STATE OF NEW YORK

4914

2017-2018 Regular Sessions

IN ASSEMBLY

February 6, 2017

Introduced by M. of A. SCHIMMINGER -- read once and referred to the Committee on Health

AN ACT to amend the public health law and the insurance law, in relation to improper practices relating to staff membership or professional privileges of a physician and board certification

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

Section 1. Subdivision 1 of section 2801-b of the public health law, as amended by chapter 605 of the laws of 2008, is amended to read as follows:

1. It shall be an improper practice for the governing body of a hospital to refuse to act upon an application for staff membership or professional privileges or to deny or withhold from a physician, podiatrist, optometrist, dentist or licensed midwife staff membership or professional privileges in a hospital, or to exclude or expel a physician, podiatrist, optometrist, dentist or licensed midwife from staff membership in a hospital or curtail, terminate or diminish in any way a physician's, podiatrist's, optometrist's, dentist's or licensed midwife's professional privileges in a hospital, without stating the reasons therefor, or if the reasons stated are unrelated to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the applicant. It shall be an improper practice for a governing body of a hospital to refuse to act upon an application or to deny or to withhold staff membership or professional privileges to a podiatrist based solely upon a practitioner's category of licensure. **It shall be an improper practice for a governing body of a hospital to refuse to act upon an application or to deny or to withhold staff membership or professional privileges of a physician solely because such physician is not board-certified.**

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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§ 2. Paragraph (a) of subdivision 1 of section 4406-d of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(a) A health care plan shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the health care plan. The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements. A health care plan shall complete review of the health care professional's application to participate in the in-network portion of the health care plan's network and shall, within ninety days of receiving a health care professional's completed application to participate in the health care plan's network, notify the health care professional as to: (i) whether he or she is credentialed; or (ii) whether additional time is necessary to make a determination in spite of the health care plan's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible. **A health care plan may not refuse to approve an application from a physician to participate in the in-network portion of the health care plan's network solely because such physician is not board-certified.**

§ 3. Paragraph (a) of subdivision 1 of section 4406-d of the public health law, as amended by chapter 425 of the laws of 2016, is amended to read as follows:

(a) A health care plan shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the health care plan. The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements. A health care plan shall complete review of the health care professional's application to participate in the in-network portion of the health care plan's network and shall, within sixty days of receiving a health care professional's completed application to participate in the health care plan's network, notify the health care professional as to: (i) whether he or she is credentialed; or (ii) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation. **A health care plan may not refuse to approve an application from a physician to participate in the in-network portion of the health care plan's network solely because such physician is not board-certified.**

§ 4. Paragraph 1 of subsection (a) of section 4803 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall

consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within ninety days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to: (A) whether he or she is credentialed; or (B) whether additional time is necessary to make a determination in spite of the insurer's best efforts or because of a failure of a third party to provide necessary documentation, or non-routine or unusual circumstances require additional time for review. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible. **An insurer may not refuse to approve an application from a physician for participation in the in-network portion of the insurer's network solely because such physician is not board-certified.**

§ 5. Paragraph 1 of subsection (a) of section 4803 of the insurance law, as amended by chapter 425 of the laws of 2016, is amended to read as follows:

(1) An insurer which offers a managed care product shall, upon request, make available and disclose to health care professionals written application procedures and minimum qualification requirements which a health care professional must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified health care professionals in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the health care professional's application to participate in the in-network portion of the insurer's network and, within sixty days of receiving a health care professional's completed application to participate in the insurer's network, will notify the health care professional as to: (A) whether he or she is credentialed; or (B) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation. **An insurer may not refuse to approve an application from a physician for participation in the in-network portion of the insurer's network solely because such physician is not board-certified.**

§ 6. This act shall take effect immediately; provided, however, that if chapter 425 of the laws of 2016 shall not have taken effect on or before such date then sections three and five of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2016 takes effect.