

<p>A 2474-A Canestrari (MS) Same as S 3186-A HANNON Public Health Law TITLE....Enacts the health care consumer and provider protection act relating to collective negotiations by health care providers with certain health care plans 01/19/11referred to health 02/08/11reported referred to ways and means 05/06/11amend and recommit to ways and means 05/06/11print number 2474a</p>	<p>S3186-A HANNON Same as A 2474-A Canestrari (MS) ON FILE: 06/01/11 Public Health Law TITLE....Enacts the health care consumer and provider protection act relating to collective negotiations by health care providers with certain health care plans 02/11/11 REFERRED TO HEALTH 05/31/11 AMEND AND RECOMMIT TO HEALTH 05/31/11 PRINT NUMBER 3186A 06/07/11 REPORTED AND COMMITTED TO FINANCE</p>
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STATE OF NEW YORK

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2011-2012 Regular Sessions

IN ASSEMBLY

January 19, 2011

Introduced by M. of A. CANESTRARI, GOTTFRIED, CAHILL, COLTON, MAGNARELLI, GALEF, PAULIN, SCHIMEL, LIFTON, CUSICK, O'DONNELL, P. RIVERA, JAFFEE, WEISENBERG, PERRY, RUSSELL, MARKEY, BRONSON, LANCMAN, ROSENTHAL -- Multi-Sponsored by -- M. of A. ABBATE, ABINANTI, AUBRY, BING, BRENNAN, BURLING, CALHOUN, CASTELLI, CONTE, COOK, CYMBROWITZ, DESTITO, DINOWITZ, ENGLEBRIGHT, GLICK, HAYES, HEASTIE, HIKIND, HOOPER, JACOBS, LATIMER, V. LOPEZ, LUPARDO, MAGEE, MALLIOTAKIS, McENENY, MENG, MILLMAN, MONTESANO, MORELLE, ORTIZ, PHEFFER, PRETLOW, RAIA, SCARBOROUGH, SPANO, SWEENEY, TOBACCO, WEINSTEIN, WRIGHT -- read once and referred to the Committee on Health -- reported and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to requirements for collective negotiations by health care providers with certain health benefit plans

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. Statement of legislative intent. The legislature finds that
 2 collective negotiation by competing health care providers for the terms
 3 and conditions of contracts with health plans can result in beneficial
 4 results for health care consumers. The legislature further finds
 5 instances where health plans dominate the market to such a degree that
 6 fair and adequate negotiations between health care providers and the
 7 plans are adversely affected, so that it is necessary and appropriate to
 8 provide for a system of collective action on behalf of health care
 9 providers. Consequently, the legislature finds it appropriate and neces-
 10 sary to displace competition with regulation of health plan-provider
 11 agreements and authorize collective negotiations on the terms and condi-
 12 tions of the relationship between health care plans and health care
 13 providers so the imbalances between the two will not result in adverse
 14 conditions of health care. This act is not intended to apply to or

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

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1 affect in any respect collective bargaining relationships involving
2 health care providers as defined in section 4920 of the public health
3 law or rights relating to collective bargaining arising under applicable
4 federal or state collective bargaining statutes.

5 § 2. This act shall be known and may be cited as the "health care
6 consumer and provider protection act".

7 § 3. Article 49 of the public health law is amended by adding a new
8 title III to read as follows:

9 TITLE III

10 COLLECTIVE NEGOTIATIONS BY HEALTH CARE
11 PROVIDERS WITH HEALTH CARE PLANS

12 Section 4920. Definitions.

13 4921. Non-fee related collective negotiation authorized.

14 4922. Fee related collective negotiation.

15 4923. Collective negotiation requirements.

16 4924. Requirements for health care providers' representative.

17 4925. Certain collective action prohibited.

18 4926. Fees.

19 4927. Monitoring of agreements.

20 4928. Confidentiality.

21 4929. Severability and construction.

22 § 4920. Definitions. For purposes of this title:

23 1. "Health care plan" means an entity (other than a health care
24 provider) that approves, provides, arranges for, or pays for health care
25 services, including but not limited to:

26 (a) a health maintenance organization licensed pursuant to article
27 forty-three of the insurance law or certified pursuant to article
28 forty-four of this chapter;

29 (b) any other organization certified pursuant to article forty-four of
30 this chapter; or

31 (c) an insurer or corporation subject to the insurance law.

32 2. "Person" means an individual, association, corporation, or any
33 other legal entity.

