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

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

PART U

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

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

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

care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

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

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

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

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

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

phone 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 insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

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

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

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

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

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

(20) information in writing and through an internet website that reasonably permits an insured or prospective insured to 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 insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

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

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

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.]; and

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

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

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

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

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

(d) An insurer that issues a comprehensive policy that utilizes a network of providers and is not a managed care health insurance contract

as defined in subsection (c) of section four thousand eight hundred one of this chapter, shall provide access to out-of-network services consistent with the requirements of subsection (a) of section four thousand eight hundred four of this chapter, subsections (g-6) and (g-7) of section four thousand nine hundred of this chapter, subsections (a-1) and (a-2) of section four thousand nine hundred four of this chapter, paragraphs three and four of subsection (b) of section four thousand nine hundred ten of this chapter, and subparagraphs (C) and (D) of paragraph four of subsection (b) of section four thousand nine hundred fourteen of this chapter.

§ 5. Section 3224-a of the insurance law is amended by adding a new subsection (j) to read as follows:

(j) An insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter shall accept claims submitted by a policyholder or covered person, in writing, including through the internet, by electronic mail or by facsimile.

§ 6. The insurance law is amended by adding a new section 3241 to read as follows:

§ 3241. Network coverage. (a) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a health insurance policy or contract with a network of health care providers shall ensure that the network is adequate to meet the

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

(b)(1) An insurer, a corporation organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter, a health maintenance organization certified pursuant to article forty-four of the public health law or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of this chapter, that issues a comprehensive group or group remittance health insurance policy or contract that covers out-of-network health care services shall make available and, if requested by the policyholder or contractholder, provide coverage for at least seventy percent of the usual and customary cost of each out-of-network health care service after imposition of a deductible or any permissible benefit maximum.

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

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

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

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

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

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

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

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

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

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

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

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

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

disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist;

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

(16-a) where applicable, 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];

(17) where applicable, 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[; and], languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or

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

(18) a description of the mechanisms by which subscribers may participate in the development of the policies of the corporation[.];

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

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

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

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

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

(21) information in writing and through an internet website that reasonably permits a subscriber or prospective subscriber to 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 corporation will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

§ 9. Paragraphs 11 and 12 of subsection (b) of section 4324 of the insurance law, as added by chapter 705 of the laws of 1996, are amended and two new paragraphs 13 and 14 are added to read as follows:

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be

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

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.]; and

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

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

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

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

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

(a) If an insurer offering a managed care product determines that it does not have 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, the insurer shall make a

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

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

(g-7) "Out-of-network referral denial" means a denial under a managed care product as defined in subsection (c) of section four thousand eight hundred one of this chapter of a request for an authorization or referral to an out-of-network provider on the basis 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. The notice of an out-of-network referral denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network referral denial pursuant to subsection (a-2) of section four thousand nine hundred four of this article. An out-of-network referral denial under this subsection does not constitute an adverse determination as defined in this article. An out-of-network referral denial

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

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

(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To 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:

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

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

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

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

(v) be admissible in any court proceeding.

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

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

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

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

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

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

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

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

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

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

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

8. For purposes of this subdivision:

(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.

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

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

§ 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 essential level of 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) where applicable, 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) a description of the amount that the health maintenance organization will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services;

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

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

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

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

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

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

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

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

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

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

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

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 enrollee, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an enrollee shall include information explaining what information the enrollee must submit in order to appeal the out-of-network referral denial pursuant to subdivision one-b of section four thousand nine hundred four of this article. An out-of-network referral denial under this subdivision does not constitute an adverse determination as defined in this article. An out-of-network referral denial shall not be construed to include an out-of-network denial as defined in subdivision seven-f of this section.

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

2. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information. To 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; (a) whether the services are considered in-network or out-of-network; (b) and whether the enrollee will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment or co-insurance; (c) as applicable, the dollar amount the health care plan will pay if the service is out-of-network;

and (d) as applicable, information explaining how an enrollee 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.

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

1-b. An enrollee or the enrollee's designee may appeal a denial of an out-of-network referral by a health care plan by submitting a written statement from the enrollee'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 enrollee for the health service sought, provided that: (a) 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 enrollee for the health service; and (b) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

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

(d)(i) The enrollee 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 enrollee, and who is able to provide the requested health service.

(ii) The enrollee'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 enrollee 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 enrollee, and recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of an enrollee, and who is able to provide the requested health service.

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

(D) For external appeals requested pursuant to paragraph (d) of subdivision two 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) that the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines, upon review of the training and experience of the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the

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

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

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

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

(v) be admissible in any court proceeding.

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

ARTICLE 6

EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS

Section 601. Dispute resolution process established.

602. Applicability.

603. Definitions.

604. Criteria for determining a reasonable fee.

605. Dispute resolution for emergency services.

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

607. Dispute resolution for surprise bills.

608. Payment for independent dispute resolution entity.

§ 601. Dispute resolution process established. The superintendent shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The superintendent shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The superintendent shall promulgate regulations establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities.

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

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

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

(b) "Emergency services" means, with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient.

(c) "Health care plan" means an insurer licensed to write accident and health insurance pursuant 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 the public health law; or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law.

(d) "Insured" means a patient covered under a health care plan's policy or contract.

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

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

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

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

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

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

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

§ 604. Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(a) whether there is a gross disparity between the fee charged by the physician for services rendered as compared to:

(1) fees paid to the involved physician for the same services rendered by the physician to other patients in health care plans in which the physician is not participating, and

(2) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians for the same services in the same region who are not participating with the health care plan;

(b) the level of training, education and experience of the physician;

(c) the physician's usual charge for comparable services with regard to patients in health care plans in which the physician is not participating;

(d) the circumstances and complexity of the particular case, including time and place of the service;

(e) individual patient characteristics; and

(f) the usual and customary cost of the service.

§ 605. Dispute resolution for emergency services. (a) Emergency services for an insured. (1) When a health care plan receives a bill for emergency services from a non-participating physician, the health care plan shall pay an amount that it determines is reasonable for the emergency services rendered by the non-participating physician, in accordance with section three thousand two hundred twenty-four-a of the insurance law, except for the insured's co-payment, coinsurance or deductible, if any, and shall ensure that the insured shall incur no greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating physician pursuant to subsection (c) of section three thousand two hundred forty-one of the insurance law.

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

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

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

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

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

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

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

the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician.

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

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

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

(4) Either the health care plan or the non-participating physician may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity, provided however, the health care plan may not submit the dispute unless it has complied with the requirements of paragraphs one, two and three of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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