

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

2474--B

2011-2012 Regular Sessions

I N A S S E M B L Y

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Introduced by M. of A. CANESTRARI, GOTTFRIED, CAHILL, COLTON, MAGNARELLI, GALEF, PAULIN, SCHIMEL, LIFTON, CUSICK, O'DONNELL, P. RIVERA, JAFFEE, WEISENBERG, PERRY, RUSSELL, MARKEY, BRONSON, LANCMAN, ROSENTHAL, KELLNER, LAVINE, THIELE, BENEDETTO, TITONE, BOYLAND, PEOPLES-STOKES, GUNTHER, WEPRIN, ABINANTI, ENGLEBRIGHT, ROBERTS, MAISEL -- Multi-Sponsored by -- M. of A. ABBATE, AUBRY, BOYLE, BRENNAN, BURLING, CALHOUN, CASTELLI, CONTE, COOK, CYMBROWITZ, DINOWITZ, GLICK, HEASTIE, HIKIND, HOOPER, JACOBS, LATIMER, LENTOL, V. LOPEZ, LOSQUADRO, LUPARDO, MAGEE, MALLIOTAKIS, MCENENY, MENG, MILLMAN, MONTESANO, ORTIZ, PRETLOW, RA, RAIA, SCARBOROUGH, SWEENEY, TOBACCO, 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 Ways and Means in accordance with Assembly Rule 3, sec. 2 -- 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 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

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

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1 with a system of collective action on behalf of health care providers.
2 Consequently, the legislature finds it appropriate and necessary in the
3 demonstration service area to displace competition with regulation of
4 health plan-provider agreements and authorize collective negotiations on
5 the terms and conditions of the relationship between health care plans
6 and health care providers so the imbalances between the two will not
7 result in adverse conditions of health care. This act is not intended to
8 apply to or affect in any respect collective bargaining relationships
9 involving health care providers as defined in section 4920 of the public
10 health law or rights relating to collective bargaining arising under
11 applicable federal or state collective bargaining statutes.

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

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

16 TITLE III
17 COLLECTIVE NEGOTIATIONS BY HEALTH CARE
18 PROVIDERS WITH HEALTH CARE PLANS

19 SECTION 4920. DEFINITIONS.

20 4921. NON-FEE RELATED COLLECTIVE NEGOTIATION AUTHORIZED.

21 4922. FEE RELATED COLLECTIVE NEGOTIATION.

22 4923. COLLECTIVE NEGOTIATION REQUIREMENTS.

23 4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE.

24 4925. CERTAIN COLLECTIVE ACTION PROHIBITED.

25 4926. FEES.

26 4927. MONITORING OF AGREEMENTS.

27 4928. CONFIDENTIALITY.

28 4929. SEVERABILITY AND CONSTRUCTION.

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

30 1. "HEALTH CARE PLAN" MEANS AN ENTITY (OTHER THAN A HEALTH CARE
31 PROVIDER) THAT APPROVES, PROVIDES, ARRANGES FOR, OR PAYS FOR HEALTH CARE
32 SERVICES IN THE DEMONSTRATION SERVICE AREA, INCLUDING BUT NOT LIMITED
33 TO:

34 (A) A HEALTH MAINTENANCE ORGANIZATION LICENSED PURSUANT TO ARTICLE
35 FORTY-THREE OF THE INSURANCE LAW OR CERTIFIED PURSUANT TO ARTICLE
36 FORTY-FOUR OF THIS CHAPTER;

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

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

40 2. "PERSON" MEANS AN INDIVIDUAL, ASSOCIATION, CORPORATION, OR ANY
41 OTHER LEGAL ENTITY.

42 3. "HEALTH CARE PROVIDERS' REPRESENTATIVE" MEANS A THIRD PARTY WHO IS
43 AUTHORIZED BY HEALTH CARE PROVIDERS TO NEGOTIATE ON THEIR BEHALF WITH
44 HEALTH CARE PLANS OVER CONTRACTUAL TERMS AND CONDITIONS AFFECTING THOSE
45 HEALTH CARE PROVIDERS.

