§ 4805. Access to end of life care. (a) Every contract issued by an insurer that provides coverage for hospital, surgical or medical care that includes coverage for acute care services shall provide coverage for an insured diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the patient's attending health care practitioner) for acute care services at an acute care facility licensed pursuant to article twenty-eight of the public health law specializing in the treatment of terminally ill patients if the patient's attending health care practitioner, in consultation with the medical director of the facility determines that the insured's care would appropriately be provided by such a facility.

(b) Notwithstanding the provisions of article forty-nine of this chapter, if the insurer disagrees with the admission of or provision or continuation of care for the insured by the facility, the insurer shall initiate an expedited external appeal in accordance with the provisions of paragraph three of subsection (b) of section four thousand nine hundred fourteen of this chapter, provided further, that until such decision is rendered, the admission of or provision or continuation of the care by the facility shall not be denied by the insurer and the insurer shall provide coverage and reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the insured's contract. The decision of the external appeal agent shall be binding on all parties. If the insurer does not initiate an expedited external appeal the insurer shall reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the insured's contract.

(c) An insurer shall provide reimbursement for those services prescribed by this section at rates negotiated between the insurer and the facility. In the absence of agreed upon rates, an insurer shall pay for acute care at the facility's acute care rate under the Medicare program (Title XVIII of the federal Social Security Act), including the Part A rate for Part A services and the Part B rate for Part B services, and shall pay for alternate level care days at seventy-five percent of the acute care rate, including the Part A rate for Part A services and the Part B rate for Part B services.

(d) Payment by an insurer pursuant to this section shall be payment in full for the services provided to the insured. An acute care facility reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an insured for the services provided by the acute care facility pursuant to this section, except for the collection of copayments, coinsurance or visit fees, or deductibles for which the insured is responsible under the terms of the applicable contract.

(e) No provision of this section shall be construed to require an insurer to provide coverage for benefits not otherwise covered under the insured's contract.