

# STATE OF NEW YORK

6775

2025-2026 Regular Sessions

## IN ASSEMBLY

March 14, 2025

Introduced by M. of A. PRETLOW -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to the health care consumer and provider protection and equity act

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 article 57 to  
2 read as follows:

### ARTICLE 57

#### HEALTH CARE CONSUMER AND PROVIDER PROTECTION

#### AND EQUITY ACT

3 Section 5701. Legislative findings.

4 5702. Collective action by competing physicians.

5 5703. Application for hearing.

6 5704. Fee for registration of authorized third parties.

7 5705. Regulations.

8 5706. Good faith negotiations.

9 5707. Prohibition of collective cessation of services.

10 5708. No interference with other statutory rights.

11 5709. Definitions.

12 § 5701. Legislative findings. The legislature finds and declares that:

13 (a) Under the McCarran-Ferguson act of 1945, 15 U.S.C. § 1011, et  
14 seq., insurance companies are exempt from federal anti-trust laws that  
15 otherwise apply to most other businesses;

16 (b) Active, robust and fully competitive markets for health care and  
17 dental services provide the best opportunity for the residents of this  
18 state to receive high-quality health care and dental services at an  
19 appropriate cost;

20 (c) A substantial amount of health care and dental services in this  
21 state is purchased for the benefit of patients by health and dental  
22 insurance carriers engaged in the financing of health care and dental  
23

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

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1 services or is otherwise delivered subject to the terms of agreements  
2 between carriers and physicians and dentists;

3 (d) Carriers are able to control the flow of patients to physicians  
4 and dentists through compelling financial incentives for patients in  
5 their health and dental benefits plans to utilize only the services of  
6 physicians and dentists with whom the carriers have contracted;

7 (e) Carriers also control the health care and dental services rendered  
8 to patients through utilization management and other managed care tools  
9 and associated coverage and payment policies;

10 (f) Carriers are often able to virtually dictate the terms of the  
11 contracts that they offer physicians and dentists and commonly offer  
12 these contracts on a take-it-or-leave-it basis;

13 (g) The power of carriers to unilaterally impose provider contract  
14 terms jeopardizes the ability of physicians and dentists to deliver the  
15 superior quality health care and dental services traditionally available  
16 in this state;

17 (h) Physicians and dentists do not have sufficient market power to  
18 reject unfair provider contract terms offered by carriers that impede  
19 their ability to deliver medically appropriate care without undue delay  
20 or difficulties;

21 (i) Inadequate reimbursement and other unfair payment terms offered by  
22 carriers adversely affect the quality of patient care and access to care  
23 by reducing the resources that physicians and dentists can devote to  
24 patient care and decreasing the time that physicians and dentists are  
25 able to spend with their patients;

26 (j) Inequitable reimbursement and other unfair payment terms also  
27 endanger the health care infrastructure and medical progress by divert-  
28 ing capital needed for reinvestment in the health care delivery system,  
29 curtailing the purchase of state-of-the-art technology, the pursuit of  
30 medical research, and expansion of medical services, all to the detri-  
31 ment of the residents of this state;

32 (k) The inevitable collateral reduction and migration of the health  
33 care work force will also have negative consequences for the economy of  
34 this state;

35 (l) Empowering independent physicians and dentists to jointly negoti-  
36 ate with carriers as provided in this article will help restore the  
37 competitive balance and improve competition in the markets for health  
38 care and dental services in this state, thereby providing benefits for  
39 consumers, physicians and dentists and less dominant carriers;

40 (m) This article is necessary and proper, and constitutes an appropri-  
41 ate exercise of the authority of this state to regulate the business of  
42 insurance and the delivery of health care and dental services;

43 (n) The pro-competitive and other benefits of the joint negotiations  
44 and related joint activity authorized by this article, including, but  
45 not limited to, restoring the competitive balance in the market for  
46 health care services, protecting access to quality patient care, promot-  
47 ing the health care infrastructure and medical progress, and improving  
48 communications, outweigh any potential anti-competitive effects of this  
49 article; and

50 (o) It is the intention of the legislature to authorize independent  
51 physicians and dentists to jointly negotiate with carriers and to quali-  
52 fy such joint negotiations and related joint activities for the state-  
53 action exemption to the federal antitrust laws through the articulated  
54 state policy and active supervision provided under this article.

