§ 4406-e. Access to end of life care. 1. For the purposes of this section, "health care plan" means a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article.

2. Every health care plan that provides coverage for hospital, surgical or medical care that includes coverage for acute care services shall provide an enrollee 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) with coverage for acute care services at an acute care facility licensed pursuant to article twenty-eight of this chapter 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 enrollee's care would appropriately be provided by the facility.

3. Notwithstanding the provisions of article forty-nine of this chapter, if the health care plan disagrees with the admission of or provision or continuation of care for the enrollee by the facility, the health care plan shall initiate an expedited external appeal in accordance with the provisions of paragraph (c) of subdivision two of section forty-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 health care plan and the health care plan shall provide coverage and reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the enrollee's contract. The decision of the external appeal agent shall be binding on all parties. If the health care plan does not initiate an expedited external appeal, the health care plan shall reimburse the facility for services provided subject to the provisions of this section and other limitations otherwise applicable under the enrollee's contract.

4. A health care plan shall provide reimbursement for those services prescribed by this section at rates negotiated between the health care

plan and the facility. In the absence of agreed upon rates, a health care plan 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.

5. Payment by a health care plan pursuant to this section shall be payment in full for the services provided to the enrollee. An acute care facility reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against an enrollee 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 enrollee is responsible under the terms of the applicable contract.

6. No provision of this section shall be construed to require a health care plan to provide coverage for benefits not otherwise covered under the enrollee's contract.