34 3. "Health care providers' representative" means a third party who is
35 authorized by health care providers to negotiate on their behalf with
36 health care plans over contractual terms and conditions affecting those
37 health care providers.

38 4. "Strike" means a work stoppage in part or in whole, direct or indi-
39 rect, by a body of workers to gain compliance with demands made on an
40 employer.

41 5. "Substantial market share in a business line" exists if a health
42 care plan's market share of a business line within a service area as
43 approved by the attorney general, alone or in combination with the
44 market shares of affiliates, exceeds either ten percent of the total
45 number of covered lives in that service area for such business line or
46 twenty-five thousand lives, or if the attorney general determines the
47 market share of the insurer in the relevant insurance product and
48 geographic markets for the services of the providers seeking to collec-
49 tively negotiate significantly exceeds the countervailing market share
50 of the providers acting individually.

51 6. "Health care provider" means a person who is licensed, certified,
52 or registered pursuant to title eight of the education law and who prac-
53 tices as a health care provider as an independent contractor and/or who
54 is an owner, officer, shareholder, or proprietor of a health care
55 provider. A health care provider under title eight of the education law

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1 who practices as an employee of a health care provider shall not be
2 deemed a health care provider for purposes of this title.

3 § 4921. Non-fee related collective negotiation authorized. 1. Health
4 care providers practicing within the service area of a health care plan
5 may meet and communicate for the purpose of collectively negotiating the
6 following terms and conditions of provider contracts with the health
7 care plan:

8 (a) the details of the utilization review plan as defined pursuant to
9 subdivision ten of section forty-nine hundred of this article and
10 subsection (j) of section four thousand nine hundred of the insurance
11 law;

12 (b) coverage provisions; health care benefits; benefit maximums,
13 including benefit limitations; and exclusions of coverage;

14 (c) the definition of medical necessity;

15 (d) the clinical practice guidelines used to make medical necessity
16 and utilization review determinations;

17 (e) preventive care and other medical management practices;

18 (f) drug formularies and standards and procedures for prescribing
19 off-formulary drugs;

20 (g) respective physician liability for the treatment or lack of treat-
21 ment of covered persons;

22 (h) the details of health care plan risk transfer arrangements with
23 providers;

24 (i) plan administrative procedures, including methods and timing of
25 health care provider payment for services;

26 (j) procedures to be utilized to resolve disputes between the health
27 care plan and health care providers;

28 (k) patient referral procedures including, but not limited to, those
29 applicable to out-of-pocket network referrals;

30 (l) the formulation and application of health care provider reimburse-
31 ment procedures;

32 (m) quality assurance programs;

33 (n) the process for rendering utilization review determinations
34 including: establishment of a process for rendering utilization review
35 determinations which shall, at a minimum, include: written procedures to
36 assure that utilization reviews and determinations are conducted within
37 the timeframes established in this article; procedures to notify an
38 enrollee, an enrollee's designee and/or an enrollee's health care
39 provider of adverse determinations; and procedures for appeal of adverse
40 determinations, including the establishment of an expedited appeals
41 process for denials of continued inpatient care or where there is immi-
42 nent or serious threat to the health of the enrollee; and

43 (o) health care provider selection and termination criteria used by
44 the health care plan.

45 2. Nothing in this section shall be construed to allow or authorize an
46 alteration of the terms of the internal and external review procedures
47 set forth in law.

48 3. Nothing in this section shall be construed to allow a strike of a
49 health care plan by health care providers or plans as otherwise set
50 forth in the laws of this state.

51 4. Nothing in this section shall be construed to allow or authorize
52 terms or conditions which would impede the ability of a health care plan
53 to obtain or retain accreditation by the national committee for quality
54 assurance or a similar body.

55 § 4922. Fee related collective negotiation. 1. If the health care plan
56 has substantial market share in a business line in any service area,

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1 health care providers practicing within that service area may collec-
2 tively negotiate the following terms and conditions relating to that
3 business line with the health care plan:

4 (a) the fees assessed by the health care plan for services, including
5 fees established through the application of reimbursement procedures;

6 (b) the conversion factors used by the health care plan in a
7 resource-based relative value scale reimbursement methodology or other
8 similar methodology; provided the same are not otherwise established by
9 state or federal law or regulation;

10 (c) the amount of any discount granted by the health care plan on the
11 fee of health care services to be rendered by health care providers;

12 (d) the dollar amount of capitation or fixed payment for health
13 services rendered by health care providers to health care plan enrol-
14 lees;

15 (e) the procedure code or other description of a health care service
16 covered by a payment and the appropriate grouping of the procedure
17 codes; or

18 (f) the amount of any other component of the reimbursement methodology
19 for a health care service.