55 § 5702. Collective action by competing physicians. (a) Competing  
56 physicians may meet and communicate in order to collectively negotiate

1 with a health benefit plan concerning any of the contract terms and  
2 conditions described in this subsection, but may not negotiate the  
3 exclusion of providers who are non-physicians from direct reimbursement  
4 by a health benefit plan, and may not negotiate the setting in which  
5 providers who are non-physicians deliver services. Competing physicians  
6 may not engage in a boycott related to these terms and conditions.  
7 Competing physicians may meet and communicate concerning:

8 (1) physician clinical practice guidelines and coverage criteria;

9 (2) the respective liability of physicians and the health benefit plan  
10 for the treatment or lack of treatment of insured or enrolled persons;

11 (3) administrative procedures, including methods and timing of the  
12 payment of services to physicians;

13 (4) procedures for the resolution of disputes between the health bene-  
14 fit plan and physicians;

15 (5) patient referral procedures;

16 (6) the formulation and application of reimbursement methodology;

17 (7) quality assurance programs;

18 (8) health service utilization review procedures; and

19 (9) criteria to be used by health benefit plans for the selection and  
20 termination of physicians, including whether to engage in selective  
21 contracting.

22 (b) An authorized third party that intends to negotiate with a health  
23 benefit plan the items identified under subsection (a) of this section  
24 shall provide the independent review panel, as established by subsection  
25 (c) of this section, with written notice of the intended negotiations  
26 before the negotiations begin.

27 (c) The independent review panel shall consist of three members:

28 (1) The attorney general, or their designee who shall have particular  
29 expertise in the area of antitrust law;

30 (2) The state commissioner of health, or their designee; and

31 (3) The state commissioner of labor, or their designee.

32 (d) In exercising the collective rights granted by subsection (a) of  
33 this section:

34 (1) physicians may communicate with each other with respect to the  
35 contractual terms and conditions to be negotiated with a health benefit  
36 plan;

37 (2) physicians may communicate with an authorized third party regard-  
38 ing the terms and conditions of contracts allowed under this section;

39 (3) the authorized third party is the sole party authorized to negoti-  
40 ate with a health benefit plan on behalf of a defined group of physi-  
41 cians;

42 (4) physicians can be bound by the terms and conditions negotiated by  
43 the authorized third party that represents their interests;

44 (5) a health benefit plan communicating or negotiating with the  
45 authorized third party may contract with, or offer different contract  
46 terms and conditions to, individual competing physicians;

47 (6) an authorized third party may not represent more than thirty  
48 percent of the market of practicing physicians for the provision of  
49 services in the geographic service area or proposed geographic service  
50 area, if the health benefit plan has less than a five percent market  
51 share as determined by the number of covered lives as reported by the  
52 superintendent for the most recently completed calendar year or by the  
53 actual number of consumers of prepaid comprehensive health services; in  
54 this paragraph, "covered lives" means the total number of individuals  
55 who are entitled to benefits under the health benefit plan;

1 (7) the independent review panel may limit the percentage of practic-  
2 ing physicians represented by an authorized third party; however, the  
3 limitation may not be less than thirty percent of the market of practic-  
4 ing physicians in the geographic service area or proposed geographic  
5 service area; when determining whether to impose a limitation described  
6 under this paragraph, the attorney general shall consider the provisions  
7 described under subsections (f), (g) and (h) of this section; this para-  
8 graph does not apply if the market of practicing physicians in the  
9 geographic service area or proposed geographic service area consists of  
10 forty or fewer individuals; and

11 (8) the authorized third party shall comply with the provisions of  
12 subsection (e) of this section.