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

49 5. "SUBSTANTIAL MARKET SHARE IN A BUSINESS LINE" EXISTS IF A HEALTH
50 CARE PLAN'S MARKET SHARE OF A BUSINESS LINE WITHIN THE DEMONSTRATION
51 SERVICE AREA AS APPROVED BY THE COMMISSIONER, IN CONSULTATION WITH THE
52 SUPERINTENDENT OF FINANCIAL SERVICES, ALONE OR IN COMBINATION WITH THE
53 MARKET SHARES OF AFFILIATES, EXCEEDS EITHER TEN PERCENT OF THE TOTAL
54 NUMBER OF COVERED LIVES IN THAT SERVICE AREA FOR SUCH BUSINESS LINE OR
55 TWENTY-FIVE THOUSAND LIVES, OR IF THE COMMISSIONER, IN CONSULTATION WITH
56 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 ALBANY, COLUMBIA, GREENE, ORANGE, RENSSELAER, SARATOGA, SCHENECTADY, SCHOHARIE, ULSTER, WARREN AND WASHINGTON.

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

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

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

(C) THE DEFINITION OF MEDICAL NECESSITY;

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

(E) PREVENTIVE CARE AND OTHER MEDICAL MANAGEMENT PRACTICES;

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

(G) RESPECTIVE PHYSICIAN LIABILITY FOR THE TREATMENT OR LACK OF TREATMENT OF COVERED PERSONS;

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

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

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

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

(L) THE FORMULATION AND APPLICATION OF HEALTH CARE PROVIDER REIMBURSEMENT PROCEDURES;

(M) QUALITY ASSURANCE PROGRAMS;

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

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

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

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

4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE TERMS OR CONDITIONS WHICH WOULD IMPEDE THE ABILITY OF A HEALTH CARE PLAN TO OBTAIN OR RETAIN ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY 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 THE DEMONSTRATION SERVICE AREA, HEALTH CARE PROVIDERS PRACTICING WITHIN THE DEMONSTRATION 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 DEMONSTRATION SERVICE AREA OR PROPOSED SERVICE AREA OF A HEALTH CARE PLAN THAT COVERS

1 LESS THAN FIVE PERCENT OF THE ACTUAL NUMBER OF COVERED LIVES OF THE
2 HEALTH CARE PLAN IN THE DEMONSTRATION SERVICE AREA, AS DETERMINED BY THE
3 DEPARTMENT.

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

8 S 4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE. 1.
9 BEFORE ENGAGING IN COLLECTIVE NEGOTIATIONS WITH A HEALTH CARE PLAN ON
10 BEHALF OF HEALTH CARE PROVIDERS, A HEALTH CARE PROVIDERS' REPRESENTATIVE
11 SHALL FILE WITH THE COMMISSIONER, IN THE MANNER PRESCRIBED BY THE
12 COMMISSIONER, INFORMATION IDENTIFYING THE REPRESENTATIVE, THE REPRESENTATIVE'S
13 PLAN OF OPERATION, AND THE REPRESENTATIVE'S PROCEDURES TO
14 ENSURE COMPLIANCE WITH THIS TITLE.

15 2. BEFORE ENGAGING IN THE COLLECTIVE NEGOTIATIONS, THE HEALTH CARE
16 PROVIDERS' REPRESENTATIVE SHALL ALSO SUBMIT TO THE COMMISSIONER FOR THE
17 COMMISSIONER'S APPROVAL A REPORT IDENTIFYING THE PROPOSED SUBJECT MATTER
18 OF THE NEGOTIATIONS OR DISCUSSIONS WITH THE HEALTH CARE PLAN AND THE
19 EFFICIENCIES OR BENEFITS EXPECTED TO BE ACHIEVED THROUGH THE NEGOTI-
20 ATIONS FOR BOTH THE PROVIDERS AND CONSUMERS OF HEALTH SERVICES. THE
21 COMMISSIONER SHALL NOT APPROVE THE REPORT IF THE COMMISSIONER, IN
22 CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, DETERMINES
23 THAT THE PROPOSED NEGOTIATIONS WOULD EXCEED THE AUTHORITY GRANTED UNDER
24 THIS TITLE.

