STATE OF NEW YORK

2140--B

2025-2026 Regular Sessions

IN ASSEMBLY

January 15, 2025

Introduced by M. of A. JACKSON, LASHER, GONZALEZ-ROJAS, SIMON, SIMONE, MEEKS, DINOWITZ, CRUZ, BORES, ROSENTHAL, KELLES, STECK, FORREST, BURROUGHS, GLICK, TAPIA, PHEFFER AMATO, BICHOTTE HERMELYN, TORRES, KASSAY, LAVINE, GALLAGHER, YEGER, R. CARROLL, RAGA, TAYLOR, WIEDER, VALDEZ, LEVENBERG, SHIMSKY, ZINERMAN, DE LOS SANTOS, BURDICK, WRIGHT, DILAN, RAJKUMAR, HOOKS, SEPTIMO, P. CARROLL, COLTON, ROZIC, HEVESI, LEE, CUNNINGHAM, SHRESTHA, MORENO, CLARK, O'PHARROW, ANDERSON, McDONALD, STIRPE -- read once and referred to the Committee on Health -- recommitted to the Committee on Health in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

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

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

Section 1. Section 2830 of the public health law, as added by chapter 764 of the laws of 2022, is renumbered section 2833 and a new section 2834 is added to read as follows:

§ 2834. Fair pricing for certain services. 1. As used in this section:

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

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

(i) any outpatient or ambulatory item or service paid by medicare on a site-neutral basis, such as services paid exclusively through non-hospi-

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

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tal fee schedules or paid at a rate set to match with a non-hospital fee schedule rate; or

(ii) the services, identified by healthcare common procedure coding system (HCPCS) codes, contained within the sixty-six ambulatory payment classifications (APCs) identified by the medicare payment advisory commission (MedPAC) in its June two thousand twenty-three report to congress and any subsequent services MedPAC recommends for site-neutral payment policy.

(c) (i) "Health care provider" means an individual, entity, corporation, person, or organization, whether for profit or nonprofit, authorized to practice or holding an operating certificate, registration, or certification under title VIII of the education law, article twenty-eight, thirty-one, or forty-seven of this chapter, or article thirty-one or thirty-two of the mental hygiene law that furnishes, bills or is paid for health care service delivery in the normal course of business, and includes, but is not limited to, hospitals, hospital extension clinics, diagnostic and treatment centers, physician offices, and clinical laboratories. It shall also include any affiliated provider or entity acting on the health care provider's or affiliated provider's behalf.

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

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

(B) a diagnostic and treatment center whose patient population is over fifty percent combined patients enrolled in Medicaid or uninsured and that is a sub-recipient of federal Title X Family Planning funding as of April twenty-eighth, two thousand twenty-six;

(C) an enhanced safety net hospital, as defined in subdivision thirty-four of section twenty-eight hundred seven-c of this article;

(D) a general hospital that is a distressed safety net hospital, which for purposes of this subdivision shall mean a private, financially distressed hospital that serves at least forty-five percent Medicaid and uninsured payor mix and has an average operating margin that is less than or equal to zero percent over the past four calendar years of available data based on audited hospital institutional cost reports; or

(E) a PPS-exempt cancer hospital under medicare. A public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county, municipality or a public benefit corporation.

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

(i) employed by the health care provider;

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

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

(e) "Health benefit plan" means a plan, policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance carrier, plan sponsor, or third-party administrator acting on behalf of a plan sponsor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services and includes all plans administered by an insurer, health maintenance organization, corporation or plan authorized, licensed or certified under article thirty-two, forty-

two, forty-three, forty-four, or forty-seven of the insurance law, or article forty-four or section twenty-five hundred eleven of this chapter. Health benefit plan does not include any plans, programs of coverage, or benefits administered under 42 U.S.C. § 1395 et seq. (Medicare).

(f) "Plan sponsor" means:

(i) the employer in the case of a benefit plan established or maintained by a single employer;

(ii) the employee organization in the case of a benefit plan established or maintained by an employee organization, provided that "employee organization" shall mean any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and that exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships, or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan; or

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

(g) "Health care contract" means a contract, agreement, or understanding, either orally or in writing, entered into, amended, restated, or renewed between a health care provider and a health insurance carrier, one or more third-party administrators, a plan sponsor or its contractors or agents for the delivery of health care services to an enrollee of a health benefit plan.

(h) "Medicare non-hospital rate" means the amount paid by medicare for those same services pursuant to the appropriate non-hospital medicare fee schedule, such as the medicare physician fee schedule, set forth under 42 U.S.C. § 1395w-4, or the ambulatory surgical center (ASC) payment system, set forth under 42 U.S.C. § 1395l(i)(2)(D), according to the site of service recommended by MedPAC as the reference rate where applicable.

2. (a) No health care provider shall charge, bill, or accept payment for any applicable services that exceeds the lesser of: (i) one hundred fifty percent of the medicare non-hospital rate; or (ii) the negotiated rate agreed upon by the health care provider and the health benefit plan. This provision applies regardless of whether the health care provider has an existing contract with the payor, including self-pay individuals.

