STATE OF NEW YORK

1915--A

2025-2026 Regular Sessions

IN ASSEMBLY

January 14, 2025

Introduced by M. of A. PAULIN, WEPRIN, HEVESI, REYES, SIMONE, BICHOTTE HERMELYN, LUNSFORD -- read once and referred to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the social services law, in relation to primary care investment

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 section 3217-k to read as follows:

§ 3217-k. Primary care spending. (a) Definitions. As used in this section, the following terms shall have the following meanings:

(1) "Overall healthcare spending" means the total cost of care for the patient population of a payor or provider entity for a given calendar year, where cost is calculated for such year as the sum of (A) all claims-based spending paid to providers by public and private payors and (B) all non-claim payments for such year, including, but not limited to, incentive payments and care coordination payments.

(2) "Plan or payor" means every insurance entity providing managed care products, individual comprehensive accident and health insurance or group or blanket comprehensive accident and health insurance, as defined in this chapter, corporation organized under article forty-three of this chapter providing comprehensive health insurance, entity licensed under article forty-four of this chapter providing comprehensive health insurance, every other plan over which the department has jurisdiction, and every third-party payor providing health coverage.

(3) "Primary care" means integrated, accessible healthcare, provided by clinicians accountable for addressing most of a patient's healthcare needs including (A) developing a sustained partnership with patients; (B) practicing in the context of family and community; and (C) coordinating patients' care, which for the purposes of this section shall only

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

LBD04789-04-5

include care coordination efforts undertaken by the clinicians rendering healthcare services to a patient and shall not include separate care coordination activities undertaken by a payor.

(4) "Primary care services" means services provided in an outpatient, non-emergency setting by or under the supervision of a physician, nurse practitioner, physician assistant, or midwife, who is practicing general primary care in the following fields, including as evidenced by billing and reporting codes: family practice; general pediatrics; primary care internal medicine; primary care obstetrics; or primary care gynecology. Behavioral or mental health and substance use disorder services are included in primary care services when integrated into a primary care setting, including when provided by a behavioral healthcare psychiatrist, social worker or psychologist. Primary care services shall not include inpatient services, emergency department services, ambulatory surgical center services, or services provided in an urgent care setting that are billed with non-primary care billing and reporting codes.

(5) "Primary care spending" means any expenditure of funds made by third party payors, public entities, or the state, for the purpose of paying for primary care services directly or paying to improve the delivery of primary care. Primary care spending includes all payment methods, such as fee-for-service, capitation, incentives, value-based payments or other methodologies, and all non-claim payments including but not limited to incentive payments and care coordination payments. For payees that own and/or operate facilities, entities, or other providers, such as health systems or hospital systems, that provide other medical services in addition to primary care, only those funds that are separately documented as funds designated for primary care services shall be considered primary care spending. Any spending shall be adjusted appropriately to exclude any portion of the expenditure that is reasonably attributed to inpatient services or other non-primary care services.

(b) Reporting. (1) Beginning on April first, two thousand twenty-six, each plan or payor as defined in this section shall annually report to the department the percentage of the plan or payor's overall annual healthcare spending that constituted primary care spending.

(2) Nothing herein shall require any plan or payor to report or publicly disclose any specific rates of reimbursement for any specific primary care services.

(3) No plan or payor shall require any healthcare provider to provide additional data or information in order to fulfill this reporting requirement.

(c) Regulation and publication. (1) The commissioner of health and the superintendent shall each promulgate consistent regulations to carry out the provisions of this section, including but not limited to setting deadlines for the reporting required in this section, and adopting further specific definitions of the primary care services for which costs must be reported under this section, including specific billing and reporting codes.

(2) The department of health and the department shall together provide an annual report to the legislature with a summary of the primary care spending data required in this section, and shall also make the report publicly available on both agencies' websites, no later than three months after the data has been collected. The first annual report shall provide the spending information without identifying any individual payor or plan's primary care spending. Each year thereafter, the report

spending data shall be published including information specific to each plan or payor.

