

S T A T E O F N E W Y O R K

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I N A S S E M B L Y

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Introduced by M. of A. CANESTRARI, GOTTFRIED, CAHILL, COLTON, JOHN, MAGNARELLI, GALEF, PAULIN, SCHIMEL, FIELDS, LIFTON, CARROZZA, CUSICK, O'DONNELL -- Multi-Sponsored by -- M. of A. ABBATE, AUBRY, BING, BRENNAN, CHRISTENSEN, COOK, CYMBROWITZ, DESTITO, DINOWITZ, ENGLEBRIGHT, GLICK, HEASTIE, HIKIND, HOOPER, JACOBS, KOON, LATIMER, V. LOPEZ, LUPARDO, MAGEE, MARKEY, MCENENY, MENG, MILLMAN, MORELLE, ORTIZ, PHEFFER, PRETLOW, RAIA, SCARBOROUGH, SPANO, SWEENEY, TOWNS, WEINSTEIN, WRIGHT -- read once and referred to the Committee on Health -- reported and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- recommitted to the Committee on Health in accordance with Assembly Rule 3, sec. 2 -- reported and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to requirements for collective negotiations by health care providers with certain health benefit plans

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 system of collective action on behalf of health care
9 providers. Consequently, the legislature finds it appropriate and neces-
10 sary to displace competition with regulation of health plan-provider
11 agreements and authorize collective negotiations on the terms and condi-
12 tions of the relationship between health care plans and health care

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

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1 providers so the imbalances between the two will not result in adverse
2 conditions of health care. This act is not intended to apply to or
3 affect in any respect collective bargaining relationships involving
4 health care providers as defined in section 4920 of the public health
5 law or rights relating to collective bargaining arising under applicable
6 federal or state collective bargaining statutes.

7 S 2. This act shall be known and may be cited as the "health care
8 consumer and provider protection act".

9 S 3. Article 49 of the public health law is amended by adding a new
10 title III to read as follows:

11 TITLE III

12 COLLECTIVE NEGOTIATIONS BY HEALTH CARE

13 PROVIDERS WITH HEALTH CARE PLANS

14 SECTION 4920. DEFINITIONS.

15 4921. NON-FEE RELATED COLLECTIVE NEGOTIATION AUTHORIZED.

16 4922. FEE RELATED COLLECTIVE NEGOTIATION.

17 4923. COLLECTIVE NEGOTIATION REQUIREMENTS.

18 4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE.

19 4925. CERTAIN COLLECTIVE ACTION PROHIBITED.

20 4926. FEES.

21 4927. MONITORING OF AGREEMENTS.

22 4928. CONFIDENTIALITY.

23 4929. SEVERABILITY AND CONSTRUCTION.

24 S 4920. DEFINITIONS. FOR PURPOSES OF THIS TITLE:

25 1. "HEALTH CARE PLAN" MEANS AN ENTITY (OTHER THAN A HEALTH CARE
26 PROVIDER) THAT APPROVES, PROVIDES, ARRANGES FOR, OR PAYS FOR HEALTH CARE
27 SERVICES, INCLUDING BUT NOT LIMITED TO:

28 (A) A HEALTH MAINTENANCE ORGANIZATION LICENSED PURSUANT TO ARTICLE
29 FORTY-THREE OF THE INSURANCE LAW OR CERTIFIED PURSUANT TO ARTICLE
30 FORTY-FOUR OF THIS CHAPTER;

31 (B) ANY OTHER ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF
32 THIS CHAPTER; OR

33 (C) AN INSURER OR CORPORATION SUBJECT TO THE INSURANCE LAW.

34 2. "PERSON" MEANS AN INDIVIDUAL, ASSOCIATION, CORPORATION, OR ANY
35 OTHER LEGAL ENTITY.

36 3. "HEALTH CARE PROVIDERS' REPRESENTATIVE" MEANS A THIRD PARTY WHO IS
37 AUTHORIZED BY HEALTH CARE PROVIDERS TO NEGOTIATE ON THEIR BEHALF WITH
38 HEALTH CARE PLANS OVER CONTRACTUAL TERMS AND CONDITIONS AFFECTING THOSE
39 HEALTH CARE PROVIDERS.

