STATE OF NEW YORK

8169

2021-2022 Regular Sessions

IN ASSEMBLY

July 7, 2021

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

AN ACT to amend the insurance law and the public health law, in relation to certain prohibited contract provisions

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

Section 1. Section 3217-b of the insurance law is amended by adding a new subsection (m) to read as follows:

(m) (1) No insurer that offers a managed care product or a comprehensive policy that utilizes a network of providers shall enter into a contract, written policy, written procedure or agreement (hereinafter and solely for purposes of this subsection collectively referred to as a "contract") with any health care provider that:

(A) requires the insurer to include within the scope of the contract all covered groups of the insurer, including groups or benefit funds that contract with the insurer, or an affiliate of the insurer, for access to the insurer's network of participating providers;

(B) requires an insurer to include all members of a provider system, including medical practice groups and affiliated facilities, in its network of participating providers;

(C) requires an insurer, or an affiliate of an insurer, to include all members of a provider system, including medical practice groups and affiliated facilities, in all products offered by the insurer or an affiliate of the insurer;

(D) restricts the ability of an insurer to create or modify a tiered network benefit plan or requires an insurer to place all members of a provider system, including medical practice groups and affiliated facilities, in the same network tier or otherwise limits the right of an insurer to place a provider in a particular tier;

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

LBD11774-01-1

(E) prohibits insurers from using benefit designs, including wellness programs and other benefits, to encourage members to seek services from value-based health care providers;

(F) contains a most-favored-nation provision; provided, however, nothing in this section shall be construed to prohibit a health insurer and a provider from negotiating payment rates and performance-based contract terms that would result in the insurer receiving a rate that is as favorable, or more favorable, than the rates negotiated between a health care provider and another entity; or

(G) restricts the ability of the insurer to disclose price or quality information, including the allowed amount, negotiated rates or discounts, or any other claim-related financial obligations covered by the provider contract to any enrollee, group or other entity receiving health care services pursuant to the contract.

(2) Beginning January first, two thousand twenty-two, any contract, written policy, written procedure or agreement that contains a clause contrary to the provisions set forth in this section shall be null and void; provided, however, the remaining clauses of the contract shall remain in effect for the duration of the contract term.

§ 2. Section 4406 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. (a) No health maintenance organization that offers a managed care product or a comprehensive policy that utilizes a network of providers shall enter into a contract, written policy, written procedure or agreement with any health care provider that:

(i) requires the insurer to include within the scope of the contract all covered groups of the insurer, including groups or benefit funds that contract with the insurer, or an affiliate of the insurer, for access to the insurer's network of participating providers;

(ii) requires an insurer to include all members of a provider system, including medical practice groups and affiliated facilities, in its network of participating providers;

(iii) requires an insurer, or an affiliate of an insurer, to include all members of a provider system, including medical practice groups and affiliated facilities, in all products offered by the insurer or an affiliate of the insurer;

(iv) restricts the ability of an insurer to create or modify a tiered network benefit plan or requires an insurer to place all members of a provider system, including medical practice groups and affiliated facilities, in the same network tier or otherwise limits the right of an insurer to place a provider in a particular tier;

(v) prohibits insurers from using benefit designs, including wellness programs and other benefits, to encourage members to seek services from value-based health care providers;

(vi) contains a most-favored-nation provision; provided, however, nothing in this section shall be construed to prohibit a health insurer and a provider from negotiating payment rates and performance-based contract terms that would result in the insurer receiving a rate that is as favorable, or more favorable, than the rates negotiated between a health care provider and another entity; or

(vii) restricts the ability of the insurer to disclose price or quality information, including the allowed amount, negotiated rates or discounts, or any other claim-related financial obligations covered by the provider contract to any enrollee, group or other entity receiving health care services pursuant to the contract.

(b) After January first, two thousand twenty-two, any contract, written policy, written procedure or agreement that contains a clause contrary to the provisions set forth in this section shall be null and void; provided, however, the remaining clauses of the contract shall remain in effect for the duration of the contract term.

§ 3. This act shall take effect January 1, 2022.