MEMORANDUM
Oppose 30-Day Budget Amendments to eliminate the expansion of prohibitions on administrative denials by insurance companies for emergency services, observation stays, and all inpatient hospital admissions.
(Article VII, HMH, S7607-A/A9507-A, Part J)

Governor Andrew Cuomo’s 30-day budget amendments to his proposed Executive Budget eliminate insurance reforms that would protect patients from insurance company practices to refuse to pay for medically necessary hospital inpatient and emergency care. **New York ACEP is opposed to these 30-day amendments.**

Currently, the State Insurance law prohibits the denial of medically necessary inpatient services following an emergency admission based solely on a hospital’s failure to notify a plan of the services. The Governor’s original proposed budget **extended this prohibition to all types of administrative denials and to emergency services, observation stays, and all inpatient admissions** with the following exceptions:

- Based on a reasonable belief of fraud, intentional misconduct, or abusive billing;
- When required by a State or federal government program (e.g. Medicaid);
- For coverage that is provided by the State or municipality to its respective employees, retirees or members;
- A duplicate claim, or for non-covered benefits or a non-covered person; or
- For services for which preauthorization was denied prior to the delivery of services.

**New York ACEP supports restoration of these insurance law reforms in the final State Budget.** These reforms protect patients and hospitals from practices by insurance companies to wrongly refuse to pay for medically necessary inpatient hospital services and emergency care.

According to a 2018 report from Crowe Horwath, delayed claims that arise from claim denials are significantly impacting hospital revenue cycles, taking an average of 16.4 more days to pay compared to claims that have not been denied. The claims which the insurance company never reimburses the provider represent a 1.9 percent decrease to an average hospital’s annual net revenue.

While the payment time for a clinical claim denial with a request for information ranged from 76.43 days to 121.66 days across five major insurance companies, the same for an administrative claim denial for a coverage or eligibility issue ranged from 42.2 days to 137.48.

In 2017, one large insurance company denied more than 12,000 emergency department (ED) claims in a six-month period in Missouri, Kentucky, and Georgia, representing 5.8% of ED claims. These denials were based on new restrictions in coverage for what are deemed to be non-emergent visits. It is only a matter of time before these denials are applied by insurance companies in New York State.

**For all of the above-stated reasons, New York ACEP urges the New York State Legislature to restore these insurance law reforms in the final State Budget**
Section 1. Subsection (j) of section 3217-b of the insurance law, as added by chapter 297 of the laws of 2012, is amended to read as follows:

(j) (1) [An] No insurer shall [not] by contract, written policy or procedure, or by any other means, deny payment to a general hospital certified pursuant to article twenty-eight of the public health law for a claim for medically necessary inpatient services [resulting from an emergency admission], observation services, or emergency department services provided by a general hospital solely on the basis that the general hospital did not [timely notify] comply with certain administrative requirements of such insurer [that the services had been provided] with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and an insurer from agreeing to certain administrative requirements [for] relating to payment for inpatient services, observation services, or emergency department services, including but not limited to timely notification that medically necessary inpatient services [resulting from an emergency admission] have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely [notify] notification; provided, however that: [(i)] [(A)] any requirement for timely notification must provide for a reasonable extension of timeframes for notification for [emergency] services provided on weekends or federal holidays, [(ii)] [(B)] any agreed to reduction in payment for failure to meet administrative requirements, including timely [notify] notification shall not exceed the lesser of two thousand dollars or twelve percent of the payment amount otherwise due for the services provided, and [(iii)] [(C)] any agreed to reduction in payment
for failure to meet administrative requirements including timely [notifi-
fy] notification shall not be imposed if the patient's insurance cover-
age could not be determined by the hospital after reasonable efforts at
the time the [inpatient] services were provided.
(3) Nothing in this subsection shall preclude an insurer from denying
payment for a claim; (A) based on a reasonable belief of fraud or inten-
tional misconduct, or abusive billing; (B) when required by a state or
federal government program or coverage that is provided by this state or
a municipality thereof to its respective employees, retirees or members;
or (C) that it believes is fraudulently submitted, is a duplicate claim,
or is for services for a benefit that is not covered under the insured's
policy or for a patient determined to be ineligible for coverage.
(4) For purposes of this subsection, an "administrative requirement"
shall not include requirements: (A) imposed on an insurer or provider
pursuant to federal or state laws, regulations or guidance; or (B)
established by the state or federal government applicable to insurers
offering benefits under a state or federal government program.
(5) The prohibition on denials set forth in this subsection shall not
apply to claims for services for which a request for preauthorization
was denied by the insurer prior to delivery of the service.
§ 2. Subsection (k) of section 4325 of the insurance law, as added by
chapter 297 of the laws of 2012, is amended to read as follows:
(k) (1) [A] No corporation organized under this article shall [not] by
written contract, written policy or procedure, or by any other means,
deny payment to a general hospital certified pursuant to article twen-
ty-eight of the public health law for a claim for medically necessary
inpatient services [resulting from an emergency admission], observation
services, or emergency department services provided by a general hospi-
tal solely on the basis that the general hospital did not [timely notify] comply with certain administrative requirements of such [insurer that the services had been provided] corporation with respect to those services.