20 2. Nothing herein shall be deemed to affect or limit the right of a
21 health care provider or group of health care providers to collectively
22 petition a government entity for a change in a law, rule, or regulation.

23 § 4923. Collective negotiation requirements. 1. Collective negotiation
24 rights granted by this title must conform to the following requirements:

25 (a) health care providers may communicate with other health care
26 providers regarding the contractual terms and conditions to be negoti-
27 ated with a health care plan;

28 (b) health care providers may communicate with health care providers'
29 representatives;

30 (c) a health care providers' representative is the only party author-
31 ized to negotiate with health care plans on behalf of the health care
32 providers as a group;

33 (d) a health care provider can be bound by the terms and conditions
34 negotiated by the health care providers' representatives; and

35 (e) in communicating or negotiating with the health care providers'
36 representative, a health care plan is entitled to contract with or offer
37 different contract terms and conditions to individual competing health
38 care providers.

39 2. A health care providers' representative may not represent more than
40 thirty percent of the market of health care providers or of a particular
41 health care provider type or specialty practicing in the service area or
42 proposed service area of a health care plan that covers less than five
43 percent of the actual number of covered lives of the health care plan in
44 the area, as determined by the department.

45 3. Nothing in this section shall be construed to prohibit collective
46 action on the part of any health care provider who is a member of a
47 collective bargaining unit recognized pursuant to the national labor
48 relations act.

49 § 4924. Requirements for health care providers' representative. 1.
50 Before engaging in collective negotiations with a health care plan on
51 behalf of health care providers, a health care providers' representative
52 shall file with the attorney general, in the manner prescribed by the
53 attorney general, information identifying the representative, the repre-
54 sentative's plan of operation, and the representative's procedures to
55 ensure compliance with this title.

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1 2. Before engaging in the collective negotiations, the health care
2 providers' representative shall also submit to the attorney general for
3 the attorney general's approval a report identifying the proposed
4 subject matter of the negotiations or discussions with the health care
5 plan and the efficiencies or benefits expected to be achieved through
6 the negotiations for both the providers and consumers of health
7 services. The attorney general shall not approve the report if the
8 attorney general determines that the proposed negotiations would exceed
9 the authority granted under this title.

10 3. The representative shall supplement the information in the report
11 on a regular basis or as new information becomes available, indicating
12 that the subject matter of the negotiations with the health care plan
13 has changed or will change. In no event shall the report be less than
14 every thirty days.

15 4. With the advice of the superintendent of insurance and the commis-
16 sioner, the attorney general shall approve or disapprove the report not
17 later than the twentieth day after the date on which the report is
18 filed. If disapproved, the attorney general shall furnish a written
19 explanation of any deficiencies, along with a statement of specific
20 proposals for remedial measures to cure the deficiencies. If the attor-
21 ney general does not so act within the twenty days, the report shall be
22 deemed approved.

23 5. A person who acts as a health care providers' representative with-
24 out the approval of the attorney general under this section shall be
25 deemed to be acting outside the authority granted under this title.

26 6. Before reporting the results of negotiations with a health care
27 plan or providing to the affected health care providers an evaluation of
28 any offer made by a health care plan, the health care providers' repre-
29 sentative shall furnish for approval by the attorney general, before
30 dissemination to the health care providers, a copy of all communications
31 to be made to the health care providers related to negotiations,
32 discussions, and offers made by the health care plan.

33 7. A health care providers' representative shall report the end of
34 negotiations to the attorney general not later than the fourteenth day
35 after the date of a health care plan decision declining negotiation,
36 canceling negotiations, or failing to respond to a request for negoti-
37 ation. In such instances, a health care providers' representative may
38 request intervention from the attorney general to require the health
39 care plan to participate in the negotiation pursuant to subdivision
40 eight of this section.

