 ment, co-insurance or deductible; (3) as applicable, the dollar amount
17 the health care plan will pay if the service is out-of-network; and (4)
18 as applicable, information explaining how an insured may determine the
19 anticipated out-of-pocket cost for out-of-network health care services
20 in a geographical area or zip code based upon the difference between
21 what the health care plan will reimburse for out-of-network health care
22 services and the usual and customary cost for out-of-network health care
23 services.

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

26 (a-2) An insured or the insured's designee may appeal an out-of-net-
27 work referral denial by a health care plan by submitting a written
28 statement from the insured's attending physician, who must be a

1 licensed, board certified or board eligible physician qualified to prac-
2 tice in the specialty area of practice appropriate to treat the insured
3 for the health service sought, provided that: (1) the in-network health
4 care provider or providers recommended by the health care plan do not
5 have the appropriate training and experience to meet the particular
6 health care needs of the insured for the health service; and (2) recom-
7 mends an out-of-network provider with the appropriate training and expe-
8 rience to meet the particular health care needs of the insured, and who
9 is able to provide the requested health service.

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

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

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

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

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

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

10 (ii) be accompanied by a written statement:

11 (I) that the out-of-network referral shall be covered by the health
12 care plan either when the reviewer or a majority of the panel of review-
13 ers determines, upon review of the training and experience of the
14 in-network health care provider or providers proposed by the plan, the
15 training and experience of the requested out-of-network provider, the
16 clinical standards of the plan, the information provided concerning the
17 insured, the attending physician's recommendation, the insured's medical
18 record, and any other pertinent information, that the health plan does
19 not have a provider with the appropriate training and experience to meet
20 the particular health care needs of an insured who is able to provide
21 the requested health service, and that the out-of-network provider has
22 the appropriate training and experience to meet the particular health
23 care needs of an insured, is able to provide the requested health
24 service, and is likely to produce a more clinically beneficial outcome;
25 or

26 (II) upholding the health plan's denial of coverage;

27 (iii) be subject to the terms and conditions generally applicable to
28 benefits under the evidence of coverage under the health care plan;

1 (iv) be binding on the plan and the insured; and

2 (v) be admissible in any court proceeding.

3 § 16. The public health law is amended by adding a new section 23 to
4 read as follows:

5 § 23. Claim forms. A physician shall include a claim form for a
6 third-party payor with a patient bill for health care services, other
7 than a bill for the patient's co-payment, coinsurance or deductible.

8 § 17. The public health law is amended by adding a new section 24 to
9 read as follows:

10 § 24. Disclosure. 1. A health care professional shall disclose to
11 patients or prospective patients in writing or through an internet
12 website the health care plans in which the health care professional is a
13 participating provider and the hospitals with which the health care
14 professional is affiliated prior to the provision of non-emergency
15 services and verbally at the time an appointment is scheduled.

16 2. If a health care professional does not participate in the network
17 of a patient's or prospective patient's health care plan, the health
18 care professional shall: (a) prior to the provision of non-emergency
19 services, inform a patient or prospective patient that the amount or
20 estimated amount the health care professional will bill the patient for
21 health care services is available upon request; and (b) upon receipt of
22 a request from a patient or prospective patient, disclose to the patient
23 or prospective patient in writing the amount or estimated amount the
24 health care professional will bill the patient or prospective patient
25 for health care services provided or anticipated to be provided to the
26 patient or prospective patient absent unforeseen medical circumstances
27 that may arise when the health care services are provided.

1 3. A health care professional who is a physician shall provide a
2 patient or prospective patient with the name, practice name, mailing
3 address, and telephone number of any health care provider scheduled to
4 perform anesthesiology, laboratory, pathology, radiology or assistant
5 surgeon services in connection with care to be provided in the physi-
6 cian's office for the patient or coordinated or referred by the physi-
7 cian for the patient prior to the provision of services.