40 4. "STRIKE" MEANS A WORK STOPPAGE IN PART OR IN WHOLE, DIRECT OR INDI-
41 RECT, BY A BODY OF WORKERS TO GAIN COMPLIANCE WITH DEMANDS MADE ON AN
42 EMPLOYER.

43 5. "SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE" EXISTS IF A HEALTH
44 CARE PLAN'S MARKET SHARE OF A BUSINESS LINE WITHIN A SERVICE AREA AS
45 APPROVED BY THE ATTORNEY GENERAL, ALONE OR IN COMBINATION WITH THE
46 MARKET SHARES OF AFFILIATES, EXCEEDS EITHER TEN PERCENT OF THE TOTAL
47 NUMBER OF COVERED LIVES IN THAT SERVICE AREA FOR SUCH BUSINESS LINE OR
48 TWENTY-FIVE THOUSAND LIVES, OR IF THE ATTORNEY GENERAL DETERMINES THE
49 MARKET SHARE OF THE INSURER IN THE RELEVANT INSURANCE PRODUCT AND
50 GEOGRAPHIC MARKETS FOR THE SERVICES OF THE PROVIDERS SEEKING TO COLLEC-
51 TIVELY NEGOTIATE SIGNIFICANTLY EXCEEDS THE COUNTERVAILING MARKET SHARE
52 OF THE PROVIDERS ACTING INDIVIDUALLY.

53 6. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED,
54 OR REGISTERED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW AND WHO PRAC-
55 TICES AS A HEALTH CARE PROVIDER AS AN INDEPENDENT CONTRACTOR AND/OR WHO
56 IS AN OWNER, OFFICER, SHAREHOLDER, OR PROPRIETOR OF A HEALTH CARE

1 PROVIDER. A HEALTH CARE PROVIDER UNDER TITLE EIGHT OF THE EDUCATION LAW
2 WHO PRACTICES AS AN EMPLOYEE OF A HEALTH CARE PROVIDER SHALL NOT BE
3 DEEMED A HEALTH CARE PROVIDER FOR PURPOSES OF THIS TITLE.

4 S 4921. NON-FEE RELATED COLLECTIVE NEGOTIATION AUTHORIZED. 1. HEALTH
5 CARE PROVIDERS PRACTICING WITHIN THE SERVICE AREA OF A HEALTH CARE PLAN
6 MAY MEET AND COMMUNICATE FOR THE PURPOSE OF COLLECTIVELY NEGOTIATING THE
7 FOLLOWING TERMS AND CONDITIONS OF PROVIDER CONTRACTS WITH THE HEALTH
8 CARE PLAN:

9 (A) THE DETAILS OF THE UTILIZATION REVIEW PLAN AS DEFINED PURSUANT TO
10 SUBDIVISION TEN OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE AND
11 SUBSECTION (J) OF SECTION FOUR THOUSAND NINE HUNDRED OF THE INSURANCE
12 LAW;

13 (B) COVERAGE PROVISIONS; HEALTH CARE BENEFITS; BENEFIT MAXIMUMS,
14 INCLUDING BENEFIT LIMITATIONS; AND EXCLUSIONS OF COVERAGE;

15 (C) THE DEFINITION OF MEDICAL NECESSITY;

16 (D) THE CLINICAL PRACTICE GUIDELINES USED TO MAKE MEDICAL NECESSITY
17 AND UTILIZATION REVIEW DETERMINATIONS;

18 (E) PREVENTIVE CARE AND OTHER MEDICAL MANAGEMENT PRACTICES;

19 (F) DRUG FORMULARIES AND STANDARDS AND PROCEDURES FOR PRESCRIBING
20 OFF-FORMULARY DRUGS;

21 (G) RESPECTIVE PHYSICIAN LIABILITY FOR THE TREATMENT OR LACK OF TREAT-
22 MENT OF COVERED PERSONS;

23 (H) THE DETAILS OF HEALTH CARE PLAN RISK TRANSFER ARRANGEMENTS WITH
24 PROVIDERS;

25 (I) PLAN ADMINISTRATIVE PROCEDURES, INCLUDING METHODS AND TIMING OF
26 HEALTH CARE PROVIDER PAYMENT FOR SERVICES;