41 8. (a) In the event the attorney general determines that an impasse
42 exists in the negotiations, or in the event a health care plan declines
43 to negotiate, cancels negotiations or fails to respond to a request for
44 negotiation, the attorney general shall render assistance as follows:

45 (1) to assist the parties to effect a voluntary resolution of the
46 negotiations, the attorney general shall appoint a mediator from a list
47 of qualified persons maintained by the attorney general. If the mediator
48 is successful in resolving the impasse, then the health care providers'
49 representative shall proceed as set forth in this article;

50 (2) if an impasse continues, the attorney general shall appoint a
51 fact-finding board of not more than three members from a list of quali-
52 fied persons maintained by the attorney general, which fact-finding
53 board shall have, in addition to the powers delegated to it by the
54 board, the power to make recommendations for the resolution of the
55 dispute;

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1 (b) The fact-finding board, acting by a majority of its members, shall
2 transmit its findings of fact and recommendations for resolution of the
3 dispute to the attorney general, and may thereafter assist the parties
4 to effect a voluntary resolution of the dispute. The fact-finding board
5 shall also share its findings of fact and recommendations with the
6 health care providers' representative and the health care plan. If with-
7 in twenty days after the submission of the findings of fact and recom-
8 mendations, the impasse continues, the attorney general shall order a
9 resolution to the negotiations based upon the findings of fact and
10 recommendations submitted by the fact-finding board.

11 9. Any proposed agreement between health care providers and a health
12 care plan negotiated pursuant to this title shall be submitted to the
13 attorney general for final approval. The attorney general shall approve
14 or disapprove the agreement within sixty days of such submission.

15 10. The attorney general may collect information from other persons to
16 assist in evaluating the impact of the proposed arrangement on the
17 health care marketplace. The attorney general shall collect information
18 from health plan companies and health care providers operating in the
19 same geographic area as the health care cooperative.

20 § 4925. Certain collective action prohibited. 1. This title is not
21 intended to authorize competing health care providers to act in concert
22 in response to a report issued by the health care providers' represen-
23 tative related to the representative's discussions or negotiations with
24 health care plans.

25 2. No health care providers' representative shall negotiate any agree-
26 ment that excludes, limits the participation or reimbursement of, or
27 otherwise limits the scope of services to be provided by any health care
28 provider or group of health care providers with respect to the perform-
29 ance of services that are within the health care provider's scope of
30 practice, license, registration, or certificate.

31 § 4926. Fees. Each person who acts as the representative or negotiat-
32 ing parties under this title shall pay to the department a fee to act as
33 a representative. The attorney general, by rule, shall set fees in
34 amounts deemed reasonable and necessary to cover the costs incurred by
35 the department in administering this title. Any fee collected under this
36 section shall be deposited in the state treasury to the credit of the
37 general fund/state operations - 003 for the New York state department of
38 health fund.

39 § 4927. Monitoring of agreements. The attorney general shall actively
40 monitor agreements approved under this title to ensure that the agree-
41 ment remains in compliance with the conditions of approval. Upon
42 request, a health care plan or health care provider shall provide infor-
43 mation regarding compliance. The attorney general may revoke an approval
44 upon a finding that the agreement is not in substantial compliance with
45 the terms of the application or the conditions of approval.

46 § 4928. Confidentiality. All reports and other information required to
47 be reported to the department of law under this title including informa-
48 tion obtained by the attorney general pursuant to subdivision ten of
49 section forty-nine hundred twenty-four of this title shall not be
50 subject to disclosure under article six of the public officers law or
51 article thirty-one of the civil practice law and rules.

52 § 4929. Severability and construction. The provisions of this title
53 shall be severable, and if any court of competent jurisdiction declares
54 any phrase, clause, sentence or provision of this title to be invalid,
55 or its applicability to any government, agency, person or circumstance
56 is declared invalid, the remainder of this title and its relevant appli-

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1 cability shall not be affected. The provisions of this title shall be
2 liberally construed to give effect to the purposes thereof.

3 § 4. This act shall take effect on the one hundred twentieth day after
4 it shall have become a law; provided that the commissioner of health is
5 authorized to promulgate any and all rules and regulations and take any
6 other measures necessary to implement this act on its effective date on
7 or before such date.

**NEW YORK STATE ASSEMBLY
MEMORANDUM IN SUPPORT OF LEGISLATION
submitted in accordance with Assembly Rule III, Sec 1(f)**

BILL NUMBER: A2474A

SPONSOR: Canestrari (MS)

TITLE OF BILL: An act to amend the public health law, in relation to requirements for collective negotiations by health care providers with certain health benefit plans

PURPOSE: This bill is designed to restore fairness in the contracting process between health care providers and large managed care plans by allowing such providers to join together to negotiate contract provisions. This legislation would not authorize strikes of health benefit plans by health care providers.