8 4. A health care professional who is a physician shall, for a
9 patient's scheduled hospital admission or scheduled outpatient hospital
10 services, provide a patient and the hospital with the name, practice
11 name, mailing address and telephone number of any other physician whose
12 services will be arranged by the physician and are scheduled at the time
13 of the pre-admission testing, registration or admission prior to the
14 provision of services; and information as to how to determine the
15 healthcare plans in which the physician participates.

16 5. A hospital shall establish, update and make public through posting
17 on the hospital's website, to the extent required by federal guidelines,
18 a list of the hospital's standard charges for items and services
19 provided by the hospital, including for diagnosis-related groups estab-
20 lished under section 1886(d)(4) of the federal social security act.

21 6. A hospital shall post on the hospital's website: (a) the health
22 care plans in which the hospital is a participating provider; (b) a
23 statement that (i) physician services provided in the hospital are not
24 included in the hospital's charges; (ii) physicians who provide services
25 in the hospital may or may not participate with the same health care
26 plans as the hospital, and; (iii) the prospective patient should check
27 with the physician arranging for the hospital services to determine the
28 health care plans in which the physician participates; (c) as applica-

1 ble, the name, mailing address and telephone number of the physician
2 groups that the hospital has contracted with to provide services includ-
3 ing anesthesiology, pathology or radiology, and instructions how to
4 contact these groups to determine the health care plan participation of
5 the physicians in these groups; and (d) as applicable, the name, mailing
6 address, and telephone number of physicians employed by the hospital and
7 whose services may be provided at the hospital, and the health care
8 plans in which they participate.

9 7. In registration or admission materials provided in advance of non-
10 emergency hospital services, a hospital shall: (a) advise the patient or
11 prospective patient to check with the physician arranging the hospital
12 services to determine: (i) the name, practice name, mailing address and
13 telephone number of any other physician whose services will be arranged
14 by the physician; and (ii) whether the services of physicians who are
15 employed or contracted by the hospital to provide services including
16 anesthesiology, pathology and/or radiology are reasonably anticipated to
17 be provided to the patient; and (b) provide patients or prospective
18 patients with information as to how to timely determine the health care
19 plans participated in by physicians who are reasonably anticipated to
20 provide services to the patient at the hospital, as determined by the
21 physician arranging the patient's hospital services, and who are employ-
22 ees of the hospital or contracted by the hospital to provide services
23 including anesthesiology, radiology and/or pathology.

24 8. For purposes of this subdivision:

25 (a) "Health care plan" means a health insurer including an insurer
26 licensed to write accident and health insurance subject to article thir-
27 ty-two of the insurance law; a corporation organized pursuant to article
28 forty-three of the insurance law; a municipal cooperative health benefit

1 plan certified pursuant to article forty-seven of the insurance law; a
2 health maintenance organization certified pursuant to article forty-four
3 of this chapter; a student health plan established or maintained pursu-
4 ant to section one thousand one hundred twenty-four of the insurance law
5 or a self-funded employee welfare benefit plan.

6 (b) "Health care professional" means an appropriately licensed, regis-
7 tered or certified health care professional pursuant to title eight of
8 the education law.

9 § 17-a. Paragraph (a) of subdivision 6 of section 4403 of the public
10 health law, as added by chapter 705 of the laws of 1996, is amended to
11 read as follows:

12 (a) If a health maintenance organization determines that it does not
13 have a health care provider with appropriate training and experience in
14 its panel or network to meet the particular health care needs of an
15 enrollee, the health maintenance organization shall make a referral to
16 an appropriate provider, pursuant to a treatment plan approved by the
17 health maintenance organization in consultation with the primary care
18 provider, the non-participating provider and the enrollee or enrollee's
19 designee, at no additional cost to the enrollee beyond what the enrollee
20 would otherwise pay for services received within the network. Nothing in
21 this paragraph shall be construed to entitle an enrollee to a referral
22 to the enrollee's preferred provider, where that provider is out-of-net-
23 work. The provisions of this paragraph shall only apply if there is no
24 in-network provider geographically accessible to the enrollee who has
25 the appropriate essential level of training and experience to meet the
26 particular needs of the enrollee.

