

STATE OF NEW YORK

3395

2023-2024 Regular Sessions

IN ASSEMBLY

February 3, 2023

Introduced by M. of A. PRETLOW, COLTON, WEPRIN, MAGNARELLI, BRONSON, L. ROSENTHAL, LAVINE, THIELE, BENEDETTO, PEOPLES-STOKES -- Multi-Sponsored by -- M. of A. AUBRY, COOK, DINOWITZ, GLICK, LUPARDO, RA -- read once and referred 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 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 public
18 health law or rights relating to collective bargaining arising under
19 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".

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

LBD08161-01-3

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

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.

1 7. "Demonstration service area" shall include the counties of Albany,
2 Columbia, Greene, Orange, Rensselaer, Saratoga, Schenectady, Schoharie,
3 Ulster, Warren and Washington.

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

1 § 4922. Fee related collective negotiation. 1. If the health care plan
2 has substantial market share in a business line in the demonstration
3 service area, health care providers practicing within the demonstration
4 service area may collectively negotiate the following terms and condi-
5 tions relating to that business line with the health care plan:

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

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

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

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

17 (e) the procedure code or other description of a health care service
18 covered by a payment and the appropriate grouping of the procedure
19 codes; or

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

22 2. Nothing herein shall be deemed to affect or limit the right of a
23 health care provider or group of health care providers to collectively
24 petition a government entity for a change in a law, rule, or regulation.

25 § 4923. Collective negotiation requirements. 1. Collective negotiation
26 rights granted by this title must conform to the following requirements:

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

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

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

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

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

41 2. A health care providers' representative may not represent more than
42 thirty percent of the market of health care providers or of a particular
43 health care provider type or specialty practicing in the demonstration
44 service area or proposed service area of a health care plan that covers
45 less than five percent of the actual number of covered lives of the
46 health care plan in the demonstration service area, as determined by the
47 department.

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

52 § 4924. Requirements for health care providers' representative. 1.
53 Before engaging in collective negotiations with a health care plan on
54 behalf of health care providers, a health care providers' representative
55 shall file with the commissioner, in the manner prescribed by the
56 commissioner, information identifying the representative, the represen-

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

13 3. The representative shall supplement the information in the report
14 on a regular basis or as new information becomes available, indicating
15 that the subject matter of the negotiations with the health care plan
16 has changed or will change. In no event shall the report be less than
17 every thirty days.

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

25 5. A person who acts as a health care providers' representative with-
26 out the approval of the commissioner under this section shall be deemed
27 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 commissioner, before dissem-
32 ination to the health care providers, a copy of all communications to be
33 made to the health care providers related to negotiations, discussions,
34 and offers made by the health care plan.

35 7. A health care providers' representative shall report the end of
36 negotiations to the commissioner not later than the fourteenth day after
37 the date of a health care plan decision declining negotiation, canceling
38 negotiations, or failing to respond to a request for negotiation. In
39 such instances, a health care providers' representative may request
40 intervention from the commissioner to require the health care plan to
41 participate in the negotiation pursuant to subdivision eight of this
42 section.

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

47 (1) to assist the parties to effect a voluntary resolution of the
48 negotiations, the commissioner shall appoint a mediator from a list of
49 qualified persons maintained by the commissioner. If the mediator is
50 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 commissioner shall appoint a fact-
53 finding board of not more than three members from a list of qualified
54 persons maintained by the commissioner, which fact-finding board shall
55 have, in addition to the powers delegated to it by the board, the power
56 to make recommendations for the resolution of the dispute;

(b) The fact-finding board, acting by a majority of its members, shall transmit its findings of fact and recommendations for resolution of the dispute to the commissioner, and may thereafter assist the parties to effect a voluntary resolution of the dispute. The fact-finding board shall also share its findings of fact and recommendations with the health care providers' representative and the health care plan. If within twenty days after the submission of the findings of fact and recommendations, the impasse continues, the commissioner shall order a resolution to the negotiations based upon the findings of fact and recommendations submitted by the fact-finding board.

9. Any proposed agreement between health care providers and a health care plan negotiated pursuant to this title shall be submitted to the commissioner for final approval. The commissioner shall approve or disapprove the agreement within sixty days of such submission. The commissioner, after consultation with the superintendent of financial services shall disapprove the agreement if he or she finds that the agreement would result in a significant increase in costs to the Medicaid managed care program pursuant to section three hundred sixty-four-j of the social services law, the family health plus program pursuant to section three hundred sixty-nine-gg of the social services law, or the child health plus program pursuant to section twenty-five hundred eleven of this chapter.

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

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

2. No health care providers' representative shall negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

§ 4926. Fees. Each person who acts as the representative or negotiating parties under this title shall pay to the department a fee to act as a representative. The commissioner, by rule, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the 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 for the New York state department of health fund.

§ 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.

§ 4928. Confidentiality. All reports and other information required to be reported to the department under this title including information

1 obtained by the commissioner pursuant to subdivision ten of section
2 forty-nine hundred twenty-four of this title shall not be subject to
3 disclosure under article six of the public officers law or article thir-
4 ty-one of the civil practice law and rules.

5 § 4929. Severability and construction. The provisions of this title
6 shall be severable, and if any court of competent jurisdiction declares
7 any phrase, clause, sentence or provision of this title to be invalid,
8 or its applicability to any government, agency, person or circumstance
9 is declared invalid, the remainder of this title and its relevant appli-
10 cability shall not be affected. The provisions of this title shall be
11 liberally construed to give effect to the purposes thereof.

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

28 § 5. This act shall take effect on the one hundred twentieth day after
29 it shall have become a law and shall expire and be deemed repealed three
30 years after it shall take effect. Effective immediately, the addition,
31 amendment and/or repeal of any rule or regulation necessary for the
32 implementation of this act on its effective date are authorized to be
33 made and completed on or before such effective date.