STATE OF NEW YORK

4681

2019-2020 Regular Sessions

IN ASSEMBLY

February 5, 2019

Introduced by M. of A. PRETLOW -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to the health care consumer and provider protection and equity act

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

Section 1. The insurance law is amended by adding a new article 57 to read as follows:

ARTICLE 57
HEALTH CARE CONSUMER AND PROVIDER PROTECTION
AND EQUITY ACT

Section 5701. Legislative findings.
5702. Collective action by competing physicians.
5703. Application for hearing.
5704. Fee for registration of authorized third parties.
5705. Regulations.
5706. Good faith negotiations.
5707. Prohibition of collective cessation of services.
5708. No interference with other statutory rights.
5709. Definitions.

§ 5701. Legislative findings. The legislature finds and declares that:

(a) Under the McCarran-Ferguson act of 1945, 15 U.S.C. § 1011, et seq., insurance companies are exempt from federal anti-trust laws that otherwise apply to most other businesses;

(b) Active, robust and fully competitive markets for health care and dental services provide the best opportunity for the residents of this state to receive high-quality health care and dental services at an appropriate cost;

(c) A substantial amount of health care and dental services in this state is purchased for the benefit of patients by health and dental insurance carriers engaged in the financing of health care and dental

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

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services or is otherwise delivered subject to the terms of agreements between carriers and physicians and dentists;

(d) Carriers are able to control the flow of patients to physicians and dentists through compelling financial incentives for patients in their health and dental benefits plans to utilize only the services of physicians and dentists with whom the carriers have contracted;

(e) Carriers also control the health care and dental services rendered to patients through utilization management and other managed care tools and associated coverage and payment policies;

(f) Carriers are often able to virtually dictate the terms of the contracts that they offer physicians and dentists and commonly offer these contracts on a take-it-or-leave-it basis;

(g) The power of carriers to unilaterally impose provider contract terms jeopardizes the ability of physicians and dentists to deliver the superior quality health care and dental services traditionally available in this state;

(h) Physicians and dentists do not have sufficient market power to reject unfair provider contract terms offered by carriers that impede their ability to deliver medically appropriate care without undue delay or difficulties;

(i) Inadequate reimbursement and other unfair payment terms offered by carriers adversely affect the quality of patient care and access to care by reducing the resources that physicians and dentists can devote to patient care and decreasing the time that physicians and dentists are able to spend with their patients;

(j) Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical progress by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and expansion of medical services, all to the detriment of the residents of this state;

(k) The inevitable collateral reduction and migration of the health care work force will also have negative consequences for the economy of this state;

(l) Empowering independent physicians and dentists to jointly negotiate with carriers as provided in this article will help restore the competitive balance and improve competition in the markets for health care and dental services in this state, thereby providing benefits for consumers, physicians and dentists and less dominant carriers;

(m) This article is necessary and proper, and constitutes an appropriate exercise of the authority of this state to regulate the business of insurance and the delivery of health care and dental services;

(n) The pro-competitive and other benefits of the joint negotiations and related joint activity authorized by this article, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical progress, and improving communications, outweigh any potential anti-competitive effects of this article; and

(o) It is the intention of the legislature to authorize independent physicians and dentists to jointly negotiate with carriers and to qualify such joint negotiations and related joint activities for the state-action exemption to the federal antitrust laws through the articulated state policy and active supervision provided under this article.

§ 5702. Collective action by competing physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate

with a health benefit plan concerning any of the contract terms and conditions described in this subsection, but may not negotiate the exclusion of providers who are non-physicians from direct reimbursement by a health benefit plan, and may not negotiate the setting in which providers who are non-physicians deliver services. Competing physicians may not engage in a boycott related to these terms and conditions. Competing physicians may meet and communicate concerning:

(1) physician clinical practice guidelines and coverage criteria;

(2) the respective liability of physicians and the health benefit plan for the treatment or lack of treatment of insured or enrolled persons;

(3) administrative procedures, including methods and timing of the payment of services to physicians;

(4) procedures for the resolution of disputes between the health benefit plan and physicians;

(5) patient referral procedures;

(6) the formulation and application of reimbursement methodology;

(7) quality assurance programs;

(8) health service utilization review procedures; and

(9) criteria to be used by health benefit plans for the selection and termination of physicians, including whether to engage in selective contracting.