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

30 4. WITH THE ADVICE OF THE SUPERINTENDENT OF FINANCIAL SERVICES, THE
31 COMMISSIONER SHALL APPROVE OR DISAPPROVE THE REPORT NOT LATER THAN THE
32 TWENTIETH DAY AFTER THE DATE ON WHICH THE REPORT IS FILED. IF DISAP-
33 PROVED, THE COMMISSIONER SHALL FURNISH A WRITTEN EXPLANATION OF ANY
34 DEFICIENCIES, ALONG WITH A STATEMENT OF SPECIFIC PROPOSALS FOR REMEDIAL
35 MEASURES TO CURE THE DEFICIENCIES. IF THE COMMISSIONER DOES NOT SO ACT
36 WITHIN THE TWENTY DAYS, THE REPORT SHALL BE DEEMED APPROVED.

37 5. A PERSON WHO ACTS AS A HEALTH CARE PROVIDERS' REPRESENTATIVE WITH-
38 OUT THE APPROVAL OF THE COMMISSIONER UNDER THIS SECTION SHALL BE DEEMED
39 TO BE ACTING OUTSIDE THE AUTHORITY GRANTED UNDER THIS TITLE.

40 6. BEFORE REPORTING THE RESULTS OF NEGOTIATIONS WITH A HEALTH CARE
41 PLAN OR PROVIDING TO THE AFFECTED HEALTH CARE PROVIDERS AN EVALUATION OF
42 ANY OFFER MADE BY A HEALTH CARE PLAN, THE HEALTH CARE PROVIDERS' REPRESENTATIVE
43 SHALL FURNISH FOR APPROVAL BY THE COMMISSIONER, BEFORE DISSEMINATION
44 TO THE HEALTH CARE PROVIDERS, A COPY OF ALL COMMUNICATIONS TO BE
45 MADE TO THE HEALTH CARE PROVIDERS RELATED TO NEGOTIATIONS, DISCUSSIONS,
46 AND OFFERS MADE BY THE HEALTH CARE PLAN.

47 7. A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL REPORT THE END OF
48 NEGOTIATIONS TO THE COMMISSIONER NOT LATER THAN THE FOURTEENTH DAY AFTER
49 THE DATE OF A HEALTH CARE PLAN DECISION DECLINING NEGOTIATION, CANCELING
50 NEGOTIATIONS, OR FAILING TO RESPOND TO A REQUEST FOR NEGOTIATION. IN
51 SUCH INSTANCES, A HEALTH CARE PROVIDERS' REPRESENTATIVE MAY REQUEST
52 INTERVENTION FROM THE COMMISSIONER TO REQUIRE THE HEALTH CARE PLAN TO
53 PARTICIPATE IN THE NEGOTIATION PURSUANT TO SUBDIVISION EIGHT OF THIS
54 SECTION.

55 8. (A) IN THE EVENT THE COMMISSIONER DETERMINES THAT AN IMPASSE EXISTS
56 IN THE NEGOTIATIONS, OR IN THE EVENT A HEALTH CARE PLAN DECLINES TO

1 NEGOTIATE, CANCELS NEGOTIATIONS OR FAILS TO RESPOND TO A REQUEST FOR
2 NEGOTIATION, THE COMMISSIONER SHALL RENDER ASSISTANCE AS FOLLOWS:

3 (1) TO ASSIST THE PARTIES TO EFFECT A VOLUNTARY RESOLUTION OF THE
4 NEGOTIATIONS, THE COMMISSIONER SHALL APPOINT A MEDIATOR FROM A LIST OF
5 QUALIFIED PERSONS MAINTAINED BY THE COMMISSIONER. IF THE MEDIATOR IS
6 SUCCESSFUL IN RESOLVING THE IMPASSE, THEN THE HEALTH CARE PROVIDERS'
7 REPRESENTATIVE SHALL PROCEED AS SET FORTH IN THIS ARTICLE;

