

STATE OF NEW YORK

5044

2017-2018 Regular Sessions

IN SENATE

March 6, 2017

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law, in relation to requirements for collective negotiations by health care providers with certain health benefit plans in certain counties; and providing for the repeal of such provisions upon the expiration thereof

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

1 Section 1. Statement of legislative intent. The legislature finds that
2 collective negotiation by competing health care providers for the terms
3 and conditions of contracts with health plans can result in beneficial
4 results for health care consumers. The legislature further finds
5 instances where health plans dominate the market to such a degree that
6 fair and adequate negotiations between health care providers and the
7 plans are adversely affected, so that it is necessary and appropriate to
8 provide for a demonstration to examine the risks and benefits associated
9 with a system of collective action on behalf of health care providers.
10 Consequently, the legislature finds it appropriate and necessary in the
11 demonstration service area to displace competition with regulation of
12 health plan provider agreements and authorize collective negotiations on
13 the terms and conditions of the relationship between health care plans
14 and health care providers so the imbalances between the two will not
15 result in adverse conditions of health care. This act is not intended to
16 apply to or affect in any respect collective bargaining relationships
17 involving health care providers, as defined in section 4920 of the
18 public health law or rights relating to collective bargaining arising
19 under applicable federal or state collective bargaining statutes.
20 § 2. Short title. This act shall be known and may be cited as the
21 "health care consumer and provider protection act".
22 § 3. Article 49 of the public health law is amended by adding a new
23 title III to read as follows:

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

LBD10367-01-7

TITLE III
COLLECTIVE NEGOTIATIONS BY HEALTH CARE
PROVIDERS WITH HEALTH CARE PLANS

Section 4920. Definitions.

4921. Non-fee related collective negotiation authorized.

4922. Fee related collective negotiation.

4923. Collective negotiation requirements.

4924. Requirements for health care providers' representative.

4925. Certain collective action prohibited.

4926. Fees.

4927. Monitoring of agreements.

4928. Confidentiality.

4929. Severability and construction.

§ 4920. Definitions. For purposes of this title:

1. "Health care plan" means an entity (other than a health care provider) that approves, provides, arranges for or pays for health care services in the demonstration service area, including but not limited to:

(a) a health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to article forty-four of this chapter;

(b) any other organization certified pursuant to article forty-four of this chapter; or

(c) an insurer or corporation subject to the insurance law.

2. "Person" means an individual, association, corporation or any other legal entity.

3. "Health care providers' representative" means a third party who is authorized by health care providers to negotiate on their behalf with health care plans over contractual terms and conditions affecting those health care providers.

4. "Strike" means a work stoppage, in part or in whole, direct or indirect, by a body of workers to gain compliance with demands made on an employer.

5. "Substantial market share in a business line" exists if a health care plan's market share of a business line within the demonstration service area as approved by the commissioner, in consultation with the superintendent of financial services, alone or in combination with the market shares of affiliates, exceeds either ten percent of the total number of covered lives in that service area for such business line or twenty-five thousand lives, or if the commissioner, in consultation with the superintendent of financial services, determines the market share of the insurer in the relevant insurance product and geographic markets for the services of the providers seeking to collectively negotiate significantly exceeds the countervailing market share of the providers acting individually.

6. "Health care provider" means a person who is licensed, certified, or registered pursuant to title eight of the education law and who practices as a health care provider as an independent contractor and/or who is an owner, officer, shareholder, or proprietor of a health care provider in the demonstration service area. A health care provider under title eight of the education law who practices as an employee of a health care provider shall not be deemed a health care provider for purposes of this title.

7. "Demonstration service area" shall include the counties of Nassau and Suffolk.

