STATE OF NEW YORK

4840

2017-2018 Regular Sessions

IN SENATE

March 3, 2017

Introduced by Sens. RIVERA, ADDABBO, ALCANTARA, BAILEY, BRESLIN, BROOKS, COMRIE, DILAN, GIANARIS, HAMILTON, HOYLMAN, KAMINSKY, KENNEDY, KRUEGER, LATIMER, MONTGOMERY, PARKER, PERALTA, PERSAUD, SANDERS, SERRANO, SQUADRON, STAVISKY, STEWART-COUSINS -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the state finance law, in relation to enacting the "New York health act" and to establishing New York Health

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

Section 1. Short title. This act shall be known and may be cited as the "New York health act".

§ 2. Legislative findings and intent. 1. The state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." (Article XVII, §3.) The legislature finds and declares that all residents of the state have the right to health care. While the federal Affordable Care Act brought many improvements in health care and health coverage, it still leaves many New Yorkers without coverage or with inadequate coverage. New Yorkers - as individuals, employers, and taxpayers - have experienced a rise in the cost of health care and coverage in recent years, including rising premiums, deductibles and co-pays, restricted provider networks and high out-of-network charges. Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely. Health care providers are also affected by inadequate health coverage in New York state. A large portion of voluntary and public hospitals, health centers and other providers now experience substantial

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

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losses due to the provision of care that is uncompensated. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic needs rather than their health care needs. To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided. Pursuant to the state constitution's charge to the legislature to provide for the health of New Yorkers, this legislation is an enactment of state concern for the purpose of establishing a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state of New York.

2. It is the intent of the Legislature to create the New York Health program to provide a universal health plan for every New Yorker, funded by broad-based revenue based on ability to pay. The state shall work to obtain waivers and other approvals relating to Medicaid, Child Health Plus, Medicare, the Affordable Care Act, and any other appropriate federal programs, under which federal funds and other subsidies that would otherwise be paid to New York State, New Yorkers, and health care providers for health coverage that will be equaled or exceeded by New York Health will be paid by the federal government to New York State and deposited in the New York Health trust fund, and for other program modifications (including elimination of cost sharing and insurance premiums). Under such waivers and approvals, health coverage under those programs will be replaced and merged into New York Health, which will operate as a true single-payer program.

If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus, even where other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers. This program will promote movement away from fee-for-service payment, which tends to reward quantity and requires excessive administrative expense, and towards alternate payment methodologies, such as global or capitated payments to providers or health care organizations, that promote quality, efficiency, investment in primary and preventive care, and innovation and integration in the organizing of health care.

3. This act does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.

4. In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among health care providers who might otherwise be competitors, under the active supervision of the commissioner of health. It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this act, and to provide state action immunity under the state and federal antitrust laws to health care providers, particularly with respect to their relations with the single-payer New York Health plan created by this act.

§ 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public health law are renumbered article 80 and sections 8000, 8001, 8002 and 8003, respectively, and a new article 51 is added to read as follows:

ARTICLE 51

NEW YORK HEALTH

§ 5100. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Board" means the board of trustees of the New York Health program created by section fifty-one hundred two of this article, and "trustee" means a trustee of the board.

2. "Care coordination" means services provided by a care coordinator under subdivision two of section fifty-one hundred five of this article.

3. "Care coordinator" means an individual or entity approved to provide care coordination under subdivision two of section fifty-one hundred five of this article.

4. "Federally-matched public health program" means the medical assistance program under title eleven of article five of the social services law, the basic health program under section three hundred sixty-nine-gg of the social services law, and the child health plus program under title one-A of article twenty-five of this chapter.

5. "Health care organization" means an entity that is approved by the commissioner under section fifty-one hundred six of this article to provide health care services to members under the program.

6. "Health care service" means any health care service, including care coordination, included as a benefit under the program.

7. "Implementation period" means the period under subdivision three of section fifty-one hundred one of this article during which the program will be subject to special eligibility and financing provisions until it is fully implemented under that section.

8. "Long term care" means long term care, treatment, maintenance, services and supports, with the exception of short term rehabilitation, as defined by the commissioner.

9. "Medicaid" or "medical assistance" means title eleven of article five of the social services law and the program thereunder. "Child health plus" means title one-A of article twenty-five of this chapter and the program thereunder. "Medicare" means title XVIII of the federal social security act and the programs thereunder. "Basic health program" means section three hundred sixty-nine-gg of the social services law and the program thereunder.

10. "Member" means an individual who is enrolled in the program.

11. "New York Health trust fund" means the New York Health trust fund established under section eighty-nine-i of the state finance law.

