STATE OF NEW YORK

705

2025-2026 Regular Sessions

IN SENATE

(Prefiled)

January 8, 2025

Introduced by Sen. KRUEGER -- read twice and ordered printed, and when printed to be committed 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:

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

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

(a) "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 recommended or required to be paid on a site-neutral basis by federal or New York statute, the U.S. Department of Health & Human Services, or the Medicare Payment Advisory Commission (MedPAC), including without limitation, the sixty-six ambulatory payment classifications (APCs) identified by MedPAC in its June 2023 Report to Congress and any subsequent APCs or services so designated;

(ii) the evaluation and management office visit codes identified by MedPAC in its March 2012 report, which are indicated by Current Procedural Terminology codes 99201 through 99215, and any additional office visit Evaluation and Management Services or preventative wellness visit codes, such as G0463, or any other codes so designated under the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) coding systems; and

(iii) any other outpatient or ambulatory items or services as designated by the commissioner or superintendent as safe and appropriate to

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

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be provided in lower-cost settings in accordance with the provisions of this section.

(b) "Health benefit plan" means a plan, policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance carrier 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 nonfederal governmental plans as defined in 29 U.S.C. § 1002(32). Health benefit plan does not include any plans, programs of coverage, or benefits administered under 42 U.S.C. § 1395 et seq. (Medicare).

(c) "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.

(d) "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.

(e) (i) "Health care provider" means an individual, entity, corporation, person, or organization, whether for profit or nonprofit, operating under this article, article thirty-one of this chapter or the education law, that furnishes, bills or is paid for health care service delivery in the normal course of business, and includes hospitals, hospital extension clinics, diagnostic and treatment centers, physician offices, or urgent care clinics. 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 USC § 1396a(aa), as amended, or any successor law thereto, including those facilities that are also licensed under article thirty-one or article thirty-two of the mental hygiene law;

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

(C) a federally designated critical access hospital;

(D) a federally designated sole community hospital;

(E) a rural emergency hospital; or

(F) a general hospital that is a 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. To be considered financially distressed, the hospital must have 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.

(f) "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.

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

(h) "Health system" means:

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

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

(i) "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital where hospital or professional medical services are provided, including without limitation, an outpatient department of the hospital.

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

(k) "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.

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

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

2. (a) All health care providers that enter into a health care contract to be a participating provider with any 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 amount paid by Medicare for those same services.

(b) 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 amount paid by Medicare; or (ii) the negotiated rate agreed upon by the health care provider and the health benefit plan. This provision applies for all individuals and entities that reimburse for applicable services, including self-pay individuals and health

benefit plans that do not have an existing contract with the health care provider.

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

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

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

(b) that 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 subdivision two of this section or for facility fees prohibited by paragraph (c) of subdivision two of this section, including any copayments, deductibles and/or coinsurance for any portion of such prohibited rates.

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

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

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

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

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

6. (a) (i) 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 one thousand dollars per claim improperly billed or a minimum statutory penalty of one hundred thousand dollars per contract occurrence.

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

(iii) The department may refer any health care provider subject to this section to the attorney general to review the contract for compliance with this section.

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

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

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

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

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

(c) Any violation of this section shall constitute an unlawful deceptive act or practice under section three hundred forty-nine of the general business law. Any person 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.

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

§ 2. 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.

§ 3. This act shall take effect immediately.