

STATE OF NEW YORK

2140

2025-2026 Regular Sessions

IN ASSEMBLY

January 15, 2025

Introduced by M. of A. JACKSON -- read once and referred to the Committee on Health

AN ACT to amend the public health law, in relation to fair pricing for low-complexity, routine medical care

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

1 Section 1. Section 2830 of the public health law, as added by chapter
2 764 of the laws of 2022, is renumbered section 2832 and a new section
3 2833 is added to read as follows:

4 § 2833. Fair pricing for certain services. 1. As used in this section:

5 (a) "Applicable services" means outpatient or ambulatory items or
6 services that can safely be provided across ambulatory care settings;
7 including:

8 (i) any outpatient or ambulatory item or service recommended or
9 required to be paid on a site-neutral basis by federal or New York stat-
10 ute, the U.S. Department of Health & Human Services, or the Medicare
11 Payment Advisory Commission (MedPAC), including without limitation, the
12 sixty-six ambulatory payment classifications (APCs) identified by MedPAC
13 in its June 2023 Report to Congress and any subsequent APCs or services
14 so designated;

15 (ii) the evaluation and management office visit codes identified by
16 MedPAC in its March 2012 report, which are indicated by Current Proce-
17 dural Terminology codes 99201 through 99215, and any additional office
18 visit Evaluation and Management Services or preventative wellness visit
19 codes, such as G0463, or any other codes so designated under the Health-
20 care Common Procedure Coding System (HCPCS) or Current Procedural Termi-
21 nology (CPT) coding systems; and

22 (iii) any other outpatient or ambulatory items or services as desig-
23 nated by the commissioner or superintendent as safe and appropriate to
24 be provided in lower-cost settings in accordance with the provisions of
25 this section.

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

LBD02527-01-5

1 (b) "Health benefit plan" means a plan, policy, contract, certificate,
2 or agreement entered into, offered, or issued by a health insurance
3 carrier or third-party administrator acting on behalf of a plan sponsor
4 to provide, deliver, arrange for, pay for, or reimburse any of the costs
5 of health care services and includes nonfederal governmental plans as
6 defined in 29 U.S.C. § 1002(32). Health benefit plan does not include
7 any plans, programs of coverage, or benefits administered under 42
8 U.S.C. § 1395 et seq. (Medicare).

9 (c) "Plan sponsor" means:

10 (i) the employer in the case of a benefit plan established or main-
11 tained by a single employer;

12 (ii) the employee organization in the case of a benefit plan estab-
13 lished or maintained by an employee organization, provided that "employ-
14 ee organization" shall mean any labor union or any organization of any
15 kind, or any agency or employee representation committee, association,
16 group, or plan, in which employees participate and that exists for the
17 purpose, in whole or in part, of dealing with employers concerning an
18 employee benefit plan, or other matters incidental to employment
19 relationships, or any employees' beneficiary association organized for
20 the purpose in whole or in part, of establishing such a plan; or

21 (iii) in the case of a benefit plan established or maintained by two
22 or more employers or jointly by one or more employers and one or more
23 employee organizations, the association, committee, joint board of trus-
24 tees, or other similar group of representatives of the parties who
25 establish or maintain the benefit plan.

26 (d) "Health care contract" means a contract, agreement, or understand-
27 ing, either orally or in writing, entered into, amended, restated, or
28 renewed between a health care provider and a health insurance carrier,
29 one or more third-party administrators, a plan sponsor or its contrac-
30 tors or agents for the delivery of health care services to an enrollee
31 of a health benefit plan.

32 (e) (i) "Health care provider" means an individual, entity, corpo-
33 ration, person, or organization, whether for profit or nonprofit, oper-
34 ating under this article, article thirty-one of this chapter or the
35 education law, that furnishes, bills or is paid for health care service
36 delivery in the normal course of business, and includes hospitals,
37 hospital extension clinics, diagnostic and treatment centers, physician
38 offices, or urgent care clinics. It shall also include any affiliated
39 provider or entity acting on the health care provider's or affiliated
40 provider's behalf.

41 (ii) "Health care provider" shall not include any of the following:

42 (A) any facility that is eligible to be designated or has received a
43 designation as a federally qualified health center in accordance with 42
44 USC § 1396a(aa), as amended, or any successor law thereto, including
45 those facilities that are also licensed under article thirty-one or
46 article thirty-two of the mental hygiene law;

47 (B) a public hospital, which for purposes of this subdivision, shall
48 mean a general hospital operated by a county, municipality or a public
49 benefit corporation;

50 (C) a federally designated critical access hospital;

51 (D) a federally designated sole community hospital;

52 (E) a rural emergency hospital; or

53 (F) a general hospital that is a safety net hospital, which for
54 purposes of this subdivision shall mean a private, financially
55 distressed hospital that serves at least forty-five percent Medicaid and
56 uninsured payor mix. To be considered financially distressed, the hospi-

1 tal must have an average operating margin that is less than or equal to
2 zero percent over the past four calendar years of available data based
3 on audited Hospital Institutional Cost Reports.