27 (J) PROCEDURES TO BE UTILIZED TO RESOLVE DISPUTES BETWEEN THE HEALTH
28 CARE PLAN AND HEALTH CARE PROVIDERS;

29 (K) PATIENT REFERRAL PROCEDURES INCLUDING, BUT NOT LIMITED TO, THOSE
30 APPLICABLE TO OUT-OF-POCKET NETWORK REFERRALS;

31 (L) THE FORMULATION AND APPLICATION OF HEALTH CARE PROVIDER REIMBURSE-
32 MENT PROCEDURES;

33 (M) QUALITY ASSURANCE PROGRAMS;

34 (N) THE PROCESS FOR RENDERING UTILIZATION REVIEW DETERMINATIONS
35 INCLUDING: ESTABLISHMENT OF A PROCESS FOR RENDERING UTILIZATION REVIEW
36 DETERMINATIONS WHICH SHALL, AT A MINIMUM, INCLUDE: WRITTEN PROCEDURES TO
37 ASSURE THAT UTILIZATION REVIEWS AND DETERMINATIONS ARE CONDUCTED WITHIN
38 THE TIMEFRAMES ESTABLISHED IN THIS ARTICLE; PROCEDURES TO NOTIFY AN
39 ENROLLEE, AN ENROLLEE'S DESIGNEE AND/OR AN ENROLLEE'S HEALTH CARE
40 PROVIDER OF ADVERSE DETERMINATIONS; AND PROCEDURES FOR APPEAL OF ADVERSE
41 DETERMINATIONS, INCLUDING THE ESTABLISHMENT OF AN EXPEDITED APPEALS
42 PROCESS FOR DENIALS OF CONTINUED INPATIENT CARE OR WHERE THERE IS IMMI-
43 NENT OR SERIOUS THREAT TO THE HEALTH OF THE ENROLLEE; AND

44 (O) HEALTH CARE PROVIDER SELECTION AND TERMINATION CRITERIA USED BY
45 THE HEALTH CARE PLAN.

46 2. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE AN
47 ALTERATION OF THE TERMS OF THE INTERNAL AND EXTERNAL REVIEW PROCEDURES
48 SET FORTH IN LAW.

49 3. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW A STRIKE OF A
50 HEALTH CARE PLAN BY HEALTH CARE PROVIDERS OR PLANS AS OTHERWISE SET
51 FORTH IN THE LAWS OF THIS STATE.

52 4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE
53 TERMS OR CONDITIONS WHICH WOULD IMPEDE THE ABILITY OF A HEALTH CARE PLAN
54 TO OBTAIN OR RETAIN ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY
55 ASSURANCE OR A SIMILAR BODY.

S 4922. FEE RELATED COLLECTIVE NEGOTIATION. 1. IF THE HEALTH CARE PLAN HAS SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE IN ANY SERVICE AREA, HEALTH CARE PROVIDERS PRACTICING WITHIN THAT SERVICE AREA MAY COLLECTIVELY NEGOTIATE THE FOLLOWING TERMS AND CONDITIONS RELATING TO THAT BUSINESS LINE WITH THE HEALTH CARE PLAN:

(A) THE FEES ASSESSED BY THE HEALTH CARE PLAN FOR SERVICES, INCLUDING FEES ESTABLISHED THROUGH THE APPLICATION OF REIMBURSEMENT PROCEDURES;

(B) THE CONVERSION FACTORS USED BY THE HEALTH CARE PLAN IN A RESOURCE-BASED RELATIVE VALUE SCALE REIMBURSEMENT METHODOLOGY OR OTHER SIMILAR METHODOLOGY; PROVIDED THE SAME ARE NOT OTHERWISE ESTABLISHED BY STATE OR FEDERAL LAW OR REGULATION;

(C) THE AMOUNT OF ANY DISCOUNT GRANTED BY THE HEALTH CARE PLAN ON THE FEE OF HEALTH CARE SERVICES TO BE RENDERED BY HEALTH CARE PROVIDERS;

(D) THE DOLLAR AMOUNT OF CAPITATION OR FIXED PAYMENT FOR HEALTH SERVICES RENDERED BY HEALTH CARE PROVIDERS TO HEALTH CARE PLAN ENROLLEES;

(E) THE PROCEDURE CODE OR OTHER DESCRIPTION OF A HEALTH CARE SERVICE COVERED BY A PAYMENT AND THE APPROPRIATE GROUPING OF THE PROCEDURE CODES; OR

(F) THE AMOUNT OF ANY OTHER COMPONENT OF THE REIMBURSEMENT METHODOLOGY FOR A HEALTH CARE SERVICE.

