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

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I N A S S E M B L Y

(PREFILED)

January 9, 2013

Introduced by M. of A. DINOWITZ, GALEF, HOOPER, GOTTFRIED -- Multi-Sponsored by -- M. of A. BOYLAND, BRENNAN, COLTON, JACOBS, LIFTON, SWEENEY -- read once and referred to the Committee on Health -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health law, in relation to access to health care providers in managed care plans

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) 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) RENDERED AN OPINION REGARDING WHETHER AN INSURED'S ILLNESS IS TERMINAL PURSUANT TO SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS ARTICLE.

S 2. Subsections (e) and (f) of section 4804 of the insurance law, as added by chapter 705 of the laws of 1996, are amended to read as follows:

(e) (1) If an insured's health care provider leaves the insurer's in-network benefits portion of its network of providers for a managed care product for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph one of subsection (b) of section [forty-eight] FOUR THOUSAND EIGHT hundred

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

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three of this [chapter] ARTICLE, the insurer shall permit the insured to continue [an ongoing course of treatment with] TO RECEIVE HEALTH CARE PROCEDURES, TREATMENTS, AND SERVICES FROM the insured's current health care provider during a transitional period of (i) up to [ninety days] ONE YEAR from the date of notice to the insured of the provider's disaffiliation from the insurer's network[;] or (ii) if the insured has entered the second trimester of pregnancy at the time of the provider's disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery; OR A TERMINAL ILLNESS OR CONDITION, UNTIL THE TIME OF SUCH INSURED'S DEATH.

(2) Notwithstanding the provisions of paragraph one of this subsection, such care shall be authorized by the insurer during the transitional period only if the health care provider agrees (i) to continue to accept reimbursement from the insurer at the rates applicable prior to the start of the transitional period as payment in full; (ii) to adhere to the insurer's quality assurance requirements and to provide to the insurer necessary medical information related to such care; and (iii) to 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.

(f) If a new insured whose health care provider is not a member of the insurer's in-network benefits portion of the provider network enrolls in the managed care product, the insurer shall permit the insured to continue [an ongoing course of treatment with] TO RECEIVE HEALTH CARE PROCEDURES, TREATMENTS, AND SERVICES FROM the insured's current health care provider during a transitional period of up to [sixty days] ONE YEAR from the effective date of enrollment OR, if (1) the insured has a [life-threatening disease or condition or a degenerative and disabling disease or condition] TERMINAL ILLNESS OR CONDITION, UNTIL THE TIME OF SUCH INSURED'S DEATH, or (2) the insured has entered the second trimester of pregnancy at the time of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an insured elects to continue to receive care from such health care provider pursuant to this [paragraph] SUBSECTION, such care shall be authorized by the insurer for the transitional period only if the health care provider agrees (A) to accept reimbursement from the insurer at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network benefits portion of the insurer's network for such services; (B) to adhere to the insurer's quality assurance requirements and agrees to provide to the insurer necessary medical information related to such care; and (C) to 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. In no event shall this subsection be construed to require an insurer to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the insured's contract.

S 3. Section 4804 of the insurance law is amended by adding two new subsections (g) and (h) to read as follows:

(G) FOR THE PURPOSES OF THIS SECTION, THE TERM "TERMINAL ILLNESS OR CONDITION" SHALL MEAN AN ILLNESS OR CONDITION WHICH, IN THE OPINION OF THE PHYSICIAN OF THE PATIENT SUFFERING FROM SUCH TERMINAL ILLNESS OR

CONDITION, IS LIKELY TO CAUSE OR BE A MAJOR CONTRIBUTING FACTOR IN CAUSING SUCH PATIENT'S DEATH WITHIN THREE YEARS.

(H) PROVIDER INCENTIVES (MONETARY OR OTHERWISE) TO A HEALTH CARE PROVIDER RELATING TO PROCEDURES, TREATMENTS, OR SERVICES PURSUANT TO THIS SECTION, WHICH ARE INTENDED TO HAVE THE EFFECT OF INDUCING SUCH PROVIDER TO PROVIDE CARE TO AN INSURED IN A MANNER INCONSISTENT WITH THIS SECTION, ARE PROHIBITED.

