

STATE OF NEW YORK

1915--A

2025-2026 Regular Sessions

IN ASSEMBLY

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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:

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
21 needs including (A) developing a sustained partnership with patients;
22 (B) practicing in the context of family and community; and (C) coordi-
23 nating 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.

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

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

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

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

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

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

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

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

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

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

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

19 (A) reimbursement;

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

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

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

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

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

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

34 § 368-g. Primary care spending. 1. Definitions. As used in this
35 section the terms "overall healthcare spending", "plan or payor",
36 "primary care", "primary care services" and "primary care spending"
37 shall have the same meanings as such terms are defined in section thir-
38 ty-two hundred seventeen-k of the insurance law.

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

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

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

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

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

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

15 (i) reimbursement;

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

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

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

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

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

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

37 § 3. This act shall take effect immediately.