4 (f) "Affiliated provider" means a provider that is billing for medical
5 goods or services that were delivered at a facility that is:

6 (i) employed by the health care provider;

7 (ii) under a professional services agreement with the health care
8 provider; or

9 (iii) a clinical faculty member of a medical school or other school
10 that trains individuals to be providers and that is affiliated with the
11 health care provider.

12 (g) "Health insurance carrier" means an entity licensed under articles
13 thirty-two and forty-three of the insurance law or article forty-four of
14 this chapter and subject to the insurance laws and regulations of this
15 state or subject to the jurisdiction of the commissioner or the super-
16 intendent of financial services that offers health insurance, health
17 benefits, or contracts for health care services, prescription drug
18 coverage, to large groups, small groups, or individuals on or outside
19 the NY State of Health, The official Health Plan Marketplace, including
20 the Essential Plan.

21 (h) "Health system" means:

22 (i) a parent corporation of one or more hospitals and any entity
23 affiliated with such parent corporation through ownership, governance,
24 membership or other means; or

25 (ii) a hospital and any entity affiliated with such hospital through
26 ownership, governance, membership or other means.

27 (i) "Hospital-based facility" means a facility that is owned or oper-
28 ated, in whole or in part, by a hospital where hospital or professional
29 medical services are provided, including without limitation, an outpa-
30 tient department of the hospital.

31 (j) "Participating provider" means a provider under contract with a
32 health benefit plan, or one of its delegates, who has agreed under such
33 contract to provide health care services to the health benefit plan's
34 beneficiaries with an expectation of receiving payment, other than coin-
35 surance, copayments, or deductibles from the beneficiary, only from the
36 health care entity under the terms of the contract.

37 (k) "Site-neutral payment policy" means the policy of reimbursing
38 health care providers the same amount for a similar service, regardless
39 of the site or setting of the service.

40 (l) "Superintendent" means the superintendent of financial services.

41 (m) "Third-party administrator" means a health plan administrator who
42 acts on behalf of a plan sponsor to administer a health benefit plan.

43 2. (a) All health care providers that enter into a health care
44 contract to be a participating provider with any health benefit plan
45 must offer to accept as payment in full for all applicable services,
46 rates that shall not exceed one hundred fifty percent of the amount paid
47 by Medicare for those same services.

48 (b) No health care provider shall charge, bill, or accept payment for
49 any applicable services that exceeds the lesser of: (i) one hundred
50 fifty percent of the amount paid by Medicare; or (ii) the negotiated
51 rate agreed upon by the health care provider and the health benefit
52 plan. This provision applies for all individuals and entities that reim-
53 burse for applicable services, including self-pay individuals and health
54 benefit plans that do not have an existing contract with the health care
55 provider.

1 (c) No health care provider shall charge, bill, or collect a facility
2 fee for any applicable services.

3 3. All health care contracts entered into with health care providers
4 shall include the following provisions:

5 (a) that the health benefit plan shall not reimburse a health care
6 provider for any applicable services in amounts in excess of the rates
7 set forth in subdivision two of this section or for facility fees
8 prohibited by paragraph (c) of subdivision two of this section; and

9 (b) that no beneficiary or self-pay individual shall be liable to any
10 health care provider for any amounts in excess of the rates set forth in
11 subdivision two of this section or for facility fees prohibited by para-
12 graph (c) of subdivision two of this section, including any copayments,
13 deductibles and/or coinsurance for any portion of such prohibited rates.

14 4. (a) The department shall collect and compile all available and
15 relevant hospital, health system, and payer-reported data, including
16 Transparency in Coverage data pursuant to 85 FR 72158, Hospital Price
17 Transparency data pursuant to 84 FR 65602, the all payor database (APD),
18 the state planning and research cooperative system (SPARCS), and/or
19 other publicly available data sources on pricing and utilization of the
20 applicable services.

21 (b) The department has the authority to request additional data
22 reports from health care providers annually as needed to efficiently and
23 fully report on pricing and utilization trends of the applicable
24 services, and shall request and compile additional data as needed. The
25 reports shall be in such format as the department may specify.

26 (c) The department shall publish the information on a publicly-acces-
27 sible website, in addition to ensuring integration into the APD, with
28 rates for applicable services charged, billed, and allowed during the
29 preceding calendar year, broken down by site of service and contract.