S 4. Paragraphs (e) and (f) of subdivision 6 of section 4403 of the public health law, as added by chapter 705 of the laws of 1996, are amended to read as follows:

(e) (1) If an enrollee's health care provider leaves the health maintenance organization's network of providers for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to paragraph [a] (A) of subdivision two of section forty-four hundred six-d of this [chapter] ARTICLE, the health maintenance organization shall permit the enrollee to continue [an ongoing course of treatment with] TO RECEIVE HEALTH CARE PROCEDURES, TREATMENTS, AND SERVICES FROM the enrollee's current health care provider during a transitional period of (i) up to [ninety days] ONE YEAR from the date of notice to the enrollee of the provider's disaffiliation from the organization's network[;] or (ii) if the enrollee has entered the second trimester of pregnancy at the time of the provider's disaffiliation, for a transitional period that includes the provision of post-partum care directly related to the delivery, OR (III) IF THE ENROLLEE HAS A TERMINAL ILLNESS OR CONDITION, UNTIL THE TIME OF SUCH ENROLLEE'S DEATH.

(2) Notwithstanding the provisions of subparagraph one of this paragraph, such care shall be authorized by the health maintenance organization during the transitional period only if the health care provider agrees (i) to 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; (ii) to adhere to the organization's quality assurance requirements and to provide to the organization necessary medical information related to such care; and (iii) to 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 organization.

(f) If a new enrollee whose health care provider is not a member of the health maintenance organization's provider network enrolls in the health maintenance organization, the organization shall permit the enrollee to continue [an ongoing course of treatment with] TO RECEIVE HEALTH CARE PROCEDURES, TREATMENTS, AND SERVICES FROM the enrollee's current health care provider during a transitional period of up to [sixty days] ONE YEAR from the effective date of enrollment, OR if (i) the enrollee has a [life-threatening disease or condition or a degenerative and disabling disease or condition] TERMINAL ILLNESS OR CONDITION, UNTIL THE TIME OF SUCH ENROLLEE'S DEATH, or (ii) the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, in which case the transitional period shall include the provision of post-partum care directly related to the delivery. If an enrollee elects to continue to receive care from such health care provider pursuant to this paragraph, such care shall be authorized by the health maintenance organization for the transitional period only if the health care provider agrees (A) to accept reimbursement from the health maintenance organization at rates established by the health maintenance organization as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within

the health maintenance organization's network for such services; (B) to adhere to the organization's quality assurance requirements and agrees to provide to the organization necessary medical information related to such care; and (C) to 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 organization. In no event shall this paragraph be construed to require a health maintenance organization to provide coverage for benefits not otherwise covered or to diminish or impair pre-existing condition limitations contained within the subscriber's contract.

S 5. Section 4403 of the public health law is amended by adding two new subdivisions 9 and 10 to read as follows:

9. FOR THE PURPOSES OF THIS SECTION, "TERMINAL ILLNESS OR CONDITION" SHALL MEAN AN ILLNESS OR CONDITION WHICH, IN THE OPINION OF THE PHYSICIAN OF THE PATIENT SUFFERING FROM SUCH TERMINAL ILLNESS OR CONDITION, IS LIKELY TO CAUSE OR BE A MAJOR CONTRIBUTING FACTOR IN CAUSING SUCH PATIENT'S DEATH WITHIN THREE YEARS.

10. PROVIDER INCENTIVES (MONETARY OR OTHERWISE) TO A HEALTH CARE PROVIDER RELATING TO PROCEDURES, TREATMENTS, OR SERVICES PROVIDED PURSUANT TO THIS SECTION, WHICH ARE INTENDED TO INDUCE OR HAVE THE EFFECT OF INDUCING SUCH PROVIDER TO PROVIDE CARE TO AN ENROLLEE IN A MANNER INCONSISTENT WITH THIS SECTION, ARE PROHIBITED.

S 6. 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]

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

(F) RENDERED AN OPINION REGARDING WHETHER A PATIENT'S ILLNESS IS TERMINAL PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE OF THIS ARTICLE.

S 7. This act shall take effect on the one hundred twentieth day after it shall have become a law and shall apply to all contracts issued, renewed, modified or amended on and after such date.