13 (e) A person acting or proposing to act as an authorized third party  
14 under this section shall:

15 (1) Before engaging in collective negotiations with a health benefit  
16 plan:

17 (A) file with the independent review panel the information that iden-  
18 tifies the authorized third party, the physicians represented by the  
19 third party, the authorized third party's plan of operation, and the  
20 authorized third party's procedures to ensure compliance with this  
21 section;

22 (B) furnish to the independent review panel for its approval, a brief  
23 report that identifies the proposed subject matter of the negotiations  
24 or discussions with a health benefit plan and that contains an explana-  
25 tion of the efficiencies or benefits that are expected to be achieved  
26 through the collective negotiations, product and geographic market defi-  
27 nition, current price levels, availability of substitutes, and ease of  
28 entry for new competing physicians;

29 (C) the panel shall review whether the group of physicians represented  
30 by the authorized third party is appropriate to represent the interests  
31 involved in the negotiations; the panel may not approve the report if  
32 the group of physicians is not appropriate to represent the interests  
33 involved in the negotiations or if the proposed negotiations exceed the  
34 authority granted in this chapter and, if the group is not appropriate  
35 or the negotiations exceed the granted authority, shall provide written  
36 notice prohibiting the collective negotiations from proceeding, at which  
37 time the proposed authorized third party may request a hearing pursuant  
38 to section five thousand seven hundred three of this article;

39 (D) the authorized third party shall provide supplemental information  
40 to the panel as new information becomes available that indicates that  
41 the subject matter of negotiations with the health benefit plan has  
42 changed or will change; the panel may, as it deems appropriate, request  
43 additional information in order to assess the likely competitive effects  
44 of negotiation; the panel may also solicit input from other physicians,  
45 affected health plans, and patients regarding the potential competitive  
46 effects of negotiations;

47 (E) within fourteen days after receiving a health benefit plan's deci-  
48 sion to decline to negotiate or to terminate negotiations, or within  
49 fourteen days after requesting negotiations with a health benefit plan  
50 that fails to respond within that time, report to the attorney general  
51 that negotiations have ended or have been declined;

52 (2) While negotiating with a health benefit plan:

53 (A) provide the independent review panel, upon the independent review  
54 panel's request, with copies of all written communications that are  
55 relevant to the negotiations, that are in the possession of the author-  
56 ized third party, and that are between:

- 1 i. physicians and the health benefit plan,
- 2 ii. physicians and authorized third parties,
- 3 iii. authorized third parties and health plans,
- 4 iv. the individual physicians, and
- 5 v. authorized third parties;

6 (B) before reporting the results of negotiations with a health benefit  
7 plan and before giving physicians an evaluation of any offer made by a  
8 health benefit plan, provide to the independent review panel for its  
9 approval, a copy of all communications to be made to physicians related  
10 to the negotiations, discussion, and health benefit plan offers.

11 (3) Must be an organization that represents both consumers and provid-  
12 ers of health care.

13 (f) The independent review panel shall either approve or disapprove  
14 the contract that was the subject of the collective negotiation within  
15 sixty days after receiving the reports required under subsection (e) of  
16 this section. If the contract is disapproved, the independent review  
17 panel shall furnish a written explanation. Upon disapproval, the inde-  
18 pendent review panel shall denote any deficiencies along with a state-  
19 ment of specific remedial measures that would correct any identified  
20 deficiencies. An authorized third party who fails to obtain the inde-  
21 pendent review panel's approval is considered to be acting outside the  
22 authority of this section.

23 (g) The independent review panel shall approve a collective negoti-  
24 ation contract if:

25 (1) the competitive and other benefits of the contract terms outweigh  
26 any anticompetitive effects; and

27 (2) the contract terms are consistent with other applicable laws and  
28 regulations.

29 (h) The competitive and other benefits of joint negotiations or nego-  
30 tiated provider contract terms must include:

31 (1) restoration of the competitive balance in the market for health  
32 care services;

33 (2) protections for access to quality patient care;

34 (3) promotion of health care infrastructure and medical advancement;  
35 or

36 (4) improved communications between health care providers and health  
37 care insurers.

38 (i) When weighing the anticompetitive effects of contract terms, the  
39 independent review panel shall consider whether the terms:

40 (1) provide for excessive payments; or

41 (2) contribute to the escalation of the cost of providing health care  
42 services.

43 (j) This section does not authorize competing physicians to act in  
44 concert in response to a report issued by an authorized third party  
45 related to the authorized third party's discussion or negotiations with  
46 a health benefit plan. The authorized third party shall advise the  
47 physicians of the provisions of this subsection and shall warn them of  
48 the potential for legal action against those who violate state or feder-  
49 al antitrust laws by exceeding the authority granted under this section.