2. NOTHING HEREIN SHALL BE DEEMED TO AFFECT OR LIMIT THE RIGHT OF A HEALTH CARE PROVIDER OR GROUP OF HEALTH CARE PROVIDERS TO COLLECTIVELY PETITION A GOVERNMENT ENTITY FOR A CHANGE IN A LAW, RULE, OR REGULATION.

S 4923. COLLECTIVE NEGOTIATION REQUIREMENTS. 1. COLLECTIVE NEGOTIATION RIGHTS GRANTED BY THIS TITLE MUST CONFORM TO THE FOLLOWING REQUIREMENTS:

(A) HEALTH CARE PROVIDERS MAY COMMUNICATE WITH OTHER HEALTH CARE PROVIDERS REGARDING THE CONTRACTUAL TERMS AND CONDITIONS TO BE NEGOTIATED WITH A HEALTH CARE PLAN;

(B) HEALTH CARE PROVIDERS MAY COMMUNICATE WITH HEALTH CARE PROVIDERS' REPRESENTATIVES;

(C) A HEALTH CARE PROVIDERS' REPRESENTATIVE IS THE ONLY PARTY AUTHORIZED TO NEGOTIATE WITH HEALTH CARE PLANS ON BEHALF OF THE HEALTH CARE PROVIDERS AS A GROUP;

(D) A HEALTH CARE PROVIDER CAN BE BOUND BY THE TERMS AND CONDITIONS NEGOTIATED BY THE HEALTH CARE PROVIDERS' REPRESENTATIVES; AND

(E) IN COMMUNICATING OR NEGOTIATING WITH THE HEALTH CARE PROVIDERS' REPRESENTATIVE, A HEALTH CARE PLAN IS ENTITLED TO CONTRACT WITH OR OFFER DIFFERENT CONTRACT TERMS AND CONDITIONS TO INDIVIDUAL COMPETING HEALTH CARE PROVIDERS.

2. A HEALTH CARE PROVIDERS' REPRESENTATIVE MAY NOT REPRESENT MORE THAN THIRTY PERCENT OF THE MARKET OF HEALTH CARE PROVIDERS OR OF A PARTICULAR HEALTH CARE PROVIDER TYPE OR SPECIALTY PRACTICING IN THE SERVICE AREA OR PROPOSED SERVICE AREA OF A HEALTH CARE PLAN THAT COVERS LESS THAN FIVE PERCENT OF THE ACTUAL NUMBER OF COVERED LIVES OF THE HEALTH CARE PLAN IN THE AREA, AS DETERMINED BY THE DEPARTMENT.

3. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT COLLECTIVE ACTION ON THE PART OF ANY HEALTH CARE PROVIDER WHO IS A MEMBER OF A COLLECTIVE BARGAINING UNIT RECOGNIZED PURSUANT TO THE NATIONAL LABOR RELATIONS ACT.

S 4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE. 1. BEFORE ENGAGING IN COLLECTIVE NEGOTIATIONS WITH A HEALTH CARE PLAN ON BEHALF OF HEALTH CARE PROVIDERS, A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL FILE WITH THE ATTORNEY GENERAL, IN THE MANNER PRESCRIBED BY THE ATTORNEY GENERAL, INFORMATION IDENTIFYING THE REPRESENTATIVE, THE REPRESENTATIVE'S

1 SENTATIVE'S PLAN OF OPERATION, AND THE REPRESENTATIVE'S PROCEDURES TO
2 ENSURE COMPLIANCE WITH THIS TITLE.

3 2. BEFORE ENGAGING IN THE COLLECTIVE NEGOTIATIONS, THE HEALTH CARE
4 PROVIDERS' REPRESENTATIVE SHALL ALSO SUBMIT TO THE ATTORNEY GENERAL FOR
5 THE ATTORNEY GENERAL'S APPROVAL A REPORT IDENTIFYING THE PROPOSED
6 SUBJECT MATTER OF THE NEGOTIATIONS OR DISCUSSIONS WITH THE HEALTH CARE
7 PLAN AND THE EFFICIENCIES OR BENEFITS EXPECTED TO BE ACHIEVED THROUGH
8 THE NEGOTIATIONS FOR BOTH THE PROVIDERS AND CONSUMERS OF HEALTH
9 SERVICES. THE ATTORNEY GENERAL SHALL NOT APPROVE THE REPORT IF THE
10 ATTORNEY GENERAL DETERMINES THAT THE PROPOSED NEGOTIATIONS WOULD EXCEED
11 THE AUTHORITY GRANTED UNDER THIS TITLE.