27 § 18. Paragraphs (k), (p-1), (q) and (r) of subdivision 1 of section
28 4408 of the public health law, paragraphs (k), (q) and (r) as added by

1 chapter 705 of the laws of 1996, and paragraph (p-1) as added by chapter
2 554 of the laws of 2002, are amended and three new paragraphs (s), (t)
3 and (u) are added to read as follows:

4 (k) notice that an enrollee may obtain a referral to a health care
5 provider outside of the health maintenance organization's network or
6 panel when the health maintenance organization does not have a health
7 care provider [with] who is geographically accessible to the enrollee
8 and who has appropriate essential level of training and experience in
9 the network or panel to meet the particular health care needs of the
10 enrollee and the procedure by which the enrollee can obtain such refer-
11 ral;

12 (p-1) notice that an enrollee shall have direct access to primary and
13 preventive obstetric and gynecologic services, including annual examina-
14 tions, care resulting from such annual examinations, and treatment of
15 acute gynecologic conditions, from a qualified provider of such services
16 of her choice from within the plan [for no fewer than two examinations
17 annually for such services] or [to] for any care related to a pregnancy
18 [and that additionally, the enrollee shall have direct access to primary
19 and preventive obstetric and gynecologic services required as a result
20 of such annual examinations or as a result of an acute gynecologic
21 condition];

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

24 (r) a listing by specialty, which may be in a separate document that
25 is updated annually, of the name, address and telephone number of all
26 participating providers, including facilities, and, in addition, in the
27 case of physicians, board certification[.], languages spoken and any
28 affiliations with participating hospitals. The listing shall also be

1 posted on the health maintenance organization's website and the health
2 maintenance organization shall update the website within fifteen days of
3 the addition or termination of a provider from the health maintenance
4 organization's network or a change in a physician's hospital affil-
5 iation;

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

8 (t) where applicable, with respect to out-of-network coverage:

9 (i) a clear description of the methodology used by the health mainte-
10 nance organization to determine reimbursement for out-of-network health
11 care services;

12 (ii) a description of the amount that the health maintenance organiza-
13 tion will reimburse under the methodology for out-of-network health care
14 services set forth as a percentage of the usual and customary cost for
15 out-of-network health care services;

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

18 (u) information in writing and through an internet website that
19 reasonably permits an enrollee or prospective enrollee to determine the
20 anticipated out-of-pocket cost for out-of-network health care services
21 in a geographical area or zip code based upon the difference between
22 what the health maintenance organization will reimburse for out-of-net-
23 work health care services and the usual and customary cost for out-of-
24 network health care services.

25 § 19. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the
26 public health law, as added by chapter 705 of the laws of 1996, are
27 amended and two new paragraphs (m) and (n) are added to read as follows:

1 (k) provide the written application procedures and minimum qualifica-
2 tion requirements for health care providers to be considered by the
3 health maintenance organization; [and]

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

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

9 (n) where applicable, with respect to out-of-network coverage,
10 disclose the dollar amount that the health maintenance organization will
11 pay for a specific out-of-network health care service.

12 § 20. Section 4408 of the public health law is amended by adding a new
13 subdivision 7 to read as follows:

14 7. For purposes of this section, "usual and customary cost" shall
15 mean the eightieth percentile of all charges for the particular health
16 care service performed by a provider in the same or similar specialty
17 and provided in the same geographical area as reported in a benchmarking
18 database maintained by a nonprofit organization specified by the super-
19 intendent of financial services. The nonprofit organization shall not be
20 affiliated with an insurer, a corporation subject to article forty-three
21 of the insurance law, a municipal cooperative health benefit plan certi-
22 fied pursuant to article forty-seven of the insurance law, or a health
23 maintenance organization certified pursuant to this article.