1 § 4921. Non-fee related collective negotiation authorized. 1. Health
2 care providers practicing within the demonstration service area may meet
3 and communicate for the purpose of collectively negotiating with a
4 health care plan the following terms and conditions of provider
5 contracts with the health care plan:

6 (a) the details of the utilization review plan as defined pursuant to
7 subdivision ten of section forty-nine hundred of this article and
8 subsection (j) of section four thousand nine hundred of the insurance
9 law;

10 (b) coverage provisions; health care benefits; benefit maximums,
11 including benefit limitations; and exclusions of coverage;

12 (c) the definition of medical necessity;

13 (d) the clinical practice guidelines used to make medical necessity
14 and utilization review determinations;

15 (e) preventive care and other medical management practices;

16 (f) drug formularies and standards and procedures for prescribing
17 off-formulary drugs;

18 (g) respective physician liability for the treatment or lack of treat-
19 ment of covered persons;

20 (h) the details of health care plan risk transfer arrangements with
21 providers;

22 (i) plan administrative procedures, including methods and timing of
23 health care provider payment for services;

24 (j) procedures to be utilized to resolve disputes between the health
25 care plan and health care providers;

26 (k) patient referral procedures including, but not limited to, those
27 applicable to out-of-pocket network referrals;

28 (l) the formulation and application of health care provider reimburse-
29 ment procedures;

30 (m) quality assurance programs;

31 (n) the process for rendering utilization review determinations
32 including: establishment of a process for rendering utilization review
33 determinations which shall, at a minimum, include: written procedures to
34 assure that utilization reviews and determinations are conducted within
35 the timeframes established in this article; procedures to notify an
36 enrollee, an enrollee's designee and/or an enrollee's health care
37 provider of adverse determinations; and procedures for appeal of adverse
38 determinations, including the establishment of an expedited appeals
39 process for denials of continued inpatient care or where there is immi-
40 nent or serious threat to the health of the enrollee;

41 (o) health care provider selection and termination criteria used by
42 the health care plan; and

43 (p) rules regarding retrospective audits.

44 2. Nothing in this section shall be construed to allow or authorize an
45 alteration of the terms of the internal and external review procedures
46 set forth in law.

47 3. Nothing in this section shall be construed to allow a strike of a
48 health care plan by health care providers or plans as otherwise set
49 forth in the laws of this state.

50 4. Nothing in this section shall be construed to allow or authorize
51 terms or conditions which would impede the ability of a health care plan
52 to obtain or retain accreditation by the national committee for quality
53 assurance or a similar body.

54 § 4922. Fee related collective negotiation. 1. Health care providers
55 practicing within the demonstration service area may collectively nego-

1 tiate the following terms and conditions relating to that business line
2 with the health care plan:

3 (a) the fees assessed by the health care plan for services, including
4 fees established through the application of reimbursement procedures;

5 (b) the conversion factors used by the health care plan in a
6 resource-based relative value scale reimbursement methodology or other
7 similar methodology; provided the same are not otherwise established by
8 state or federal law or regulation;

9 (c) the amount of any discount granted by the health care plan on the
10 fee of health care services to be rendered by health care providers;

11 (d) the dollar amount of capitation or fixed payment for health
12 services rendered by health care providers to health care plan enrol-
13 lees;

14 (e) the procedure code or other description of a health care service
15 covered by a payment and the appropriate grouping of the procedure
16 codes; or

17 (f) the amount of any other component of the reimbursement methodology
18 for a health care service.

19 2. Nothing in this section shall be deemed to affect or limit the
20 right of a health care provider or group of health care providers to
21 collectively petition a government entity for a change in a law, rule or
22 regulation.

23 § 4923. Collective negotiation requirements. 1. Collective negotiation
24 rights granted by this title shall conform to the following require-
25 ments:

26 (a) health care providers may communicate with other health care
27 providers regarding the contractual terms and conditions to be negoti-
28 ated with a health care plan;

29 (b) health care providers may communicate with health care providers'
30 representatives;

31 (c) a health care providers' representative is the only party author-
32 ized to negotiate with health care plans on behalf of the health care
33 providers as a group;

34 (d) a health care provider can be bound by the terms and conditions
35 negotiated by the health care providers' representatives; and

36 (e) in communicating or negotiating with the health care providers'
37 representative, a health care plan is entitled to contract with or offer
38 different contract terms and conditions to individual competing health
39 care providers.

