§ 4406. Health maintenance organizations; regulation of contracts. 1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of one hundred or fewer employees or members, exclusive of spouses and dependents, or to any employee or member of the group, including dependents, applying for such contract at any time throughout the year. An individual direct payment contract shall be issued only in accordance with section four thousand three hundred twenty-eight of the insurance law. The superintendent may, after giving consideration to the public interest, exempt a health maintenance organization from the requirements of this section provided that another health insurer or health maintenance organization within the health maintenance organization's same holding company system, as defined in article fifteen of the insurance law, including a health maintenance organization operated as a line of business of a health service corporation licensed under article forty-three of the insurance law, offers coverage that, at a minimum, complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to this chapter and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of this chapter. The requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of this chapter or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four

thousand three hundred twenty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four.

2. (a) Upon approval of the commissioner, an organization may implement an out-of-plan benefits system that allows enrollees to use providers not participating in the plan pursuant to a contract, employment or other association. The commissioner, in consultation with the superintendent, shall not approve an organization to implement an out-of-plan benefits system unless the organization demonstrates that:

(i) the requirements of this article and any regulations promulgated thereunder have been met and will continue to be met;

(ii) it can establish and maintain a contingent reserve fund of not less than two percent of the entire net premium income for the calendar year of the organization in addition to any other contingent reserve fund required by the commissioner in regulations subject to the approval of the superintendent; and

(iii) it has established mechanisms to ensure and monitor compliance with the provisions of paragraph (b) of this subdivision.

(b) Except as provided in paragraph (c) of this subdivision, an organization may not permit the benefits provided pursuant to such out-of-plan system to exceed ten percent of the total health care expenditures of the organization, as determined on a quarterly basis, but such limitation shall not apply to individual direct payment contracts issued pursuant to section forty-three hundred twenty-two of the insurance law. In determining the amount of benefits provided in connection with the use of such providers, an organization shall not include benefits provided pursuant to a referral made by a participating provider or benefits provided in emergency situations.

(c) An organization may exceed the ten percent level by up to two percent in any given quarter provided that the organization does not exceed the ten percent level by the end of the following quarter.

(d) If the commissioner determines that an organization has permitted the benefits provided pursuant to an out-of-plan system to exceed ten percent, except as permitted by paragraph (b) or (c) of this subdivision, the commissioner may, where appropriate, assess an organization a civil penalty not to exceed the amount determined by

multiplying the percentage permitted in excess of ten percent by the amount, in dollars, of the difference between what the organization paid all inpatient hospitals for such year and the amount such organization would have paid such hospitals had it been a payor within the categories specified in paragraph (b) of subdivision one of section twenty-eight hundred seven-c of this chapter and not authorized to negotiate hospital rates. The commissioner, in consultation with the superintendent, may revoke, suspend or limit an approval issued pursuant to this subdivision for non-compliance by the organization with any of the provisions of this article or the rules and regulations promulgated thereunder.

(e) The indemnification of enrollees of the services of a non-participating provider may be subject to deductibles, copayments and/or coinsurance approved by the superintendent.

(f) Nothing in this subdivision shall be construed to limit an organization's ability to manage the care of enrollees or the types of health services covered, to conduct utilization review of quality assurance activities.

(g) The commissioner may prohibit an organization determined to have an inadequate network of participating providers from permitting new elections pursuant to this subdivision as of the date of notification of such determination by the commissioner. Notification of such action shall be given by the organization to each enrollee.

(h) An organization providing comprehensive health services under one or more assumed names shall be deemed to be offering its plan through a line of business corresponding to each such assumed name. An organization may, pursuant to the provisions of this subdivision, permit enrollees of one or more lines of business to elect to receive services from providers not participating in such line or lines of business provided, however, that with respect to each line of business such elections shall be permitted only to the extent authorized pursuant to paragraphs (b) and (c) of this subdivision.

(i) Nothing herein shall be deemed to prohibit a health maintenance organization from offering services in connection with a company appropriately licensed pursuant to the insurance law.

3. (a) No contract issued pursuant to this section shall provide that services of a participating hospital will be covered as out-of-network

services solely on the basis that the health care provider admitting or rendering services to the enrollee is not a participating provider.

(b) No contract issued pursuant to this section shall provide that services of a participating health care provider will be covered as out-of-network services solely on the basis that the services are rendered in a non-participating hospital.

(c) For purposes of this subdivision, a "health care provider" is a health care professional licensed, registered or certified pursuant to title eight of the education law or a health care professional comparably licensed, registered or certified by another state.

4. Nothing in this section shall be construed to require a health maintenance organization in its provision of a comprehensive health services plan to meet the requirements of an insurer under the insurance law.

5. If an enrollee requires nursing facility placement and is a resident of a continuing care retirement community authorized under article forty-six of this chapter, the enrollee's primary care practitioner must refer the enrollee to that community's nursing facility if medically appropriate; if the facility agrees to be reimbursed at the health maintenance organization's contract rate negotiated with similar providers for similar services and supplies, or negotiates a mutually agreed upon rate; and if the facility meets the health maintenance organization's guidelines and standards for the delivery of medical services.