12. "Out-of-state health care service" means a health care service provided to a member while the member is out of the state and (a) it is medically necessary that the health care service be provided while the member is out of the state, or (b) it is clinically appropriate that the health care service be provided by a particular health care provider located out of the state rather than in the state. However, any health care service provided to a New York Health enrollee by a health care provider qualified under paragraph (a) of subdivision three of section fifty-one hundred five of this article that is located outside the state shall not be considered an out-of-state service and shall be covered as otherwise provided in this article.

13. "Participating provider" means any individual or entity that is a health care provider qualified under subdivision three of section fifty-one hundred five of this article that provides health care services to members under the program, or a health care organization.

14. "Affordable care act" means the federal patient protection and affordable care act, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and as otherwise amended and any regulations or guidance issued thereunder.

15. "Person" means any individual or natural person, trust, partnership, association, unincorporated association, corporation, company, limited liability company, proprietorship, joint venture, firm, joint stock association, department, agency, authority, or other legal entity, whether for-profit, not-for-profit or governmental.

16. "Program" means the New York Health program created by section fifty-one hundred one of this article.

17. "Prescription and non-prescription drugs" means prescription drugs as defined in section two hundred seventy of this chapter, and non-prescription smoking cessation products or devices.

18. "Resident" means an individual whose primary place of abode is in the state, without regard to the individual's immigration status, as determined according to regulations of the commissioner.

§ 5101. Program created. 1. The New York Health program is hereby created in the department. The commissioner shall establish and implement the program under this article. The program shall provide comprehensive health coverage to every resident who enrolls in the program.

2. The commissioner shall, to the maximum extent possible, organize, administer and market the program and services as a single program under the name "New York Health" or such other name as the commissioner shall determine, regardless of under which law or source the definition of a benefit is found including (on a voluntary basis) retiree health benefits. In implementing this subdivision, the commissioner shall avoid jeopardizing federal financial participation in these programs and shall take care to promote public understanding and awareness of available benefits and programs.

3. The commissioner shall determine when individuals may begin enrolling in the program. There shall be an implementation period, which shall begin on the date that individuals may begin enrolling in the program and shall end as determined by the commissioner.

4. An insurer authorized to provide coverage pursuant to the insurance law or a health maintenance organization certified under this chapter may, if otherwise authorized, offer benefits that do not cover any service for which coverage is offered to individuals under the program, but may not offer benefits that cover any service for which coverage is offered to individuals under the program. Provided, however, that this subdivision shall not prohibit (a) the offering of any benefits to or

for individuals, including their families, who are employed or self-employed in the state but who are not residents of the state, or (b) the offering of benefits during the implementation period to individuals who enrolled or may enroll as members of the program, or (c) the offering of retiree health benefits.

5. A college, university or other institution of higher education in the state may purchase coverage under the program for any student, or student's dependent, who is not a resident of the state.

6. To the extent any provision of this chapter, the social services law or the insurance law:

(a) is inconsistent with any provision of this article or the legislative intent of the New York Health Act, this article shall apply and prevail, except where explicitly provided otherwise by this article; and

(b) is consistent with the provisions of this article and the legislative intent of the New York Health Act, the provision of that law shall apply.

7. The program shall be deemed to be a health care plan for purposes of utilization review and external appeal under article forty-nine of this chapter.

8. No member shall be required to receive any health care service through any entity organized, certified or operating under guidelines under article forty-four of this chapter, or specified under section three hundred sixty-four-j of the social services law. No such entity shall receive payment for health care services (other than care coordination) from the program.

§ 5102. Board of trustees. 1. The New York Health board of trustees is hereby created in the department. The board of trustees shall, at the request of the commissioner, consider any matter to effectuate the provisions and purposes of this article, and may advise the commissioner thereon; and it may, from time to time, submit to the commissioner any recommendations to effectuate the provisions and purposes of this article. The commissioner may propose regulations under this article and amendments thereto for consideration by the board. The board of trustees shall have no executive, administrative or appointive duties except as otherwise provided by law. The board of trustees shall have power to establish, and from time to time, amend regulations to effectuate the provisions and purposes of this article, subject to approval by the commissioner.