24 § 21. Subdivision 7-g of section 4900 of the public health law is
25 renumbered subdivision 7-h and a new subdivision 7-g is added to read as
26 follows:

27 7-g. "Out-of-network referral denial" means a denial of a request for
28 an authorization or referral to an out-of-network provider on the basis

1 that the health care plan has a health care provider in the in-network
2 benefits portion of its network with appropriate training and experience
3 to meet the particular health care needs of an enrollee, and who is able
4 to provide the requested health service. The notice of an out-of-network
5 referral denial provided to an enrollee shall include information
6 explaining what information the enrollee must submit in order to appeal
7 the out-of-network referral denial pursuant to subdivision one-b of
8 section four thousand nine hundred four of this article. An out-of-net-
9 work referral denial under this subdivision does not constitute an
10 adverse determination as defined in this article. An out-of-network
11 referral denial shall not be construed to include an out-of-network
12 denial as defined in subdivision seven-f of this section.

13 § 22. Subdivision 2 of section 4903 of the public health law, as
14 amended by chapter 514 of the laws of 2013, is amended to read as
15 follows:

16 2. A utilization review agent shall make a utilization review determi-
17 nation involving health care services which require pre-authorization
18 and provide notice of a determination to the enrollee or enrollee's
19 designee and the enrollee's health care provider by telephone and in
20 writing within three business days of receipt of the necessary informa-
21 tion. To the extent practicable, such written notification to the
22 enrollee's health care provider shall be transmitted electronically, in
23 a manner and in a form agreed upon by the parties. The notification
24 shall identify; (a) whether the services are considered in-network or
25 out-of-network; (b) and whether the enrollee will be held harmless for
26 the services and not be responsible for any payment, other than any
27 applicable co-payment or co-insurance; (c) as applicable, the dollar
28 amount the health care plan will pay if the service is out-of-network;

1 and (d) as applicable, information explaining how an enrollee may deter-
2 mine the anticipated out-of-pocket cost for out-of-network health care
3 services in a geographical area or zip code based upon the difference
4 between what the health care plan will reimburse for out-of-network
5 health care services and the usual and customary cost for out-of-network
6 health care services.

7 § 23. Section 4904 of the public health law is amended by adding a new
8 subdivision 1-b to read as follows:

9 1-b. An enrollee or the enrollee's designee may appeal a denial of an
10 out-of-network referral by a health care plan by submitting a written
11 statement from the enrollee's attending physician, who must be a
12 licensed, board certified or board eligible physician qualified to prac-
13 tice in the specialty area of practice appropriate to treat the enrollee
14 for the health service sought, provided that: (a) the in-network health
15 care provider or providers recommended by the health care plan do not
16 have the appropriate training and experience to meet the particular
17 health care needs of the enrollee for the health service; and (b) recom-
18 mends an out-of-network provider with the appropriate training and expe-
19 rience to meet the particular health care needs of the enrollee, and who
20 is able to provide the requested health service.

21 § 24. Subdivision 2 of section 4910 of the public health law is
22 amended by adding a new paragraph (d) to read as follows:

23 (d)(i) The enrollee has had an out-of-network referral denied on the
24 grounds that the health care plan has a health care provider in the
25 in-network benefits portion of its network with appropriate training and
26 experience to meet the particular health care needs of an enrollee, and
27 who is able to provide the requested health service.

1 (ii) The enrollee's attending physician, who shall be a licensed,
2 board certified or board eligible physician qualified to practice in the
3 specialty area of practice appropriate to treat the enrollee for the
4 health service sought, certifies that the in-network health care provid-
5 er or providers recommended by the health care plan do not have the
6 appropriate training and experience to meet the particular health care
7 needs of an enrollee, and recommends an out-of-network provider with the
8 appropriate training and experience to meet the particular health care
9 needs of an enrollee, and who is able to provide the requested health
10 service.