(b) No health care provider shall charge, bill, or collect, or otherwise demand payment for any applicable service on an institutional claim form when a professional claim form is appropriate to be filed for the same service. In no circumstance should both a professional claim and an institutional claim be charged or billed for the same service.

(c) All health care providers that enter into a health care contract to be a participating provider with a health benefit plan, must offer to accept as payment in full for all applicable services, rates that shall not exceed one hundred fifty percent of the medicare non-hospital rate.

(d) No beneficiary or self-pay individual shall be liable to any health care provider for any amounts in excess of the rates set forth in this subdivision or for claims, charges, or bills prohibited by paragraph (b) of this subdivision, including any copayments, deductibles and/or coinsurance for any portion of such prohibited rates.

3. (a) Commencing one year after the effective date of this section, the department, in consultation with the superintendent, shall publish on a publicly accessible website an annual report on multi-year spending trends and cost drivers for ambulatory services, including the applicable services, stratified by site of service. The report shall include, but is not limited to, the following:

(i) analysis of impact from this section on utilization of, and spending on, the applicable services, including average prices charged and allowed relative to medicare non-hospital rates, patient cost-sharing, service volumes, total spending, and an estimate of savings to payers and consumers;

(ii) service-specific rates for the most common services, formatted to allow price comparisons stratified by site and across each of the largest hospitals and non-hospital provider groups;

(iii) a list of general hospitals which charge for services in violation of paragraph (a) of subdivision two of this section and actions taken by the state for non-compliance; and

(iv) recommendations to the governor and legislature regarding ambulatory services pricing, including other items or services that should be considered for site-neutral payment policy.

(b) If the all payer database data is not in a format sufficient for the reporting described in this subdivision, the department shall collect any additional data submissions needed for the purposes of accurate and comprehensive reporting.

(c) The department shall annually post on a publicly available website an official list of health care facilities exempt from this section as described in subparagraph (ii) of paragraph (c) of subdivision one of this section.

4. A health care provider that violates any provision of this section or any of the rules and regulations adopted pursuant hereto shall be subject to an administrative penalty in an amount which is the greater of:

(a) a statutory penalty of one hundred thousand dollars per contract occurrence; or

(b) one thousand dollars per claim improperly billed.

5. Any violation of this section, subsection (q) of section three thousand two hundred seventeen-b, subsection (w) of section three thousand two hundred twenty-one, section four thousand two hundred forty-two, subsection (q) of section four thousand three hundred twenty-five, subsection (h) of section four thousand four hundred thirteen, or section four thousand seven hundred fifteen of the insurance law, or of subdivision fifteen of section forty-four hundred six-c of this chapter shall constitute an unlawful deceptive act or practice under section three hundred forty-nine of the general business law. Any person or entity who suffers a loss as a result of a violation of this section shall be entitled to initiate an action and seek all remedies, damages, costs, and fees available under subdivision (h) of section three hundred forty-nine of the general business law.

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

(q) No insurer that provides coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of the public health law shall reimburse or enter into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of the public health law

or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of the public health law. The superintendent, after notice and hearing, may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this subsection.

§ 3. Section 3221 of the insurance law is amended by adding a new subsection (w) to read as follows:

(w) No policy that provides coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of the public health law shall reimburse or enter into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of the public health law or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of the public health law. The superintendent, after notice and hearing, may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this subsection.

§ 4. The insurance law is amended by adding a new section 4242 to read as follows:

§ 4242. Penalty for violation of fair pricing law. Any authorized insurer that offers group or blanket insurance and provides coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of the public health law shall not reimburse or enter into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of the public health law or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of the public health law. The superintendent, after notice and hearing, may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this section.

§ 5. Section 4325 of the insurance law is amended by adding a new subsection (q) to read as follows:

(q) No corporation organized under this article that provides coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of the public health law shall reimburse or enter into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of the public health law or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of the public health law. The superintendent, after notice and hearing, may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this subsection.

§ 6. Section 4413 of the insurance law is amended by adding a new subsection (h) to read as follows:

(h) Any employee welfare fund organized under this article that offers coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of the public health law that reimburses or enters into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of the public health law or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of the public health law. The superintendent, after

notice and hearing, may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this subsection.

§ 7. The insurance law is amended by adding a new section 4715 to read as follows:

§ 4715. Fair pricing. No municipal cooperative health benefit plan organized under this article that provides coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of the public health law shall reimburse or enter into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of the public health law or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of the public health law. The superintendent, after notice and hearing, may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this section.

§ 8. Section 4406-c of the public health law is amended by adding a new subdivision 15 to read as follows:

15. No health care plan that provides coverage for applicable services as defined in subdivision one of section twenty-eight hundred thirty-four of this chapter shall reimburse or enter into contracts that include provisions to reimburse a health care provider for any applicable services in amounts in excess of the rates set forth in subdivision two of section twenty-eight hundred thirty-four of this chapter or for services billed in violation of paragraph (a) of subdivision two of section twenty-eight hundred thirty-four of this chapter. The department may impose a penalty of up to fifty thousand dollars per day for each day that a contract is in violation of this subdivision.