12 3. THE REPRESENTATIVE SHALL SUPPLEMENT THE INFORMATION IN THE REPORT
13 ON A REGULAR BASIS OR AS NEW INFORMATION BECOMES AVAILABLE, INDICATING
14 THAT THE SUBJECT MATTER OF THE NEGOTIATIONS WITH THE HEALTH CARE PLAN
15 HAS CHANGED OR WILL CHANGE. IN NO EVENT SHALL THE REPORT BE LESS THAN
16 EVERY THIRTY DAYS.

17 4. WITH THE ADVICE OF THE SUPERINTENDENT OF INSURANCE AND THE COMMIS-
18 SIONER, THE ATTORNEY GENERAL SHALL APPROVE OR DISAPPROVE THE REPORT NOT
19 LATER THAN THE TWENTIETH DAY AFTER THE DATE ON WHICH THE REPORT IS
20 FILED. IF DISAPPROVED, THE ATTORNEY GENERAL SHALL FURNISH A WRITTEN
21 EXPLANATION OF ANY DEFICIENCIES, ALONG WITH A STATEMENT OF SPECIFIC
22 PROPOSALS FOR REMEDIAL MEASURES TO CURE THE DEFICIENCIES. IF THE ATTOR-
23 NEY GENERAL DOES NOT SO ACT WITHIN THE TWENTY DAYS, THE REPORT SHALL BE
24 DEEMED APPROVED.

25 5. A PERSON WHO ACTS AS A HEALTH CARE PROVIDERS' REPRESENTATIVE WITH-
26 OUT THE APPROVAL OF THE ATTORNEY GENERAL UNDER THIS SECTION SHALL BE
27 DEEMED TO BE ACTING OUTSIDE THE AUTHORITY GRANTED UNDER THIS TITLE.

28 6. BEFORE REPORTING THE RESULTS OF NEGOTIATIONS WITH A HEALTH CARE
29 PLAN OR PROVIDING TO THE AFFECTED HEALTH CARE PROVIDERS AN EVALUATION OF
30 ANY OFFER MADE BY A HEALTH CARE PLAN, THE HEALTH CARE PROVIDERS' REPRE-
31 SENTATIVE SHALL FURNISH FOR APPROVAL BY THE ATTORNEY GENERAL, BEFORE
32 DISSEMINATION TO THE HEALTH CARE PROVIDERS, A COPY OF ALL COMMUNICATIONS
33 TO BE MADE TO THE HEALTH CARE PROVIDERS RELATED TO NEGOTIATIONS,
34 DISCUSSIONS, AND OFFERS MADE BY THE HEALTH CARE PLAN.

35 7. A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL REPORT THE END OF
36 NEGOTIATIONS TO THE ATTORNEY GENERAL NOT LATER THAN THE FOURTEENTH DAY
37 AFTER THE DATE OF A HEALTH CARE PLAN DECISION DECLINING NEGOTIATION,
38 CANCELING NEGOTIATIONS, OR FAILING TO RESPOND TO A REQUEST FOR NEGOTI-
39 ATION. IN SUCH INSTANCES, A HEALTH CARE PROVIDERS' REPRESENTATIVE MAY
40 REQUEST INTERVENTION FROM THE ATTORNEY GENERAL TO REQUIRE THE HEALTH
41 CARE PLAN TO PARTICIPATE IN THE NEGOTIATION PURSUANT TO SUBDIVISION
42 EIGHT OF THIS SECTION.