40 2. A health care providers' representative shall not represent more
41 than thirty percent of the market of health care providers or of a
42 particular health care provider type or specialty practicing in the
43 demonstration service area.

44 3. Nothing in this section shall be construed to prohibit collective
45 action on the part of any health care provider who is a member of a
46 collective bargaining unit recognized pursuant to the national labor
47 relations act.

48 § 4924. Requirements for health care providers' representative. 1.
49 Before engaging in collective negotiations with a health care plan on
50 behalf of health care providers, a health care providers' representative
51 shall file with the commissioner, in the manner prescribed by the
52 commissioner, information identifying the representative, the represen-
53 tative's plan of operation, and the representative's procedures to
54 ensure compliance with this title.

55 2. Before engaging in the collective negotiations, a health care
56 providers' representative shall also submit to the commissioner, for the

1 commissioner's approval, a report identifying the proposed subject
2 matter of the negotiations or discussions with the health care plan and
3 the efficiencies or benefits expected to be achieved through the negoti-
4 ations for both the providers and consumers of health services. The
5 commissioner shall not approve the report if he or she, in consultation
6 with the superintendent of financial services, determines that the
7 proposed negotiations would exceed the authority granted under this
8 title.

9 3. The representative shall supplement the information in the report
10 on a regular basis or as new information becomes available, in the event
11 it changes or will change the subject matter of the negotiations with
12 the health care plan. In no event shall the report be less than every
13 sixty days.

14 4. With the advice of the superintendent of financial services, the
15 commissioner shall approve or disapprove the report not later than the
16 twentieth day after the date on which the report is filed. If disap-
17 proved, the commissioner shall furnish a written explanation of any
18 deficiencies, along with a statement of specific proposals for remedial
19 measures to cure the deficiencies. If the commissioner does not so act
20 within the twenty days, the report shall be deemed approved.

21 5. A person who acts as a health care providers' representative with-
22 out the approval of the commissioner under this section shall be deemed
23 to be acting outside the authority granted under this title.

24 6. Before reporting the results of negotiations with a health care
25 plan, the health care providers' representative shall furnish to the
26 commissioner a copy of all memorandums and meeting minutes pertaining to
27 negotiations in relation to the health care provider.

28 7. A health care providers' representative shall report the end of
29 negotiations to the commissioner not later than the fourteenth day after
30 the date of a health care plan decision declining negotiation, canceling
31 negotiations or failing to respond to a request for negotiation. In such
32 instances, a health care providers' representative may request inter-
33 vention from the commissioner to require the health care plan to partic-
34 ipate in the negotiation pursuant to subdivision eight of this section.

35 8. (a) In the event the commissioner determines that an impasse exists
36 in the negotiations, or in the event a health care plan declines to
37 negotiate, cancels negotiations or fails to respond to a request for
38 negotiation, the commissioner shall render assistance as follows:

39 (i) to assist the parties to effect a voluntary resolution of the
40 negotiations, the commissioner shall appoint a mediator from a list of
41 qualified persons maintained by the commissioner. If the mediator is
42 successful in resolving the impasse, then the health care providers'
43 representative shall proceed as set forth in this article; and

44 (ii) if an impasse continues, the commissioner shall appoint a fact-
45 finding board of not more than three members from a list of qualified
46 persons maintained by the commissioner, which fact-finding board shall
47 have, in addition to the powers delegated to it by the board, the power
48 to make recommendations for the resolution of the dispute.

49 (b) The fact-finding board, acting by a majority of its members, shall
50 transmit its findings of fact and recommendations for resolution of the
51 dispute to the commissioner, and may thereafter assist the parties to
52 effect a voluntary resolution of the dispute. The fact-finding board
53 shall also share its findings of fact and recommendations with the
54 health care providers' representative and the health care plan. If with-
55 in twenty days after the submission of the findings of fact and recom-
56 mendations, the impasse continues, the commissioner shall order a resol-

1 ution to the negotiations based upon the findings of fact and
2 recommendations submitted by the fact-finding board.

