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Introduced by M. of A. PAULIN, WEPRIN, HEVESI, REYES, SIMONE, BICHOTTE HERMELYN, LUNSFORD, McDONALD, ROSENTHAL, GONZALEZ-ROJAS, STECK, DINOWITZ, KELLES, TAPIA, WOERNER, GRIFFIN, MEEKS, ROMERO, SEAWRIGHT, GIBBS, TAYLOR, CHANDLER-WATERMAN, K. BROWN, SAYEGH, KAY, RIVERA, SIMON, LEE, CRUZ, RAGA, LEVENBERG, WRIGHT, McMAHON, SHIMSKY -- read once and referred to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- reported and referred to the Committee on Ways and Means -- recommitted to the Committee on Ways and Means in accordance with Assembly Rule 3, sec. 2 -- 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

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

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1 article forty-four of this chapter providing comprehensive health insur-
2 ance, every other plan over which the department has jurisdiction, and
3 every third-party payor providing health coverage.

4 (3) "Primary care" means integrated, accessible healthcare, provided
5 by clinicians accountable for addressing most of a patient's healthcare
6 needs including (A) developing a sustained partnership with patients;
7 (B) practicing in the context of family and community; and (C) coordi-
8 nating patients' care, which for the purposes of this section shall only
9 include care coordination efforts undertaken by the clinicians rendering
10 healthcare services to a patient and shall not include separate care
11 coordination activities undertaken by a payor.

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

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

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

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

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

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

1 (2) The department of health and the department shall together provide
2 an annual report to the legislature with a summary of the primary care
3 spending data required in this section, and shall also make the report
4 publicly available on both agencies' websites, no later than three
5 months after the data has been collected. The first annual report shall
6 provide the spending information without identifying any individual
7 payor or plan's primary care spending. Each year thereafter, the report
8 spending data shall be published including information specific to each
9 plan or payor.

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

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

26 (A) reimbursement;

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

28 (C) upgrading technology, including electronic health record systems
29 and telehealth capabilities;

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

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

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

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

41 § 368-g. Primary care spending. 1. Definitions. As used in this
42 section the terms "overall healthcare spending", "plan or payor",
43 "primary care", "primary care services" and "primary care spending"
44 shall have the same meanings as such terms are defined in section thir-
45 ty-two hundred seventeen-k of the insurance law.

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

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

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

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

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

22 (i) reimbursement;

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

24 (iii) upgrading technology, including electronic health record systems
25 and telehealth capabilities;

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

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

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

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

44 § 3. This act shall take effect immediately.