STATE OF NEW YORK

3711

2017-2018 Regular Sessions

IN ASSEMBLY

January 30, 2017

Introduced by M. of A. ORTIZ -- Multi-Sponsored by -- M. of A. CRESPO -- read once and referred to the Committee on Health

AN ACT to amend the public health law and the insurance law, in relation to providing access to diagnostic laboratories by patients in health maintenance organizations

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

Section 1. Section 4406 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. Notwithstanding any other provision of law, if an enrollee is referred by an in-plan provider to a provider of clinical laboratory services not participating in the plan (a "non-participating provider"), any service provided by a non-participating provider that would otherwise be paid for by the plan to other non-participating providers shall be paid for by the plan, and the plan shall be responsible for payment directly to the non-participating provider for that service in accordance with the time frame for such payments set forth in section three thousand two hundred twenty-four-a of the insurance law; provided, however, that the enrollee shall be responsible for any applicable copay, coinsurance or deductible for such services. Clinical laboratories seeking reimbursement pursuant to this article for services rendered shall directly bill the plan whose enrollee received the services. Any payment made by a plan directly to the enrollee rather than to the clinical laboratory seeking reimbursement shall not satisfy the plan's payment obligation to the clinical laboratory.

§ 2. Section 4406-c of the public health law is amended by adding two new subdivisions 4-a and 4-b to read as follows:

4-a. No health care plan, not-for-profit or for-profit health maintenance organization, preferred provider organization, point of service plan, government subsidized health care plan or self insured plan (collectively, "plan") shall exclude from participating within its

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

LBD08996-01-7

network any provider of clinical laboratory services that meets the following requirements: (a) such provider is licensed as a Medicare provider by the United States department of health and human services; (b) such provider is either accredited by the college of American pathologists, or licensed by the New York state department of health; and (c) such provider submits electronic claims to the plan for the payment of clinical laboratory services rendered to enrollees. Each plan shall directly pay for clinical laboratory services rendered to enrollees by any provider of clinical laboratory services practicing within its network in accordance with the time frame for such payments set forth in section three thousand two hundred twenty-four-a of the insurance law; provided, however, that the enrollee shall be responsible for any applicable copay, coinsurance or deductible for such services.

4-b. Notwithstanding any other provision of law, in no event shall any plan: (a) reimburse any in-plan provider of clinical laboratory services for a particular laboratory test but not reimburse another in-plan provider of clinical laboratory services for that laboratory test; (b) assign preferential status nor provide preferential treatment to a provider of clinical laboratory services practicing within its network. Such prohibited preferential treatment shall include, but is not limited to, maintaining a substantially different rate of payment or fees for similar products and services provided by one in-plan provider over those of other in-plan providers, or establishing a payment procedure with one in-plan provider as opposed to other in-plan providers known to likely result in the loss of payment for such in-plan providers; (c) establish different performance measures or requirements for one in-plan provider over those of other in-plan providers of clinical laboratory services, including but not limited to, the number of patient service centers required to be operated in a covered area or fluctuating reporting guidelines and requirements; (d) subcontract the management of the network to an in-plan laboratory that collects a management fee for such management services; or (e) treat any enrollee utilizing the services of any provider of clinical laboratory services practicing within its network in a manner which is not the same as or similar in all material respects to the manner in which all other enrollees utilizing the services of any provider of clinical laboratory services practicing within its network are treated.

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

(g) Notwithstanding any other provision of law, if an insured is referred by an in-plan provider to a provider of clinical laboratory services not participating in the plan (a "non-participating provider"), any service that would otherwise be covered as an in-plan service under the plan that is provided by the non-participating provider shall be covered, and the organization shall be responsible for payment directly to the non-participating provider for those services in accordance with the time frame for such payments set forth in section three thousand two hundred twenty-four-a of this chapter; provided, however, that the insured shall be responsible for any applicable copay, coinsurance or deductible for such services. Clinical laboratories seeking reimbursement pursuant to this article for services rendered shall directly bill the organization whose insured received the services. Any payment made by an organization directly to the insured rather than to the clinical laboratory seeking reimbursement shall not satisfy the organization's payment obligation to the clinical laboratory.

§ 4. This act shall take effect immediately.