(b) An authorized third party that intends to negotiate with a health benefit plan the items identified under subsection (a) of this section shall provide the independent review panel, as established by subsection (c) of this section, with written notice of the intended negotiations before the negotiations begin.

(c) The independent review panel shall consist of three members:

(1) The attorney general, or his or her designee who shall have particular expertise in the area of antitrust law;

(2) The state commissioner of health, or his or her designee; and

(3) The state commissioner of labor, or his or her designee.

(d) In exercising the collective rights granted by subsection (a) of this section:

(1) physicians may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan;

(2) physicians may communicate with an authorized third party regarding the terms and conditions of contracts allowed under this section;

(3) the authorized third party is the sole party authorized to negotiate with a health benefit plan on behalf of a defined group of physicians;

(4) physicians can be bound by the terms and conditions negotiated by the authorized third party that represents their interests;

(5) a health benefit plan communicating or negotiating with the authorized third party may contract with, or offer different contract terms and conditions to, individual competing physicians;

(6) an authorized third party may not represent more than thirty percent of the market of practicing physicians for the provision of services in the geographic service area or proposed geographic service area, if the health benefit plan has less than a five percent market share as determined by the number of covered lives as reported by the superintendent of the insurance department for the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services; in this paragraph, "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(7) the independent review panel may limit the percentage of practicing physicians represented by an authorized third party; however, the limitation may not be less than thirty percent of the market of practicing physicians in the geographic service area or proposed geographic service area; when determining whether to impose a limitation described under this paragraph, the attorney general shall consider the provisions described under subsections (f), (g) and (h) of this section; this paragraph does not apply if the market of practicing physicians in the geographic service area or proposed geographic service area consists of forty or fewer individuals; and

(8) the authorized third party shall comply with the provisions of subsection (e) of this section.

(e) A person acting or proposing to act as an authorized third party under this section shall:

(1) Before engaging in collective negotiations with a health benefit plan:

(A) file with the independent review panel the information that identifies the authorized third party, the physicians represented by the third party, the authorized third party's plan of operation, and the authorized third party's procedures to ensure compliance with this section;

(B) furnish to the independent review panel for its approval, a brief report that identifies the proposed subject matter of the negotiations or discussions with a health benefit plan and that contains an explanation of the efficiencies or benefits that are expected to be achieved through the collective negotiations, product and geographic market definition, current price levels, availability of substitutes, and ease of entry for new competing physicians;

(C) the panel shall review whether the group of physicians represented by the authorized third party is appropriate to represent the interests involved in the negotiations; the panel may not approve the report if the group of physicians is not appropriate to represent the interests involved in the negotiations or if the proposed negotiations exceed the authority granted in this chapter and, if the group is not appropriate or the negotiations exceed the granted authority, shall provide written notice prohibiting the collective negotiations from proceeding, at which time the proposed authorized third party may request a hearing pursuant to section five thousand seven hundred three of this article;

(D) the authorized third party shall provide supplemental information to the panel as new information becomes available that indicates that the subject matter of negotiations with the health benefit plan has changed or will change; the panel may, as it deems appropriate, request additional information in order to assess the likely competitive effects of negotiation; the panel may also solicit input from other physicians, affected health plans, and patients regarding the potential competitive effects of negotiations;

(E) within fourteen days after receiving a health benefit plan's decision to decline to negotiate or to terminate negotiations, or within fourteen days after requesting negotiations with a health benefit plan that fails to respond within that time, report to the attorney general that negotiations have ended or have been declined;

(2) While negotiating with a health benefit plan:

(A) provide the independent review panel, upon the independent review panel's request, with copies of all written communications that are relevant to the negotiations, that are in the possession of the authorized third party, and that are between:

i. physicians and the health benefit plan,
ii. physicians and authorized third parties,
iii. authorized third parties and health plans,
iv. the individual physicians, and
v. authorized third parties;

(B) before reporting the results of negotiations with a health benefit plan and before giving physicians an evaluation of any offer made by a health benefit plan, provide to the independent review panel for its approval, a copy of all communications to be made to physicians related to the negotiations, discussion, and health benefit plan offers.