SUMMARY OF BILL: Section 1 is a statement of legislative intent that states that the legislature finds it appropriate and necessary to authorize collective negotiations on patient care issues and on fee-related and other issues where it determines that health plans have an undue advantage negotiating the terms of contracts with health care providers. The legislative intent clarifies that the act is not intended to apply or affect collective bargaining relationships involving health care providers who are employees or rights relating to collective bargaining arising under applicable federal/state collective bargaining statutes.

Section 2 cites the bill as the Health Care Consumer and Provider Protection Act

Section 3 amends article 49 to the public health law by adding a new title 111 titled Collective Negotiations by Health Care Providers with Health Care Plans

This legislation adds a new Article 49-A to the public health law to authorize collective bargaining for independent contractor health care providers including physicians. This bill would create a system under which the state would closely monitor those negotiations, and any negotiations involving fee-related matters would only be permitted when an individual managed care plan controls a substantial share of the managed care market. The Attorney General would be authorized to approve the health care providers' representative request to negotiate based upon the benefits to be achieved for providers and consumers of health services, and is required to review any offer submitted to the health care providers' representative prior to sharing with affected health care providers. The legislation would also create a mechanism for resolving disputes when there is an impasse or when the health plan refuses to negotiate. The bill would also direct the Attorney General to approve any final agreement as well as monitor the implemented agreements to ensure continued compliance with the law. Importantly, this legislation would not authorize strikes or concerted action by health care providers in response to negotiations with health care plans.

Section 4. This act shall take effect 120 days after it shall have become a law, provided that the department of health may promulgate and establish any regulations pursuant hereto prior to the effective date.

JUSTIFICATION: Currently, federal antitrust laws prohibit individual health care providers from collectively negotiating any provisions of contracts they sign with managed care entities. This bill would allow health care providers in New York State to conduct some collective negotiations by creating a system under which the state would closely monitor those negotiations, facilitate resolution of negotiation impasses, and actively monitor implementation of agreements. Negotiations involving fee-related matters would be prohibited unless an individual managed care plan controls a substantial share of the managed care market.

Giving health care providers greater ability to advocate for patients in contract negotiations is critical since large health maintenance organizations control huge shares of the health insurance market, both in New York and across the country. In the last few years we have seen the mergers of United Healthcare and Oxford, MVP and Preferred Care, and Welipoint with Wellchoice (Empire). As of March 2008, almost 75% of the enrollees in managed care plans in New York State were enrolled in just five health plans (GM/HIP, United/Oxford/Amerchoice, Excellus, Empire and MVP/Preferred Care). We have also seen an emerging trend of long-time not-for-profit health insurance companies such as Empire and HIP seeking to convert to for-profit status.

Due to the current imbalance of negotiating power in favor of the managed care plans, physicians and other health care providers are offered take-it-or-leave-it contracts by health plans that significantly hamper their ability to provide quality patient care. These contracts permit burdensome processes and unjustifiably long wait times for obtaining pre-authorization to provide needed patient care; impose limitations on whom a physician or other health care provider may refer a patient for necessary care; permit demands for refunds of payments long after the time that such payments were originally made; permit health plans to make major changes to key elements of a contract without physician or other health care provider consent; and cede to physicians and other health care providers the legal consequences for patients harmed by health plan utilization review decisions.

This bill, by allowing independent contractor physicians and health care providers to conduct some collective negotiations while being closely monitored by the state, would give physicians and health care providers greater ability to advocate for patients in contract negotiations. This bill would create a system under which the state would closely monitor those negotiations, and any negotiations involving fee-related matters would only be permitted when an individual managed care plan controls a substantial share of the managed care market. This legislation would not authorize strikes or boycotts of health benefit plans by physicians.

LEGISLATIVE HISTORY:

2009-2010 A.4301-B/S.5204-A Reported to Ways & Means
2007-2008 A.2177 Reported to Ways & Means
2005-2006: A.6458 Reported to Ways & Means
2003-2004: A.1317 A Reported to Ways & Means
2001-2002: A.5466/S.3569 Reported to Third Reading Calendar
2000: A.9484-A/S.7541-A Referred to Health/Senate Finance

FISCAL IMPLICATIONS: None to the State. The bill would provide the legal basis for an appropriation of funds to implement the provisions of the bill.

EFFECTIVE DATE: 120 days after it shall have become a law, provided that the department of health may promulgate and establish any regulations pursuant hereto prior to the effective date.