43 8. (A) IN THE EVENT THE ATTORNEY GENERAL DETERMINES THAT AN IMPASSE
44 EXISTS IN THE NEGOTIATIONS, OR IN THE EVENT A HEALTH CARE PLAN DECLINES
45 TO NEGOTIATE, CANCELS NEGOTIATIONS OR FAILS TO RESPOND TO A REQUEST FOR
46 NEGOTIATION, THE ATTORNEY GENERAL SHALL RENDER ASSISTANCE AS FOLLOWS:

47 (1) TO ASSIST THE PARTIES TO EFFECT A VOLUNTARY RESOLUTION OF THE
48 NEGOTIATIONS, THE ATTORNEY GENERAL SHALL APPOINT A MEDIATOR FROM A LIST
49 OF QUALIFIED PERSONS MAINTAINED BY THE ATTORNEY GENERAL. IF THE MEDIATOR
50 IS SUCCESSFUL IN RESOLVING THE IMPASSE, THEN THE HEALTH CARE PROVIDERS'
51 REPRESENTATIVE SHALL PROCEED AS SET FORTH IN THIS ARTICLE;

52 (2) IF AN IMPASSE CONTINUES, THE ATTORNEY GENERAL SHALL APPOINT A
53 FACT-FINDING BOARD OF NOT MORE THAN THREE MEMBERS FROM A LIST OF QUALI-
54 FIED PERSONS MAINTAINED BY THE ATTORNEY GENERAL, WHICH FACT-FINDING
55 BOARD SHALL HAVE, IN ADDITION TO THE POWERS DELEGATED TO IT BY THE

1 BOARD, THE POWER TO MAKE RECOMMENDATIONS FOR THE RESOLUTION OF THE
2 DISPUTE;

3 (B) THE FACT-FINDING BOARD, ACTING BY A MAJORITY OF ITS MEMBERS, SHALL
4 TRANSMIT ITS FINDINGS OF FACT AND RECOMMENDATIONS FOR RESOLUTION OF THE
5 DISPUTE TO THE ATTORNEY GENERAL, AND MAY THEREAFTER ASSIST THE PARTIES
6 TO EFFECT A VOLUNTARY RESOLUTION OF THE DISPUTE. THE FACT-FINDING BOARD
7 SHALL ALSO SHARE ITS FINDINGS OF FACT AND RECOMMENDATIONS WITH THE
8 HEALTH CARE PROVIDERS' REPRESENTATIVE AND THE HEALTH CARE PLAN. IF WITH-
9 IN TWENTY DAYS AFTER THE SUBMISSION OF THE FINDINGS OF FACT AND RECOM-
10 MENDATIONS, THE IMPASSE CONTINUES, THE ATTORNEY GENERAL SHALL ORDER A
11 RESOLUTION TO THE NEGOTIATIONS BASED UPON THE FINDINGS OF FACT AND
12 RECOMMENDATIONS SUBMITTED BY THE FACT-FINDING BOARD.

13 9. ANY PROPOSED AGREEMENT BETWEEN HEALTH CARE PROVIDERS AND A HEALTH
14 CARE PLAN NEGOTIATED PURSUANT TO THIS TITLE SHALL BE SUBMITTED TO THE
15 ATTORNEY GENERAL FOR FINAL APPROVAL. THE ATTORNEY GENERAL SHALL APPROVE
16 OR DISAPPROVE THE AGREEMENT WITHIN SIXTY DAYS OF SUCH SUBMISSION.

17 10. THE ATTORNEY GENERAL MAY COLLECT INFORMATION FROM OTHER PERSONS TO
18 ASSIST IN EVALUATING THE IMPACT OF THE PROPOSED ARRANGEMENT ON THE
19 HEALTH CARE MARKETPLACE. THE ATTORNEY GENERAL SHALL COLLECT INFORMATION
20 FROM HEALTH PLAN COMPANIES AND HEALTH CARE PROVIDERS OPERATING IN THE
21 SAME GEOGRAPHIC AREA AS THE HEALTH CARE COOPERATIVE.

22 S 4925. CERTAIN COLLECTIVE ACTION PROHIBITED. 1. THIS TITLE IS NOT
23 INTENDED TO AUTHORIZE COMPETING HEALTH CARE PROVIDERS TO ACT IN CONCERT
24 IN RESPONSE TO A REPORT ISSUED BY THE HEALTH CARE PROVIDERS' REPRESEN-
25 TATIVE RELATED TO THE REPRESENTATIVE'S DISCUSSIONS OR NEGOTIATIONS WITH
26 HEALTH CARE PLANS.