50 (k) A contract allowed under this section may not exceed a term of  
51 five years.

52 (l) The documents relating to a collective negotiation described under  
53 this section that are in the possession of the department of law are  
54 confidential and not open to public inspection.

55 (m) Nothing in this section shall be construed as exempting from the  
56 application of the antitrust laws the conduct of providers or negoti-

1 ations or agreements between providers and a health benefit plan if the  
2 purpose or effect of the conduct, negotiations, or agreements would be,  
3 directly or indirectly, to exclude, limit the participation or  
4 reimbursement of, or otherwise limit the scope of services to be  
5 provided by separate or competing classes of providers who practice or  
6 seek to practice within the scope of the occupational licenses held by  
7 the providers.

8 (n) In this section, "geographic service area" means the geographic  
9 area of the physicians seeking to jointly negotiate.

10 § 5703. Application for hearing. (a) Within thirty days from the mail-  
11 ing by the independent review panel of the notice of disapproval of an  
12 application by a proposed authorized third party representative under  
13 subsection (e) of section five thousand seven hundred two of this arti-  
14 cle, said representative may make a written application to the independ-  
15 ent review panel for a hearing, the sole purpose of which would be to  
16 review the independent review panel's disapproval.

17 (b) Upon receipt of a timely application for a hearing, the independ-  
18 ent review panel shall schedule and conduct an administrative hearing.  
19 The hearing shall be held within thirty days of the application unless  
20 the representative seeks an extension.

21 (c) The independent review panel shall appoint a neutral hearing offi-  
22 cer to preside over the hearing.

23 § 5704. Fee for registration of authorized third parties. (a) The  
24 independent review panel shall adopt regulations that establish the  
25 amount and manner of payment of a registration fee for authorized third  
26 parties. The independent review panel shall establish the fee level so  
27 that the total amount of fees collected from authorized third parties  
28 approximately equals the actual regulatory costs for the oversight of  
29 joint negotiations between physicians and health benefit plans. The  
30 independent review panel shall annually review the fee level to deter-  
31 mine whether the regulatory costs are approximately equal to fee  
32 collections. If the review indicates that the fee collections and regu-  
33 latory costs are not approximately equal, the independent review panel  
34 shall calculate fee adjustments and adopt regulations under this  
35 subsection to implement the adjustments. In January of each year, the  
36 independent review panel shall report on the fee level and revisions for  
37 the previous year under this subsection to the office of management and  
38 budget.

39 (b) In this section, "regulatory costs" means costs of the independent  
40 review panel that are attributable to oversight of joint negotiations  
41 between physicians and health benefit plans.

42 § 5705. Regulations. The attorney general may promulgate any rules and  
43 regulations necessary to implement this article.

44 § 5706. Good faith negotiations. A health benefit plan and an author-  
45 ized third party shall negotiate in good faith regarding the terms and  
46 conditions of physician or dentist contracts pursuant to this article.

47 § 5707. Prohibition of collective cessation of services. The  
48 provisions of this article shall not be construed to permit two or more  
49 physicians or dentists to jointly engage in a coordinated cessation,  
50 reduction or limitation of the health care or dental services they  
51 provide.

52 § 5708. No interference with other statutory rights. The provisions of  
53 this article shall not affect the collective bargaining rights an indi-  
54 vidual provider may otherwise have pursuant to the National Labor  
55 Relations Act, 29 U.S.C. § 151, et seq.; New York state public employ-

1 ees' fair employment act (article fourteen of the civil service law); or  
2 any other statute.

3 § 5709. Definitions. In this article:

4 (a) "authorized third party" means a person authorized by the physi-  
5 cians to negotiate on their behalf with a health benefit plan under this  
6 chapter; and

7 (b) "health benefit plan" means a health care insurer subject to arti-  
8 cle thirty-two or forty-three of this chapter, or any organization  
9 licensed under article forty-three of this chapter, but does not include  
10 a self-insured health benefit plan.

11 § 2. This act shall take effect on the one hundred eightieth day after  
12 it shall have become a law.