(d) Primary care spending. (1) Beginning on April first, two thousand twenty-seven, each plan or payor that reports less than twelve and one-half percent of its total expenditures on physical and mental health is primary care spending, as defined by this section, shall additionally submit to the superintendent a plan to increase primary care spending as a percentage of its total overall healthcare spending by at least one percent each year. Beginning on April first, two thousand twenty-eight and on April first of every subsequent year after such plan has been submitted, and until such time as the plan or payor's reported primary care spending is equal to or more than twelve and one-half percent of that plan or payor's overall healthcare spending, the plan or payor's annual reporting shall include information regarding steps that have been taken to increase its proportion of primary care spending.

(2) The commissioner of health and the superintendent may jointly issue guidelines or promulgate regulations regarding the areas on which primary care spending could be increased, including but not limited to:

(A) reimbursement;

(B) capacity-building, technical assistance and training;

(C) upgrading technology, including electronic health record systems and telehealth capabilities;

(D) incentive payments, including but not limited to per-member-per-month, value-based-payment arrangements, shared savings, quality-based payments, risk-based payments; and

(E) transitioning to value-based-payment arrangements.

(e) Limits on premium increases. Plans or payors shall adopt strategies that improve value and quality of care and shift current spending without increasing total medical expenditures. Spending shifts resulting from compliance with this section shall not result in higher premiums or cost-sharing requirements for insured individuals.

§ 2. The social services law is amended by adding a new section 368-g to read as follows:

§ 368-g. Primary care spending. 1. Definitions. As used in this section the terms "overall healthcare spending", "plan or payor", "primary care", "primary care services" and "primary care spending" shall have the same meanings as such terms are defined in section thirty-two hundred seventeen-k of the insurance law.

2. Reporting. (a) Beginning on April first, two thousand twenty-six, each Medicaid managed care provider under section three hundred sixty-four-j of this title and any payor that provides coverage through Medicaid fee-for-service, as such term is defined in paragraph (e) of subdivision thirty-eight of section two of this chapter, shall annually report to the department the percentage of the provider's overall annual healthcare spending that constituted primary care spending.

(b) Nothing herein shall require any Medicaid managed care provider to report or publicly disclose any specific rates of reimbursement for any specific primary care services.

(c) No Medicaid managed care provider shall require any healthcare provider to provide additional data or information in order to fulfill this reporting requirement.

3. Primary care spending. (a) Beginning on April first, two thousand twenty-seven, and in each subsequent year, each Medicaid managed care provider under section three hundred sixty-four-j of this title and any payor that provides coverage through Medicaid fee-for-service, as such term is defined in paragraph (e) of subdivision thirty-eight of section

two of this chapter, that reports less than twelve and one-half percent of its total expenditures on physical and mental health are on primary care spending shall additionally submit to the commissioner a plan to increase primary care spending as a percentage of its total overall healthcare spending by at least one percent each year. Beginning on April first, two thousand twenty-eight, and in each subsequent year thereafter, until twelve and one-half percent of that provider or payor's expenditures are on primary care spending, the payor or provider's annual reporting under this section shall include information on steps that have been taken to increase their proportion of primary care spending.

(b) The commissioner and the superintendent of financial services may jointly issue guidelines or promulgate regulations regarding the areas on which spending could be increased, including but not limited to:

(i) reimbursement;

(ii) capacity-building, technical assistance and training;

(iii) upgrading technology, including electronic health record systems and telehealth capabilities;

(iv) incentive payments, including but not limited to per-member-per-month, value-based-payment arrangements, shared savings, quality-based payments, risk-based payments; and

(v) transitioning to value-based-payment arrangements.

(c) The provisions of this section are subject to compliance with all applicable federal and state laws and regulations, including the Centers for Medicare and Medicaid Services approved Medicaid state plan. To the extent required by federal law, the commissioner shall seek any federal approvals necessary to implement this section, including, but not limited to, any state-directed payments, permissions, state plan amendments or federal waivers by the federal Centers for Medicare and Medicaid Services. The commissioner may also apply for appropriate waivers or state directed payments under federal law and regulation or take other actions to secure federal financial participation to assist in promoting the objectives of this section.

4. Limits on cost increases. Plans or payors shall adopt strategies that improve value and quality of care and shift current spending without increasing total medical expenditures.

§ 3. This act shall take effect immediately.