8 (2) IF AN IMPASSE CONTINUES, THE COMMISSIONER SHALL APPOINT A
9 FACT-FINDING BOARD OF NOT MORE THAN THREE MEMBERS FROM A LIST OF QUALI-
10 FIED PERSONS MAINTAINED BY THE COMMISSIONER, WHICH FACT-FINDING BOARD
11 SHALL HAVE, IN ADDITION TO THE POWERS DELEGATED TO IT BY THE BOARD, THE
12 POWER TO MAKE RECOMMENDATIONS FOR THE RESOLUTION OF THE DISPUTE;

13 (B) THE FACT-FINDING BOARD, ACTING BY A MAJORITY OF ITS MEMBERS, SHALL
14 TRANSMIT ITS FINDINGS OF FACT AND RECOMMENDATIONS FOR RESOLUTION OF THE
15 DISPUTE TO THE COMMISSIONER, AND MAY THEREAFTER ASSIST THE PARTIES TO
16 EFFECT A VOLUNTARY RESOLUTION OF THE DISPUTE. THE FACT-FINDING BOARD
17 SHALL ALSO SHARE ITS FINDINGS OF FACT AND RECOMMENDATIONS WITH THE
18 HEALTH CARE PROVIDERS' REPRESENTATIVE AND THE HEALTH CARE PLAN. IF WITH-
19 IN TWENTY DAYS AFTER THE SUBMISSION OF THE FINDINGS OF FACT AND RECOM-
20 MENDATIONS, THE IMPASSE CONTINUES, THE COMMISSIONER SHALL ORDER A RESOL-
21 UTION TO THE NEGOTIATIONS BASED UPON THE FINDINGS OF FACT AND
22 RECOMMENDATIONS SUBMITTED BY THE FACT-FINDING BOARD.

23 9. ANY PROPOSED AGREEMENT BETWEEN HEALTH CARE PROVIDERS AND A HEALTH
24 CARE PLAN NEGOTIATED PURSUANT TO THIS TITLE SHALL BE SUBMITTED TO THE
25 COMMISSIONER FOR FINAL APPROVAL. THE COMMISSIONER SHALL APPROVE OR
26 DISAPPROVE THE AGREEMENT WITHIN SIXTY DAYS OF SUCH SUBMISSION. THE
27 COMMISSIONER, AFTER CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL
28 SERVICES SHALL DISAPPROVE THE AGREEMENT IF HE OR SHE FINDS THAT THE
29 AGREEMENT WOULD RESULT IN A SIGNIFICANT INCREASE IN COSTS TO THE MEDI-
30 CAID MANAGED CARE PROGRAM PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J
31 OF THE SOCIAL SERVICES LAW, THE FAMILY HEALTH PLUS PROGRAM PURSUANT TO
32 SECTION THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW, OR THE
33 CHILD HEALTH PLUS PROGRAM PURSUANT TO SECTION TWENTY-FIVE HUNDRED ELEVEN
34 OF THE PUBLIC HEALTH LAW.

35 10. THE COMMISSIONER MAY COLLECT INFORMATION FROM THE DEPARTMENT OF
36 FINANCIAL SERVICES AND OTHER PERSONS TO ASSIST IN EVALUATING THE IMPACT
37 OF THE PROPOSED ARRANGEMENT ON THE HEALTH CARE MARKETPLACE. THE COMMIS-
38 SIONER SHALL COLLECT INFORMATION FROM HEALTH PLAN COMPANIES AND HEALTH
39 CARE PROVIDERS OPERATING IN THE SAME GEOGRAPHIC AREA AS THE HEALTH CARE
40 COOPERATIVE.