3 9. Any proposed agreement between health care providers and a health
4 care plan negotiated pursuant to this title shall be submitted to the
5 commissioner for final approval. The commissioner, with consultation of
6 the superintendent of financial services, shall approve or disapprove
7 the agreement within sixty days of such submission.

8 10. The commissioner may collect information from the department of
9 financial services and other persons to assist in evaluating the impact
10 of the proposed arrangement on the health care marketplace. The commis-
11 sioner shall collect information from health plan companies and health
12 care providers operating in the same geographic area as the health care
13 cooperative.

14 § 4925. Certain collective action prohibited. 1. This title is not
15 intended to authorize competing health care providers to act in concert
16 in response to a report issued by the health care providers' represen-
17 tative related to the representative's discussions or negotiations with
18 health care plans.

19 2. No health care providers' representative shall negotiate any agree-
20 ment that excludes, limits the participation or reimbursement of or
21 otherwise limits the scope of services to be provided by any health care
22 provider or group of health care providers with respect to the perform-
23 ance of services that are within the health care provider's scope of
24 practice, license, registration, or certificate.

25 § 4926. Fees. Each person who acts as the representative or negotiat-
26 ing party under this title, in any given year, shall pay to the depart-
27 ment a fee not to exceed one hundred dollars per represented physician
28 or thirty thousand dollars, whichever is less, to act as a represen-
29 tative.

30 The fees collected pursuant to this section shall be deposited in the
31 state treasury to the credit of the general fund/state operations for
32 the New York state department of health fund.

33 § 4927. Monitoring of agreements. The commissioner shall actively
34 monitor agreements approved under this title to ensure that the agree-
35 ment remains in compliance with the conditions of approval. Upon
36 request, a health care plan or health care provider shall provide infor-
37 mation regarding compliance. The commissioner may revoke an approval
38 upon a finding that the agreement is not in substantial compliance with
39 the terms of the application or the conditions of approval.

40 § 4928. Confidentiality. All reports and other information required to
41 be reported to the department under this title including information
42 obtained by the commissioner pursuant to subdivision ten of section
43 forty-nine hundred twenty-four of this title shall not be subject to
44 disclosure under article six of the public officers law or article thir-
45 ty-one of the civil practice law and rules.

46 § 4929. Severability and construction. The provisions of this title
47 shall be severable, and if any court of competent jurisdiction declares
48 any phrase, clause, sentence or provision of this title to be invalid,
49 or its applicability to any government, agency, person or circumstance
50 is declared invalid, the remainder of this title and its relevant appli-
51 cability shall not be affected. The provisions of this title shall be
52 liberally construed to give effect to the purposes thereof.

53 § 4. The department of health, in consultation with the department of
54 financial services, shall prepare or shall arrange for the preparation
55 of a report on the implementation of the demonstration program on
56 collective negotiation pursuant to title III of article 49 of the public

1 health law. The report shall be submitted to the governor, the speaker
2 of the assembly, the temporary president of the senate and the chairs of
3 the senate and assembly health and insurance committees at least four
4 months prior to the expiration and repeal of this act. The report shall
5 review the extent to which collective negotiations were conducted in the
6 demonstration service area and shall examine whether and the extent to
7 which collective negotiation contributed to the improvement of quality
8 of care for patients, enhanced access to medically necessary care,
9 reduced unnecessary health care expenditures, and was otherwise in the
10 public interest. The report may make recommendations regarding the
11 extension, alteration and/or expansion of the provisions of title III
12 of article 49 of the public health law and make any other recommenda-
13 tions related to the implementation of collective negotiation pursuant
14 to this act.

15 § 5. This act shall take effect on the one hundred twentieth day after
16 it shall have become a law and shall expire and be deemed repealed five
17 years after such date; provided that, effective immediately, the commis-
18 sioner of health is authorized to promulgate any and all rules and regu-
19 lations and take any other measures necessary to implement the
20 provisions of this act on its effective date on or before such date.