(3) Must be an organization that represents both consumers and providers of health care.

(f) The independent review panel shall either approve or disapprove the contract that was the subject of the collective negotiation within sixty days after receiving the reports required under subsection (d) of this section. If the contract is disapproved, the independent review panel shall furnish a written explanation. Upon disapproval, the independent review panel shall denote any deficiencies along with a statement of specific remedial measures that would correct any identified deficiencies. An authorized third party who fails to obtain the independent review panel's approval is considered to be acting outside the authority of this section.

(g) The independent review panel shall approve a collective negotiation contract if:

(1) the competitive and other benefits of the contract terms outweigh any anticompetitive effects; and

(2) the contract terms are consistent with other applicable laws and regulations.

(h) The competitive and other benefits of joint negotiations or negotiated provider contract terms must include:

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

(i) When weighing the anticompetitive effects of contract terms, the independent review panel shall consider whether the terms:

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services.

(j) This section does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the authorized third party's discussion or negotiations with a health benefit plan. The authorized third party shall advise the physicians of the provisions of this subsection and shall warn them of the potential for legal action against those who violate state or federal antitrust laws by exceeding the authority granted under this section.

(k) A contract allowed under this section may not exceed a term of five years.

(l) The documents relating to a collective negotiation described under this section that are in the possession of the department of law are confidential and not open to public inspection.

(m) Nothing in this section shall be construed as exempting from the application of the antitrust laws the conduct of providers or negoti-

ations or agreements between providers and a health benefit plan if the purpose or effect of the conduct, negotiations, or agreements would be, directly or indirectly, to exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by separate or competing classes of providers who practice or seek to practice within the scope of the occupational licenses held by the providers.

(n) In this section, "geographic service area" means the geographic area of the physicians seeking to jointly negotiate.

§ 5703. Application for hearing. (a) Within thirty days from the mailing by the independent review panel of the notice of disapproval of an application by a proposed authorized third party representative under subsection (e) of section five thousand seven hundred two of this article, said representative may make a written application to the independent review panel for a hearing, the sole purpose of which would be to review the independent review panel's disapproval.

(b) Upon receipt of a timely application for a hearing, the independent review panel shall schedule and conduct an administrative hearing. The hearing shall be held within thirty days of the application unless the representative seeks an extension.

(c) The independent review panel shall appoint a neutral hearing officer to preside over the hearing.

§ 5704. Fee for registration of authorized third parties. (a) The independent review panel shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The independent review panel shall establish the fee level so that the total amount of fees collected from authorized third parties approximately equals the actual regulatory costs for the oversight of joint negotiations between physicians and health benefit plans. The independent review panel shall annually review the fee level to determine whether the regulatory costs are approximately equal to fee collections. If the review indicates that the fee collections and regulatory costs are not approximately equal, the independent review panel shall calculate fee adjustments and adopt regulations under this subsection to implement the adjustments. In January of each year, the independent review panel shall report on the fee level and revisions for the previous year under this subsection to the office of management and budget.

(b) In this section, "regulatory costs" means costs of the independent review panel that are attributable to oversight of joint negotiations between physicians and health benefit plans.

§ 5705. Regulations. The attorney general may promulgate any rules and regulations necessary to implement this article.

§ 5706. Good faith negotiations. A health benefit plan and an authorized third party shall negotiate in good faith regarding the terms and conditions of physician or dentist contracts pursuant to this article.

§ 5707. Prohibition of collective cessation of services. The provisions of this article shall not be construed to permit two or more physicians or dentists to jointly engage in a coordinated cessation, reduction or limitation of the health care or dental services they provide.

§ 5708. No interference with other statutory rights. The provisions of this article shall not affect the collective bargaining rights an individual provider may otherwise have pursuant to the National Labor Relations Act, 29 U.S.C. § 151, et seq.; New York state public employ-

ees' fair employment act (article fourteen of the civil service law); or any other statute.

§ 5709. Definitions. In this article:

(a) "authorized third party" means a person authorized by the physicians to negotiate on their behalf with a health benefit plan under this chapter; and

(b) "health benefit plan" means a health care insurer subject to article thirty-two or forty-three of this chapter, or any organization licensed under article forty-three of this chapter, but does not include a self-insured health benefit plan.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law.