27 2. NO HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL NEGOTIATE ANY AGREE-
28 MENT THAT EXCLUDES, LIMITS THE PARTICIPATION OR REIMBURSEMENT OF, OR
29 OTHERWISE LIMITS THE SCOPE OF SERVICES TO BE PROVIDED BY ANY HEALTH CARE
30 PROVIDER OR GROUP OF HEALTH CARE PROVIDERS WITH RESPECT TO THE PERFORM-
31 ANCE OF SERVICES THAT ARE WITHIN THE HEALTH CARE PROVIDER'S SCOPE OF
32 PRACTICE, LICENSE, REGISTRATION, OR CERTIFICATE.

33 S 4926. FEES. EACH PERSON WHO ACTS AS THE REPRESENTATIVE OR NEGOTIAT-
34 ING PARTIES UNDER THIS TITLE SHALL PAY TO THE DEPARTMENT A FEE TO ACT AS
35 A REPRESENTATIVE. THE ATTORNEY GENERAL, BY RULE, SHALL SET FEES IN
36 AMOUNTS DEEMED REASONABLE AND NECESSARY TO COVER THE COSTS INCURRED BY
37 THE DEPARTMENT IN ADMINISTERING THIS TITLE. ANY FEE COLLECTED UNDER THIS
38 SECTION SHALL BE DEPOSITED IN THE STATE TREASURY TO THE CREDIT OF THE
39 GENERAL FUND/STATE OPERATIONS - 003 FOR THE NEW YORK STATE DEPARTMENT OF
40 HEALTH FUND.

41 S 4927. MONITORING OF AGREEMENTS. THE ATTORNEY GENERAL SHALL ACTIVELY
42 MONITOR AGREEMENTS APPROVED UNDER THIS TITLE TO ENSURE THAT THE AGREE-
43 MENT REMAINS IN COMPLIANCE WITH THE CONDITIONS OF APPROVAL. UPON
44 REQUEST, A HEALTH CARE PLAN OR HEALTH CARE PROVIDER SHALL PROVIDE INFOR-
45 MATION REGARDING COMPLIANCE. THE ATTORNEY GENERAL MAY REVOKE AN APPROVAL
46 UPON A FINDING THAT THE AGREEMENT IS NOT IN SUBSTANTIAL COMPLIANCE WITH
47 THE TERMS OF THE APPLICATION OR THE CONDITIONS OF APPROVAL.

48 S 4928. CONFIDENTIALITY. ALL REPORTS AND OTHER INFORMATION REQUIRED TO
49 BE REPORTED TO THE DEPARTMENT OF LAW UNDER THIS TITLE INCLUDING INFORMA-
50 TION OBTAINED BY THE ATTORNEY GENERAL PURSUANT TO SUBDIVISION TEN OF
51 SECTION FORTY-NINE HUNDRED TWENTY-FOUR OF THIS TITLE SHALL NOT BE
52 SUBJECT TO DISCLOSURE UNDER ARTICLE SIX OF THE PUBLIC OFFICERS LAW OR
53 ARTICLE THIRTY-ONE OF THE CIVIL PRACTICE LAW AND RULES.

54 S 4929. SEVERABILITY AND CONSTRUCTION. THE PROVISIONS OF THIS TITLE
55 SHALL BE SEVERABLE, AND IF ANY COURT OF COMPETENT JURISDICTION DECLARES
56 ANY PHRASE, CLAUSE, SENTENCE OR PROVISION OF THIS TITLE TO BE INVALID,

1 OR ITS APPLICABILITY TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE
2 IS DECLARED INVALID, THE REMAINDER OF THIS TITLE AND ITS RELEVANT APPLI-
3 CABILITY SHALL NOT BE AFFECTED. THE PROVISIONS OF THIS TITLE SHALL BE
4 LIBERALLY CONSTRUED TO GIVE EFFECT TO THE PURPOSES THEREOF.

5 S 4. This act shall take effect on the one hundred twentieth day after
6 it shall have become a law; provided that the commissioner of health is
7 authorized to promulgate any and all rules and regulations and take any
8 other measures necessary to implement this act on its effective date on
9 or before such date.