30 5. (a) Each health insurance carrier shall submit a report annually to
31 the superintendent concerning rates for applicable services agreed to,
32 paid, or allowed, during the preceding calendar year, broken down by
33 site of service and contract. The report shall be in such format as the
34 superintendent shall specify. The superintendent shall publish the
35 information reported on a publicly-accessible website designated by the
36 superintendent.

37 (b) Commencing one year after the effective date of this section and
38 every year thereafter, the commissioner and the superintendent shall
39 submit a joint report to the governor, the temporary president of the
40 senate, the speaker of the assembly, the minority leader of the senate
41 and the minority leader of the assembly that summarizes for the preced-
42 ing calendar year: (i) multi-year trends and annual calculations of
43 total spending; (ii) average rates charged and allowed relative to Medi-
44 care rates; (iii) utilization rates; and (iv) service volumes for appli-
45 cable services subject to the site-neutral payment policy set forth in
46 this section broken down by health care provider, site of service, and
47 payer. The report shall also include any instances of non-compliance
48 and actions taken and an estimate of savings for payers and consumers
49 compared with rates charged for applicable services in the contract year
50 immediately prior to the effective date of this section inflated to
51 current dollars.

52 6. (a) (i) A health care provider that violates any provision of this
53 section or any of the rules and regulations adopted pursuant hereto
54 shall be subject to an administrative penalty in an amount which is the
55 greater of one thousand dollars per claim improperly billed or a minimum

1 statutory penalty of one hundred thousand dollars per contract occur-
2 rence.

3 (ii) The department or its designee may audit any health care provider
4 for compliance with the requirements of this section. Until the expira-
5 tion of four years after the furnishing of any services for which a
6 facility fee was charged, billed, or collected, each health care provid-
7 er shall make available, upon written request of the department or its
8 designee, copies of any books, documents, records, or data that are
9 necessary for the purposes of completing the audit.

10 (iii) The department may refer any health care provider subject to
11 this section to the attorney general to review the contract for compli-
12 ance with this section.

13 (b) (i) All records and papers of health insurance carriers pertaining
14 to health benefit plans or negotiations between the health insurance
15 carrier and any health care provider shall be subject to inspection by
16 the superintendent or by any agent the superintendent may designate for
17 that purpose.

18 (ii) The superintendent may require any health insurance carrier to
19 produce a list or copies of all health care contracts, transactions, or
20 pricing arrangements entered into within the preceding twelve months.

21 (iii) The superintendent may impose upon a health insurance carrier an
22 administrative penalty of up to fifty thousand dollars per day for each
23 day that a contract in violation of subdivision three of this section is
24 in effect.

25 (iv) The superintendent may, under section three thousand two hundred
26 thirty-one of the insurance law, disapprove of health care contract
27 between a health insurance carrier and any health care provider that is
28 in violation of subdivision three of this section.

29 (v) The superintendent may refer any health care contract subject to
30 this section to the attorney general to review the contract for compli-
31 ance with this section. The referral of any health care contract by the
32 superintendent to the attorney general does not constitute a violation
33 of any confidentiality agreement between the health insurance carrier
34 and the superintendent that may exist under paragraph one of subsection
35 (b) of section three thousand two hundred one of the insurance law.

36 (c) Any violation of this section shall constitute an unlawful decep-
37 tive act or practice under section three hundred forty-nine of the
38 general business law. Any person who suffers a loss as a result of a
39 violation of this section shall be entitled to initiate an action and
40 seek all remedies, damages, costs, and fees available under subdivision
41 (h) of section three hundred forty-nine of the general business law.

42 7. The commissioner and the superintendent shall promulgate joint
43 regulations necessary to implement this section, specify the format and
44 content of reports, and the department shall impose penalties for non-
45 compliance consistent with the department's authority to regulate health
46 care providers and health insurers. The commissioner and the super-
47 intendent shall have the discretion to add additional services based on
48 additional ambulatory payment classifications (APCs) or services desig-
49 nated, any additional office visit Evaluation and Management Services or
50 preventative wellness visit codes, or any other codes so designated
51 under the Healthcare Common Procedure Coding System (HCPCS) or Current
52 Procedural Terminology (CPT) coding systems identified by the Medicare
53 Payment Advisory Commission (MedPAC), through processes such as notice-
54 and-comment rulemaking, technical advisory panels, or other processes to
55 gain community and expert input.

1 § 2. Severability. If any clause, sentence, paragraph, subdivision,
2 section or part of this act shall be adjudged by any court of competent
3 jurisdiction to be invalid, such judgment shall not affect, impair, or
4 invalidate the remainder thereof, but shall be confined in its operation
5 to the clause, sentence, paragraph, subdivision, section or part thereof
6 directly involved in the controversy in which such judgment shall have
7 been rendered. It is hereby declared to be the intent of the legislature
8 that this act would have been enacted even if such invalid provisions
9 had not been included herein.

10 § 3. This act shall take effect immediately.