(2) Nothing in this subsection shall preclude a general hospital and a corporation from agreeing to certain administrative requirements [for] relating to payment for inpatient services, observation services, or emergency department services, including, but not limited to timely notification that medically necessary inpatient services [resulting from an emergency admission] have been provided and to reductions in payment for failure to comply with certain administrative requirements including timely [notify] notification; provided, however that: [(i)] [(A) any requirement for timely notification must provide for a reasonable extension of timeframes for notification for [emergency] services provided on weekends or federal holidays, [(ii)] [(B) any agreed to reduction in payment for failure to meet administrative requirements including timely [notify] notification shall not exceed the lesser of two thousand dollars or twelve percent of the payment amount otherwise due for the services provided, and [(iii)] [(C) any agreed to reduction in payment for failure to meet administrative requirements including timely notification shall not be imposed if the patient's insurance coverage could not be determined by the hospital after reasonable efforts at the time the [inpatient] services were provided.

(3) Nothing in this subsection shall preclude a corporation from denying payment for a claim: [(A) based on a reasonable belief of fraud or intentional misconduct, or abusive billing; (B) when required by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or
members; or (c) that it believes is fraudulently submitted, is a dupli-
cate claim or is for services for a benefit that is not covered under
the insured's contract or for a patient determined to be ineligible for
coverage.

(4) For purposes of this subsection, an "administrative requirement"
shall not include requirements: (A) imposed on a corporation or provider
pursuant to federal or state laws, regulations or guidance; (B) estab-
lished by the state or federal government applicable to corporations
offering benefits under a state or federal government program.

(5) The prohibition on denials set forth in this subsection shall not
apply to claims for services for which a request for preauthorization
was denied by the corporation prior to delivery of the service.

§ 3. Subdivision 8 of section 4406-c of the public health law, as
added by chapter 297 of the laws of 2012, is amended to read as follows:

6. (a) [A] No health care plan shall [not] by contract, written policy
or procedure, or by any other means, deny payment to a general hospital
certified pursuant to article twenty-eight of this chapter for a claim
for medically necessary inpatient services [resulting from an emergency
admission], observation services, or emergency department services
provided by a general hospital solely on the basis that the general
hospital did not [timely notify such health care plan that the services
had been provided] comply with certain administrative requirements of
such health care plan with respect to those services.

(b) Nothing in this subdivision shall preclude a general hospital and
a health care plan from agreeing to certain administrative requirements
[for] relating to payment for inpatient services, observation services,
or emergency department services, including, but not limited to, timely
notification that medically necessary inpatient services [resulting from
an emergency admission] have been provided and to reductions in payment
for failure to comply with certain administrative requirements including
timely [notify] notification; provided, however that: (i) any require-
ment for timely notification must provide for a reasonable extension of
timeframes for notification for [emergency] services provided on week-
ends or federal holidays, (ii) any agreed to reduction in payment for
failure to meet administrative requirements, including timely [notify]
notification shall not exceed the lesser of two thousand dollars or
twelve percent of the payment amount otherwise due for the service
provided, and (iii) any agreed to reduction in payment for failure to
meet administrative requirements including timely notification shall not
be imposed if the patient's coverage could not be determined by the
hospital after reasonable efforts at the time the [inpatient] services
were provided.

(c) Nothing in this subdivision shall preclude a health care plan from
denying payment for a claim: (i) based on a reasonable belief of fraud
or intentional misconduct, or abusive billing; (ii) when required by a
state or federal government program or coverage that is provided by this
state or a municipality thereof to its respective employees, retirees or
members; (iii) that it believes is fraudulently submitted, is a dupli-
cate claim, or is for services for a benefit that is not covered under
the insured's contract or for a patient determined to be ineligible for
coverage.

(d) For purposes of this subdivision, an "administrative requirement"
shall not include requirements: (i) imposed on a health care plan or
provider pursuant to federal or state laws, regulations or guidance; or
(ii) established by the state or federal government applicable to health
care plans offering benefits under a state or federal government program.

(e) The prohibition on denials set forth in this subdivision shall not apply to claims for services for which a request for preauthorization was denied by the health care plan prior to delivery of the service.