11 § 25. Paragraph (d) of subdivision 2 of section 4914 of the public
12 health law is amended by adding a new subparagraph (D) to read as
13 follows:

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

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

23 (ii) be accompanied by a written statement:

24 (1) that the out-of-network referral shall be covered by the health
25 care plan either when the reviewer or a majority of the panel of review-
26 ers determines, upon review of the training and experience of the
27 in-network health care provider or providers proposed by the plan, the
28 training and experience of the requested out-of-network provider, the

1 clinical standards of the plan, the information provided concerning the
2 enrollee, the attending physician's recommendation, the enrollee's
3 medical record, and any other pertinent information, that the health
4 plan does not have a provider with the appropriate training and experi-
5 ence to meet the particular health care needs of an enrollee who is able
6 to provide the requested health service, and that the out-of-network
7 provider has the appropriate training and experience to meet the partic-
8 ular health care needs of an enrollee, is able to provide the requested
9 health service, and is likely to produce a more clinically beneficial
10 outcome; or

11 (2) upholding the health plan's denial of coverage;

12 (iii) be subject to the terms and conditions generally applicable to
13 benefits under the evidence of coverage under the health care plan;

14 (iv) be binding on the plan and the enrollee; and

15 (v) be admissible in any court proceeding.

16 § 26. The financial services law is amended by adding a new article 6
17 to read as follows:

18 ARTICLE 6

19 EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS

20 Section 601. Dispute resolution process established.

21 602. Applicability.

22 603. Definitions.

23 604. Criteria for determining a reasonable fee.

24 605. Dispute resolution for emergency services.

25 606. Hold harmless and assignment of benefits for surprise bills
26 for insureds.

27 607. Dispute resolution for surprise bills.

28 608. Payment for independent dispute resolution entity.

1 § 601. Dispute resolution process established. The superintendent
2 shall establish a dispute resolution process by which a dispute for a
3 bill for emergency services or a surprise bill may be resolved. The
4 superintendent shall have the power to grant and revoke certifications
5 of independent dispute resolution entities to conduct the dispute resol-
6 ution process. The superintendent shall promulgate regulations estab-
7 lishing standards for the dispute resolution process, including a proc-
8 ess for certifying and selecting independent dispute resolution
9 entities.

10 § 602. Applicability. This article shall not apply to health care
11 services, including emergency services, where physician fees are subject
12 to schedules or other monetary limitations under any other law, includ-
13 ing the workers' compensation law and article fifty-one of the insurance
14 law, and shall not preempt any such law.

15 § 603. Definitions. For the purposes of this article:

16 (a) "Emergency condition" means a medical or behavioral condition that
17 manifests itself by acute symptoms of sufficient severity, including
18 severe pain, such that a prudent layperson, possessing an average know-
19 ledge of medicine and health, could reasonably expect the absence of
20 immediate medical attention to result in : (1) placing the health of the
21 person afflicted with such condition in serious jeopardy, or in the case
22 of a behavioral condition placing the health of such person or others in
23 serious jeopardy; (2) serious impairment to such person's bodily func-
24 tions; (3) serious dysfunction of any bodily organ or part of such
25 person; (4) serious disfigurement of such person; or (5) a condition
26 described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the
27 social security act 42 U.S.C. § 1395dd.

1 (b) "Emergency services" means, with respect to an emergency condi-
2 tion: (1) a medical screening examination as required under section 1867
3 of the social security act, 42 U.S.C. § 1395dd, which is within the
4 capability of the emergency department of a hospital, including ancil-
5 lary services routinely available to the emergency department to evalu-
6 ate such emergency medical condition; and (2) within the capabilities of
7 the staff and facilities available at the hospital, such further medical
8 examination and treatment as are required under section 1867 of the
9 social security act, 42 U.S.C. § 1395dd, to stabilize the patient.

10 (c) "Health care plan" means an insurer licensed to write accident and
11 health insurance pursuant to article thirty-two of the insurance law; a
12 corporation organized pursuant to article forty-three of the insurance
13 law; a municipal cooperative health benefit plan certified pursuant to
14 article forty-seven of the insurance law; a health maintenance organiza-
15 tion certified pursuant to article forty-four of the public health law;
16 or a student health plan established or maintained pursuant to section
17 one thousand one hundred twenty-four of the insurance law.