41 S 4925. CERTAIN COLLECTIVE ACTION PROHIBITED. 1. THIS TITLE IS NOT
42 INTENDED TO AUTHORIZE COMPETING HEALTH CARE PROVIDERS TO ACT IN CONCERT
43 IN RESPONSE TO A REPORT ISSUED BY THE HEALTH CARE PROVIDERS' REPRESEN-
44 TATIVE RELATED TO THE REPRESENTATIVE'S DISCUSSIONS OR NEGOTIATIONS WITH
45 HEALTH CARE PLANS.

46 2. NO HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL NEGOTIATE ANY AGREE-
47 MENT THAT EXCLUDES, LIMITS THE PARTICIPATION OR REIMBURSEMENT OF, OR
48 OTHERWISE LIMITS THE SCOPE OF SERVICES TO BE PROVIDED BY ANY HEALTH CARE
49 PROVIDER OR GROUP OF HEALTH CARE PROVIDERS WITH RESPECT TO THE PERFORM-
50 ANCE OF SERVICES THAT ARE WITHIN THE HEALTH CARE PROVIDER'S SCOPE OF
51 PRACTICE, LICENSE, REGISTRATION, OR CERTIFICATE.

52 S 4926. FEES. EACH PERSON WHO ACTS AS THE REPRESENTATIVE OR NEGOTIAT-
53 ING PARTIES UNDER THIS TITLE SHALL PAY TO THE DEPARTMENT A FEE TO ACT AS
54 A REPRESENTATIVE. THE COMMISSIONER, BY RULE, SHALL SET FEES IN AMOUNTS
55 DEEMED REASONABLE AND NECESSARY TO COVER THE COSTS INCURRED BY THE
56 DEPARTMENT IN ADMINISTERING THIS TITLE. ANY FEE COLLECTED UNDER THIS

SECTION SHALL BE DEPOSITED IN THE STATE TREASURY TO THE CREDIT OF THE GENERAL FUND/STATE OPERATIONS - 003 FOR THE NEW YORK STATE DEPARTMENT OF HEALTH FUND.

S 4927. MONITORING OF AGREEMENTS. THE COMMISSIONER SHALL ACTIVELY MONITOR AGREEMENTS APPROVED UNDER THIS TITLE TO ENSURE THAT THE AGREEMENT REMAINS IN COMPLIANCE WITH THE CONDITIONS OF APPROVAL. UPON REQUEST, A HEALTH CARE PLAN OR HEALTH CARE PROVIDER SHALL PROVIDE INFORMATION REGARDING COMPLIANCE. THE COMMISSIONER MAY REVOKE AN APPROVAL UPON A FINDING THAT THE AGREEMENT IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE TERMS OF THE APPLICATION OR THE CONDITIONS OF APPROVAL.

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

S 4929. SEVERABILITY AND CONSTRUCTION. THE PROVISIONS OF THIS TITLE SHALL BE SEVERABLE, AND IF ANY COURT OF COMPETENT JURISDICTION DECLARES ANY PHRASE, CLAUSE, SENTENCE OR PROVISION OF THIS TITLE TO BE INVALID, OR ITS APPLICABILITY TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE IS DECLARED INVALID, THE REMAINDER OF THIS TITLE AND ITS RELEVANT APPLICABILITY SHALL NOT BE AFFECTED. THE PROVISIONS OF THIS TITLE SHALL BE LIBERALLY CONSTRUED TO GIVE EFFECT TO THE PURPOSES THEREOF.

S 4. The department of health, in consultation with the department of financial services, shall prepare or shall arrange for the preparation of a report on the implementation of the demonstration program on collective negotiation. The report shall be submitted to the governor, the speaker of the assembly, the temporary president of the senate and the chairs of the senate and assembly health and insurance committees at least four months prior to the expiration of this act. The report shall review the extent to which collective negotiations were conducted in the demonstration service area and shall examine whether and the extent to which collective negotiation contributed to the improvement of quality of care for patients, enhanced access to medically necessary care, reduced unnecessary health care expenditures, and was otherwise in the public interest. The report may make recommendations regarding the extension, alteration and/or expansion of these provisions and make any other recommendations related to the implementation of collective negotiation pursuant to this act.

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