S T A T E O F N E W Y O R K

3195

2009-2010 Regular Sessions

I N A S S E M B L Y

January 23, 2009

Introduced by M. of A. BRADLEY, GOTTFRIED, J. RIVERA, MAYERSOHN, COLTON, JAFFEE, SCARBOROUGH, LATIMER, SCHIMEL -- Multi-Sponsored by -- M. of A. BRENNAN, CHRISTENSEN, CLARK, ESPAILLAT, FARRELL, GREENE, JOHN, PHEFFER, SWEENEY -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to the termination of a health care professional's participation in a managed care plan

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subsection (e) of section 4803 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(e) No insurer shall terminate or refuse to renew a contract for participation in the in-network benefits portion of an insurer's network for a managed care product solely because the health care professional [has] (1) HAS advocated on behalf of an insured; (2) has filed a complaint against the insurer; (3) has appealed a decision of the insurer; (4) provided information or filed a report pursuant to section forty-four hundred six-c of the public health law; [or] (5) requested a hearing or review pursuant to this section; OR (6) IS CREDENTIALED ONLY AT A HOSPITAL OR HOSPITALS THAT NO LONGER PARTICIPATE IN THE IN-NETWORK BENEFITS PORTION OF THE INSURER'S NETWORK FOR THE MANAGED CARE PRODUCT.

S 2. Subdivision 5 of section 4406-d of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

5. No health care plan shall terminate a contract or employment, or refuse to renew a contract, solely because a health care provider [has]:

(a) advocated on behalf of an enrollee;

(b) filed a complaint against the health care plan;

(c) appealed a decision of the health care plan;

(d) provided information or filed a report pursuant to section forty-four hundred six-c of this article; [or]

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

LBD03286-01-9

(e) requested a hearing or review pursuant to this section; OR

(F) IS CREDENTIALED ONLY AT A HOSPITAL OR HOSPITALS THAT NO LONGER PARTICIPATE IN THE HEALTH CARE PLAN'S NETWORK OF PROVIDERS.

S 3. Section 4804 of the insurance law is amended by adding a new subsection (g) to read as follows:

(G) IF AN INSURER TERMINATES A GENERAL HOSPITAL FROM THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK FOR A MANAGED CARE PRODUCT OR IF A GENERAL HOSPITAL TERMINATES ITS IN-NETWORK PROVIDER CONTRACT WITH AN INSURER FOR A MANAGED CARE PRODUCT, SUCH GENERAL HOSPITAL SHALL BE ALLOWED TO CONTINUE TO PROVIDE SERVICES TO PATIENTS OF ANY HEALTH CARE PROFESSIONAL WHO PARTICIPATES IN THE IN-NETWORK BENEFITS PORTION OF THE INSURER'S NETWORK FOR A MANAGED CARE PRODUCT AND HAS STAFF MEMBERSHIP AND CLINICAL PRIVILEGES AT SUCH GENERAL HOSPITAL FOR A TRANSITIONAL PERIOD OF UP TO ONE HUNDRED TWENTY DAYS FROM THE DATE OF SUCH TERMINATION; PROVIDED HOWEVER, THE PROVISIONS OF THIS SUBSECTION SHALL NOT APPLY IF A PATIENT'S HEALTH CARE PROFESSIONAL HAS STAFF MEMBERSHIP AND CLINICAL PRIVILEGES AT ANOTHER GENERAL HOSPITAL WHICH IS PART OF THE IN-NETWORK PORTION OF THE INSURER'S NETWORK FOR A MANAGED CARE PRODUCT. SUCH CARE SHALL BE AUTHORIZED BY THE INSURER ONLY IF THE GENERAL HOSPITAL AGREES TO (1) CONTINUE TO ACCEPT REIMBURSEMENT FROM THE INSURER AT THE RATES APPLICABLE PRIOR TO THE START OF THE TRANSITIONAL PERIOD AS PAYMENT IN FULL; (2) ADHERE TO THE INSURER'S QUALITY ASSURANCE REQUIREMENTS AND PROVIDE TO THE INSURER NECESSARY MEDICAL INFORMATION RELATED TO SUCH CARE; AND (3) OTHERWISE ADHERE TO THE INSURER'S POLICIES AND PROCEDURES, INCLUDING BUT NOT LIMITED TO PROCEDURES REGARDING REFERRALS AND OBTAINING PRE-AUTHORIZATION AND A TREATMENT PLAN APPROVED BY THE INSURER.

S 4. Section 4403 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. IF A HEALTH MAINTENANCE ORGANIZATION TERMINATES A GENERAL HOSPITAL FROM ITS NETWORK OF PROVIDERS OR IF A GENERAL HOSPITAL TERMINATES ITS NETWORK PROVIDER CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION, SUCH GENERAL HOSPITAL SHALL BE ALLOWED TO CONTINUE TO PROVIDE SERVICES TO PATIENTS OF ANY HEALTH CARE PROFESSIONAL WHO IS PART OF THE HEALTH MAINTENANCE ORGANIZATION'S NETWORK OF PROVIDERS AND HAS STAFF MEMBERSHIP AND CLINICAL PRIVILEGES AT SUCH GENERAL HOSPITAL FOR A TRANSITIONAL PERIOD OF UP TO ONE HUNDRED TWENTY DAYS FROM THE DATE OF SUCH TERMINATION; PROVIDED HOWEVER, THIS SUBDIVISION SHALL NOT APPLY IF A PATIENT'S HEALTH CARE PROFESSIONAL HAS STAFF MEMBERSHIP AND CLINICAL PRIVILEGES AT ANOTHER GENERAL HOSPITAL WHICH IS PART OF THE HEALTH MAINTENANCE ORGANIZATION'S NETWORK OF PROVIDERS. SUCH SERVICES SHALL BE AUTHORIZED BY THE HEALTH MAINTENANCE ORGANIZATION IF THE GENERAL HOSPITAL AGREES TO: (A) CONTINUE TO ACCEPT REIMBURSEMENT FROM THE HEALTH MAINTENANCE ORGANIZATION AT THE RATES APPLICABLE PRIOR TO THE START OF THE TRANSITIONAL PERIOD AS PAYMENT IN FULL; (B) ADHERE TO THE HEALTH MAINTENANCE ORGANIZATION'S QUALITY ASSURANCE REQUIREMENTS AND PROVIDE TO THE ORGANIZATION NECESSARY MEDICAL INFORMATION RELATED TO SUCH CARE; AND (C) OTHERWISE ADHERE TO THE ORGANIZATION'S POLICIES AND PROCEDURES, INCLUDING BUT NOT LIMITED TO PROCEDURES REGARDING REFERRALS AND OBTAINING PRE-AUTHORIZATION AND A TREATMENT PLAN APPROVED BY THE HEALTH MAINTENANCE ORGANIZATION.

S 5. This act shall take effect on the sixtieth day after it shall have become a law.