2. The board shall be composed of:

(a) the commissioner, the superintendent of financial services, and the director of the budget, or their designees, as ex officio members;

(b) twenty-six trustees appointed by the governor;

(i) six of whom shall be representatives of health care consumer advocacy organizations which have a statewide or regional constituency, who have been involved in activities related to health care consumer advocacy, including issues of interest to low- and moderate-income individuals;

(ii) two of whom shall be representatives of professional organizations representing physicians;

(iii) two of whom shall be representatives of professional organizations representing licensed or registered health care professionals other than physicians;

(iv) three of whom shall be representatives of general hospitals, one of whom shall be a representative of public general hospitals;

(v) one of whom shall be a representative of community health centers;

(vi) two of whom shall be representatives of long term care providers;

(vii) two of whom shall be representatives of behavioral or mental health care providers;

(viii) two of whom shall be representatives of health care organizations;

(ix) two of whom shall be representatives of organized labor;

(x) two of whom shall have demonstrated expertise in health care finance; and

(xi) two of whom shall be employers or representatives of employers who pay the payroll tax under this article, or, prior to the tax becoming effective, will pay the tax;

(c) fourteen trustees appointed by the governor; five of whom to be appointed on the recommendation of the speaker of the assembly; five of whom to be appointed on the recommendation of the temporary president of the senate; two of whom to be appointed on the recommendation of the minority leader of the assembly; and two of whom to be appointed on the recommendation of the minority leader of the senate.

3. After the end of the implementation period, no person shall be a trustee unless he or she is a member of the program, except the ex officio trustees. Each trustee shall serve at the pleasure of the appointing officer, except the ex officio trustees.

4. The chair of the board shall be appointed, and may be removed as chair, by the governor from among the trustees. The board shall meet at least four times each calendar year. Meetings shall be held upon the call of the chair and as provided by the board. A majority of the appointed trustees shall be a quorum of the board, and the affirmative vote of a majority of the trustees voting, but not less than ten, shall be necessary for any action to be taken by the board. The board may establish an executive committee to exercise any powers or duties of the board as it may provide, and other committees to assist the board or the executive committee. The chair of the board shall chair the executive committee and shall appoint the chair and members of all other committees. The board of trustees may appoint one or more advisory committees. Members of advisory committees need not be members of the board of trustees.

5. Trustees shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the board.

6. Notwithstanding any provision of law to the contrary, no officer or employee of the state or any local government shall forfeit or be deemed to have forfeited his or her office or employment by reason of being a trustee.

7. The board and its committees and advisory committees may request and receive the assistance of the department and any other state or local governmental entity in exercising its powers and duties.

8. No later than two years after the effective date of this article:

(a) The board shall develop a proposal, consistent with the principles of this article, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the principles of this article, for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chair of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, labor, and other interested parties. The board shall present its proposal to the governor and the legislature.

(b) The board shall develop proposals for: (i) incorporating retiree health benefits into New York Health; (ii) accommodating employer reti-

ree health benefits for people who have been members of New York Health but live as retirees out of the state; and (iii) accommodating employer retiree health benefits for people who earned or accrued such benefits while residing in the state prior to the implementation of New York Health and live as retirees out of the state.

(c) The board shall develop a proposal for New York Health coverage of health care services covered under the workers' compensation law, including whether and how to continue funding for those services under that law and whether and how to incorporate an element of experience rating.

§ 5103. Eligibility and enrollment. 1. Every resident of the state shall be eligible and entitled to enroll as a member under the program.

2. No member shall be required to pay any premium or other charge for enrolling in or being a member under the program.

3. A newborn child shall be enrolled as of the date of the child's birth if enrollment is done prior to the child's birth or within sixty days after the child's birth.

4. The program shall provide for payment for health care services provided to members or individuals entitled to become members who have not had a reasonable opportunity to enroll in the program, including newly arrived residents.

§ 5104. Benefits. 1. The program shall provide comprehensive health coverage to every member, which shall include all health care services required to be covered under any of the following, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:

(a) child health plus;

(b) Medicaid;

(c) Medicare;

(d) article forty-four of this chapter or article thirty-two or forty-three of the insurance law;

(e) article eleven of the civil service law, as of the date one year before the beginning of the implementation period;

(f) any cost incurred defined in paragraph one of subsection (a) of section fifty-one hundred two of the insurance law, provided that this coverage shall not replace coverage under article fifty-one of the insurance law; and

(g) any additional health care service authorized to be added to the program's benefits by the program;

(h) provided that none of the above shall include long term care, until a proposal under paragraph (a) of subdivision eight of section fifty-one hundred two of this article is enacted into law.

2. No member shall be required to pay any premium, deductible, co-payment or co-insurance under the program.

3. The program shall provide for payment under the program for emergency and temporary health care services provided to members or individuals entitled to become members who have not had a reasonable opportunity to become a member or to enroll with a care coordinator.

§ 5105. Health care providers; care coordination; payment methodologies. 1. Choice of health care provider. (a) Any health care provider qualified to participate under this section may provide health care services under the program, provided that the health care provider is otherwise legally authorized to perform the health care service for the individual and under the circumstances involved.

(b) A member may choose to receive health care services under the program from any participating provider, consistent with provisions of

this article relating to care coordination and health care organizations, the willingness or availability of the provider (subject to provisions of this article relating to discrimination), and the appropriate clinically-relevant circumstances.