18 (d) "Insured" means a patient covered under a health care plan's poli-
19 cy or contract.

20 (e) "Non-participating" means not having a contract with a health care
21 plan to provide health care services to an insured.

22 (f) "Participating" means having a contract with a health care plan to
23 provide health care services to an insured.

24 (g) "Patient" means a person who receives health care services,
25 including emergency services, in this state.

26 (h) "Surprise bill" means a bill for health care services, other than
27 emergency services, received by:

1 (1) an insured for services rendered by a non-participating physician
2 at a participating hospital or ambulatory surgical center, where a
3 participating physician is unavailable at the time the health care
4 services are rendered; provided, however, that a surprise bill shall not
5 mean a bill received for health care services when a participating
6 physician is available and the insured has elected to obtain services
7 from a non-participating physician; or

8 (2) a patient who is not an insured for services rendered by a physi-
9 cian at a hospital or ambulatory surgical center, where the patient has
10 not timely received all of the disclosures required pursuant to section
11 twenty-four of the public health law.

12 (i) "Usual and customary cost" means the eightieth percentile of all
13 charges for the particular health care service performed by a provider
14 in the same or similar specialty and provided in the same geographical
15 area as reported in a benchmarking database maintained by a nonprofit
16 organization specified by the superintendent. The nonprofit organization
17 shall not be affiliated with an insurer, a corporation subject to arti-
18 cle forty-three of the insurance law, a municipal cooperative health
19 benefit plan certified pursuant to article forty-seven of the insurance
20 law, or a health maintenance organization certified pursuant to article
21 forty-four of the public health law.

22 § 604. Criteria for determining a reasonable fee. In determining the
23 appropriate amount to pay for a health care service, an independent
24 dispute resolution entity shall consider all relevant factors, includ-
25 ing:

26 (a) whether there is a gross disparity between the fee charged by the
27 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.

1 (2) A non-participating physician or a health care plan may submit a
2 dispute regarding a fee or payment for emergency services for review to
3 an independent dispute resolution entity.

4 (3) In determining a reasonable fee for the services rendered, an
5 independent dispute resolution entity shall select either the health
6 care plan's payment or the non-participating physician's fee. The inde-
7 pendent dispute resolution entity shall determine which amount to select
8 based upon the conditions and factors set forth in section six hundred
9 four of this article.

10 (b) Emergency services for a patient that is not an insured. (1) A
11 patient that is not an insured or the patient's physician may submit a
12 dispute regarding a fee for emergency services for review to an inde-
13 pendent dispute resolution entity upon approval of the superintendent.

14 (2) An independent dispute resolution entity shall determine a reason-
15 able fee for the services based upon the same conditions and factors set
16 forth in section six hundred four of this article.

17 (3) A patient that is not an insured shall not be required to pay the
18 physician's fee in order to be eligible to submit the dispute for review
19 to an independent dispute resolution entity.

20 (c) The determination of an independent dispute resolution entity
21 shall be binding on the health care plan, physician and patient, and
22 shall be admissible in any court proceeding between the health care
23 plan, physician or patient, or in any administrative proceeding between
24 this state and the physician.

25 § 606. Hold harmless and assignment of benefits for surprise bills for
26 insureds. When an insured assigns benefits for a surprise bill in writ-
27 ing to a non-participating physician that knows the insured is insured
28 under a health care plan, the non-participating physician shall not bill

1 the insured except for any applicable copayment, coinsurance or deduct-
2 ible that would be owed if the insured utilized a participating physi-
3 cian.

4 § 607. Dispute resolution for surprise bills. (a) Surprise bill
5 received by an insured who assigns benefits. (1) If an insured assigns
6 benefits to a non-participating physician, the health care plan shall
7 pay the non-participating physician in accordance with paragraphs two
8 and three of this subsection.

