

STATE OF NEW YORK

2140--A

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 -- 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

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

(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

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

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1 commission (MedPAC) in its June two thousand twenty-three report to
2 congress and any subsequent services MedPAC recommends for site-neutral
3 payment policy; or

4 (iii) additional outpatient or ambulatory items or services as desig-
5 nated by the commissioner as safe and appropriate to be provided in
6 lower-cost settings, as evaluated every five years, as needed to keep
7 the applicable services list consistent with changes in codes and tech-
8 nological updates that may occur over time.

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

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

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

27 (B) an enhanced safety net hospital, as defined in subdivision thir-
28 ty-four of section twenty-eight hundred seven-c of this article;

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

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

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

40 (i) employed by the health care provider;

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

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

46 (e) "Health benefit plan" means a plan, policy, contract, certificate,
47 or agreement entered into, offered, or issued by a health insurance
48 carrier, plan sponsor, or third-party administrator acting on behalf of
49 a plan sponsor to provide, deliver, arrange for, pay for, or reimburse
50 any of the costs of health care services and includes all plans adminis-
51 tered by an insurer, health maintenance organization, corporation or
52 plan authorized, licensed or certified under article thirty-two, forty-
53 two, forty-three, forty-four, or forty-seven of the insurance law, or
54 article forty-four or section twenty-five hundred eleven of this chap-
55 ter. Health benefit plan does not include any plans, programs of cover-
56 age, or benefits administered under 42 U.S.C. § 1395 et seq. (Medicare).

1 (f) "Plan sponsor" means:

2 (i) the employer in the case of a benefit plan established or main-
3 tained by a single employer;

4 (ii) the employee organization in the case of a benefit plan estab-
5 lished or maintained by an employee organization, provided that "employ-
6 ee organization" shall mean any labor union or any organization of any
7 kind, or any agency or employee representation committee, association,
8 group, or plan, in which employees participate and that exists for the
9 purpose, in whole or in part, of dealing with employers concerning an
10 employee benefit plan, or other matters incidental to employment
11 relationships, or any employees' beneficiary association organized for
12 the purpose in whole or in part, of establishing such a plan; or

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

18 (g) "Health care contract" means a contract, agreement, or understand-
19 ing, either orally or in writing, entered into, amended, restated, or
20 renewed between a health care provider and a health insurance carrier,
21 one or more third-party administrators, a plan sponsor or its contrac-
22 tors or agents for the delivery of health care services to an enrollee
23 of a health benefit plan.

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

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

37 (b) No health care provider shall charge, bill, or collect, or other-
38 wise demand payment for any applicable service on an institutional claim
39 form such as a UB-04 or CMS-1450 form, or successor forms, when a
40 professional claim, such as CMS-1500 form, or successor forms, may be
41 filed for the same service. In no circumstance should both a profes-
42 sional claim and an institutional claim be charged or billed for the
43 same service.

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

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

53 3. (a) Commencing one year after the effective date of this section,
54 the department, in consultation with the superintendent, shall publish
55 on a publicly accessible website an annual report on multi-year spending
56 trends and cost drivers for ambulatory services, including the applica-

1 ble services, stratified by site of service. The report shall include,
2 but is not limited to, the following:

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

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

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

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

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

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

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

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

31 (b) one thousand dollars per claim improperly billed.

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

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

47 (q) No insurer that provides coverage for applicable services as
48 defined in subdivision one of section twenty-eight hundred thirty-four
49 of the public health law shall reimburse or enter into contracts that
50 include provisions to reimburse a health care provider for any applica-
51 ble services in amounts in excess of the rates set forth in subdivision
52 two of section twenty-eight hundred thirty-four of the public health law
53 or for services billed in violation of paragraph (a) of subdivision two
54 of section twenty-eight hundred thirty-four of the public health law.
55 The superintendent, after notice and hearing, may impose a penalty of up

1 to fifty thousand dollars per day for each day that a contract is in
2 violation of this subsection.

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

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

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

18 § 4242. Penalty for violation of fair pricing law. Any authorized
19 insurer that offers group or blanket insurance and provides coverage for
20 applicable services as defined in subdivision one of section twenty-
21 eight hundred thirty-four of the public health law shall not reimburse
22 or enter into contracts that include provisions to reimburse a health
23 care provider for any applicable services in amounts in excess of the
24 rates set forth in subdivision two of section twenty-eight hundred thir-
25 ty-four of the public health law or for services billed in violation of
26 paragraph (a) of subdivision two of section twenty-eight hundred thir-
27 ty-four of the public health law. The superintendent, after notice and
28 hearing, may impose a penalty of up to fifty thousand dollars per day
29 for each day that a contract is in violation of this section.

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

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

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

45 (h) Any employee welfare fund organized under this article that offers
46 coverage for applicable services as defined in subdivision one of
47 section twenty-eight hundred thirty-four of the public health law that
48 reimburses or enters into contracts that include provisions to reimburse
49 a health care provider for any applicable services in amounts in excess
50 of the rates set forth in subdivision two of section twenty-eight
51 hundred thirty-four of the public health law or for services billed in
52 violation of paragraph (a) of subdivision two of section twenty-eight
53 hundred thirty-four of the public health law. The superintendent, after
54 notice and hearing, may impose a penalty of up to fifty thousand dollars
55 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 addition, the determination of the superintendent shall modify the final rate determination to reflect the reduced payments to health care

1 providers as a result of the requirements in section twenty-eight
2 hundred thirty-four of the public health law. Should the superintendent
3 require additional information from the corporation in order to make a
4 determination, the superintendent shall require the corporation to
5 furnish such information, and in such event, the sixty days shall be
6 tolled and shall resume as of the date the corporation furnishes the
7 information to the superintendent. If the superintendent requests addi-
8 tional information less than ten days from the expiration of the sixty
9 days (exclusive of tolling), the superintendent may extend the sixty day
10 period an additional twenty days, to make a determination. The applica-
11 tion or rate filing will be deemed approved if a determination is not
12 rendered within the time allotted under this section. A corporation
13 shall not implement a rate adjustment unless the corporation provides at
14 least sixty days advance written notice of the premium rate adjustment
15 approved by the superintendent to each contract holder and subscriber
16 affected by the rate adjustment.

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

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

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