

# STATE OF NEW YORK

1634--A

2025-2026 Regular Sessions

## IN SENATE

January 13, 2025

Introduced by Sens. RIVERA, ADDABBO, BROUK, CLEARE, COMRIE, COONEY, FERNANDEZ, GONZALEZ, GOUNARDES, HINCHEY, JACKSON, MAY, MYRIE, RAMOS, C. RYAN, SALAZAR, SEPULVEDA, SERRANO, SUTTON, WEBB -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- recommitted to the Committee on Health in accordance with Senate Rule 6, sec. 8 -- 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:

1 Section 1. The insurance law is amended by adding a new section 3217-k  
2 to read as follows:

3 § 3217-k. Primary care spending. (a) Definitions. As used in this  
4 section, the following terms shall have the following meanings:

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

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

19 (3) "Primary care" means integrated, accessible healthcare, provided  
20 by clinicians accountable for addressing most of a patient's healthcare

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

LBD04789-15-6

1 needs including (A) developing a sustained partnership with patients;  
2 (B) practicing in the context of family and community; and (C) coordi-  
3 nating patients' care, which for the purposes of this section shall only  
4 include care coordination efforts undertaken by the clinicians rendering  
5 healthcare services to a patient and shall not include separate care  
6 coordination activities undertaken by a payor.

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

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

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

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

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

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

52 (2) The department of health and the department shall together provide  
53 an annual report to the legislature with a summary of the primary care  
54 spending data required in this section, and shall also make the report  
55 publicly available on both agencies' websites, no later than three  
56 months after the data has been collected. The first annual report shall

1 provide the spending information without identifying any individual  
2 payor or plan's primary care spending. Each year thereafter, the report  
3 spending data shall be published including information specific to each  
4 plan or payor.

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

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

21 (A) reimbursement;

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

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

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

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

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

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

36 § 368-g. Primary care spending. 1. Definitions. As used in this  
37 section the terms "overall healthcare spending", "plan or payor",  
38 "primary care", "primary care services" and "primary care spending"  
39 shall have the same meanings as such terms are defined in section thirty-  
40 two hundred seventeen-k of the insurance law.

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

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

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

54 3. Primary care spending. (a) Beginning on April first, two thousand  
55 twenty-eight, and in each subsequent year, each Medicaid managed care  
56 provider under section three hundred sixty-four-j of this title and any

1 payor that provides coverage through Medicaid fee-for-service, as such  
2 term is defined in paragraph (e) of subdivision thirty-eight of section  
3 two of this chapter, that reports less than twelve and one-half percent  
4 of its total expenditures on physical and mental health are on primary  
5 care spending shall additionally submit to the commissioner a plan to  
6 increase primary care spending as a percentage of its total overall  
7 healthcare spending by at least one percent each year. Beginning on  
8 April first, two thousand twenty-nine, and in each subsequent year ther-  
9 eafter, until twelve and one-half percent of that provider or payor's  
10 expenditures are on primary care spending, the payor or provider's annu-  
11 al reporting under this section shall include information on steps that  
12 have been taken to increase their proportion of primary care spending.

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

16 (i) reimbursement;

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

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

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

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

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

35 4. Limits on cost increases. Plans or payors shall adopt strategies  
36 that improve value and quality of care and shift current spending with-  
37 out increasing total medical expenditures.

38 § 3. This act shall take effect immediately.