9 (2) The non-participating physician may bill the health care plan for
10 the health care services rendered, and the health care plan shall pay
11 the non-participating physician the billed amount or attempt to negoti-
12 ate reimbursement with the non-participating physician.

13 (3) If the health care plan's attempts to negotiate reimbursement for
14 health care services provided by a non-participating physician does not
15 result in a resolution of the payment dispute between the non-partici-
16 pating physician and the health care plan, the health care plan shall
17 pay the non-participating physician an amount the health care plan
18 determines is reasonable for the health care services rendered, except
19 for the insured's copayment, coinsurance or deductible, in accordance
20 with section three thousand two hundred twenty-four-a of the insurance
21 law.

22 (4) Either the health care plan or the non-participating physician may
23 submit the dispute regarding the surprise bill for review to an inde-
24 pendent dispute resolution entity, provided however, the health care
25 plan may not submit the dispute unless it has complied with the require-
26 ments of paragraphs one, two and three of this subsection.

27 (5) When determining a reasonable fee for the services rendered, the
28 independent dispute resolution entity shall select either the health

1 care plan's payment or the non-participating physician's fee. An inde-
2 pendent dispute resolution entity shall determine which amount to select
3 based upon the conditions and factors set forth in section six hundred
4 four of this article.

5 (b) Surprise bill received by an insured who does not assign benefits
6 or by a patient who is not an insured. (1) An insured who does not
7 assign benefits in accordance with subsection (a) of this section or a
8 patient who is not an insured and who receives a surprise bill may
9 submit a dispute regarding the surprise bill for review to an independ-
10 ent dispute resolution entity.

11 (2) The independent dispute resolution entity shall determine a
12 reasonable fee for the services rendered based upon the conditions and
13 factors set forth in section six hundred four of this article.

14 (3) A patient or insured who does not assign benefits in accordance
15 with subsection (a) of this section shall not be required to pay the
16 physician's fee to be eligible to submit the dispute for review to the
17 independent dispute entity.

18 (c) The determination of an independent dispute resolution entity
19 shall be binding on the patient, physician and health care plan, and
20 shall be admissible in any court proceeding between the patient or
21 insured, physician or health care plan, or in any administrative
22 proceeding between this state and the physician.

23 § 608. Payment for independent dispute resolution entity. (a) For
24 disputes involving an insured, when the independent dispute resolution
25 entity determines the health care plan's payment is reasonable, payment
26 for the dispute resolution process shall be the responsibility of the
27 non-participating physician. When the independent dispute resolution
28 entity determines the non-participating physician's fee is reasonable,

1 payment for the dispute resolution process shall be the responsibility
2 of the health care plan.

3 (b) For disputes involving a patient that is not an insured, when the
4 independent dispute resolution entity determines the physician's fee is
5 reasonable, payment for the dispute resolution process shall be the
6 responsibility of the patient unless payment for the dispute resolution
7 process would pose a hardship to the patient. The superintendent shall
8 promulgate a regulation to determine payment for the dispute resolution
9 process in cases of hardship. When the independent dispute resolution
10 entity determines the physician's fee is unreasonable, payment for the
11 dispute resolution process shall be the responsibility of the physician.

12 § 27. This act shall take effect one year after it shall have become a
13 law, provided, however, that:

14 1. if the amendments by chapter 514 of the laws of 2013 made to
15 subsection (b) of section 4903 of the insurance law and subdivision 2 of
16 section 4903 of the public health law, as amended by sections twelve and
17 twenty-two of this act, respectively, take effect after such date, then
18 sections twelve and twenty-two of this act shall take effect on the same
19 date as chapter 514 of the laws of 2013 takes effect;

20 2. for policies renewed on and after such date this act shall take
21 effect on the renewal date;

22 3. sections twelve, sixteen, seventeen, twenty-two and twenty-six of
23 this act shall apply to health care services provided on and after such
24 date;

25 4. sections eleven, thirteen, fourteen, fifteen, twenty-one, twenty-
26 three, twenty-four and twenty-five of this act shall apply to denials
27 issued on and after such date; and