§ 9. Subparagraph (A) of paragraph 1 of subsection (e) of section 3231 of the insurance law, as amended by chapter 107 of the laws of 2010 and as further amended by section 104 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

(A) An insurer desiring to increase or decrease premiums for any policy form subject to this section shall submit a rate filing or application to the superintendent.

An insurer shall send written notice of the proposed rate adjustment, including the specific change requested, to each policy holder and certificate holder affected by the adjustment on or before the date the rate filing or application is submitted to the superintendent. The notice shall prominently include mailing and website addresses for both the department of financial services and the insurer through which a person may, within thirty days from the date the rate filing or application is submitted to the superintendent, contact the department of financial services or insurer to receive additional information or to submit written comments to the department of financial services on the rate filing or application. The superintendent shall establish a process to post on the department's website, in a timely manner, all relevant written comments received pertaining to rate filings or applications. The insurer shall provide a copy of the notice to the superintendent with the rate filing or application. The superintendent shall immediately cause the notice to be posted on the department of financial services' website. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. The superintendent may modify or disapprove the rate filing or application if the superintendent finds that the premiums are unreasonable, excessive, inadequate, or unfairly

discriminatory, and may consider the financial condition of the insurer when approving, modifying or disapproving any premium adjustment. The determination of the superintendent shall be supported by sound actuarial assumptions and methods, and shall be rendered in writing between thirty and sixty days from the date the rate filing or application is submitted to the superintendent. **In addition, the determination of the superintendent shall modify the final rate determination to reflect the reduced payments to health care providers as a result of the requirements in section twenty-eight hundred thirty-four of the public health law.** Should the superintendent require additional information from the insurer in order to make a determination, the superintendent shall require the insurer to furnish such information, and in such event, the sixty days shall be tolled and shall resume as of the date the insurer furnishes the information to the superintendent. If the superintendent requests additional information less than ten days from the expiration of the sixty days (exclusive of tolling), the superintendent may extend the sixty day period an additional twenty days to make a determination. The application or rate filing will be deemed approved if a determination is not rendered within the time allotted under this section. An insurer shall not implement a rate adjustment unless the insurer provides at least sixty days advance written notice of the premium rate adjustment approved by the superintendent to each policy holder and certificate holder affected by the rate adjustment.

§ 10. Paragraph 2 of subsection (c) of section 4308 of the insurance law, as amended by chapter 107 of the laws of 2010 and as further amended by section 104 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

(2) A corporation desiring to increase or decrease premiums for any contract subject to this subsection shall submit a rate filing or application to the superintendent. A corporation shall send written notice of the proposed rate adjustment, including the specific change requested, to each contract holder and subscriber affected by the adjustment on or before the date the rate filing or application is submitted to the superintendent. The notice shall prominently include mailing and website addresses for both the department of financial services and the corporation through which a person may, within thirty days from the date the rate filing or application is submitted to the superintendent, contact the department of financial services or corporation to receive additional information or to submit written comments to the department of financial services on the rate filing or application. The superintendent shall establish a process to post on the department's website, in a timely manner, all relevant written comments received pertaining to rate filings or applications. The corporation shall provide a copy of the notice to the superintendent with the rate filing or application. The superintendent shall immediately cause the notice to be posted on the department of financial services' website. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. The superintendent may modify or disapprove the rate filing or application if the superintendent finds that the premiums are unreasonable, excessive, inadequate, or unfairly discriminatory, and may consider the financial condition of the corporation in approving, modifying or disapproving any premium adjustment. The determination of the superintendent shall be supported by sound actuarial assumptions and methods, and shall be rendered in writing between thirty and sixty days from the date the rate filing or application is submitted to the superintendent. **In addi-**

tion, the determination of the superintendent shall modify the final rate determination to reflect the reduced payments to health care providers as a result of the requirements in section twenty-eight hundred thirty-four of the public health law. Should the superintendent require additional information from the corporation in order to make a determination, the superintendent shall require the corporation to furnish such information, and in such event, the sixty days shall be tolled and shall resume as of the date the corporation furnishes the information to the superintendent. If the superintendent requests additional information less than ten days from the expiration of the sixty days (exclusive of tolling), the superintendent may extend the sixty day period an additional twenty days, to make a determination. The application or rate filing will be deemed approved if a determination is not rendered within the time allotted under this section. A corporation shall not implement a rate adjustment unless the corporation provides at least sixty days advance written notice of the premium rate adjustment approved by the superintendent to each contract holder and subscriber affected by the rate adjustment.

§ 11. The commissioner of health and the superintendent of financial services shall promulgate joint regulations necessary to implement the provisions of this act.

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

§ 13. This act shall take effect on the first of January next succeeding the date upon which it shall have become a law, and shall apply to policies and contracts issued, amended, or renewed on or after such date. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.