2. Care coordination.

(a) Care coordination shall include, but not be limited to, managing, referring to, locating, coordinating, and monitoring health care services for the member to assure that all medically necessary health care services are made available to and are effectively used by the member in a timely manner, consistent with patient autonomy. Care coordination is not a requirement for prior authorization for health care services and referral shall not be required for a member to receive a health care service.

(b) A care coordinator may be an individual or entity that is approved by the program that is:

(i) a health care practitioner who is: (A) the member's primary care practitioner; (B) at the option of a female member, the member's provider of primary gynecological care; or (C) at the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment for that condition to the member;

(ii) an entity licensed under article twenty-eight of this chapter or certified under article thirty-six of this chapter, a managed long term care plan under section forty-four hundred three-f of this chapter or other program model under paragraph (b) of subdivision seven of such section, or, with respect to a member who receives chronic mental health care services, an entity licensed under article thirty-one of the mental hygiene law or other entity approved by the commissioner in consultation with the commissioner of mental health;

(iii) a health care organization;

(iv) a Taft-Hartley fund, with respect to its members and their family members; provided that this provision shall not preclude a Taft-Hartley fund from becoming a care coordinator under subparagraph (v) of this paragraph or a health care organization under section fifty-one hundred six of this article; or

(v) any not-for-profit or governmental entity approved by the program.

(c) Health care services provided to a member shall not be subject to payment under the program unless the member is enrolled with a care coordinator at the time the health care service is provided, except where provided under subdivision three of section fifty-one hundred four of this article. Every member shall enroll with a care coordinator that agrees to provide care coordination to the member prior to receiving health care services to be paid for under the program. The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coordinator on terms at least as permissive as the provisions of section three hundred sixty-four-j of the social services law relating to an individual changing his or her primary care provider or managed care provider.

(d) Care coordination shall be provided to the member by the member's care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the commissioner.

(e) A health care organization may establish rules relating to care coordination for members in the health care organization, different from this subdivision but otherwise consistent with this article and other

applicable laws. Nothing in this subdivision shall authorize any individual to engage in any act in violation of title eight of the education law.

(f) The commissioner shall develop and implement procedures and standards for an individual or entity to be approved to be a care coordinator in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a care coordinator in the program for economic purposes and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working on care coordination or similar models, including health care practitioners, hospitals, clinics, and consumers and their representatives. When developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the commissioner shall consult with the commissioner of mental health. An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

(g) To maintain approval under the program, a care coordinator must: (i) renew its status at a frequency determined by the commissioner; and (ii) provide data to the department as required by the commissioner to enable the commissioner to evaluate the impact of care coordinators on quality, outcomes and cost.

3. Health care providers. (a) The commissioner shall establish and maintain procedures and standards for health care providers to be qualified to participate in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of qualification to participate on a determination that the health care provider is an incompetent provider of specific health care services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit health care provider participation in the program for economic purposes and shall be consistent with good professional practice. Any health care provider who is qualified to participate under Medicaid, child health plus or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified under this sentence shall follow the procedures to become qualified under the program by the end of the implementation period.

(b) The commissioner shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under the program for out-of-state health care services.

4. Payment for health care services. (a) The commissioner may establish by regulation payment methodologies for health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of health care service. Until and unless another payment methodology is established, health care services provided to members under the program shall be paid for on a fee-for-service basis, except for care coordination.

(b) The program shall engage in good faith negotiations with health care providers' representatives under title III of article forty-nine of this chapter, including, but not limited to, in relation to rates of payment and payment methodologies.

(c) Notwithstanding any provision of law to the contrary, payment for drugs provided by pharmacies under the program shall be made pursuant to title one of article two-A of this chapter. However, the program shall provide for payment for prescription drugs under section 340B of the federal public service act where applicable. Payment for prescription drugs provided by health care providers other than pharmacies shall be pursuant to other provisions of this article.

(d) Payment for health care services established under this article shall be considered payment in full. A participating provider shall not charge any rate in excess of the payment established under this article for any health care service under the program provided to a member and shall not solicit or accept payment from any member or third party for any such service except as provided under section fifty-one hundred nine of this article. However, this paragraph shall not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer where permitted under section fifty-one hundred nine of this article.

(e) The program may provide in payment methodologies for payment for capital related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities certified under article twenty-eight of this chapter. Any capital related expense generated by a capital expenditure that requires or required approval under article twenty-eight of this chapter must have received that approval for the capital related expense to be paid for under the program.

(f) Payment methodologies and rates shall include a distinct component of reimbursement for direct and indirect graduate medical education as defined, calculated and implemented pursuant to section twenty-eight hundred seven-c of this chapter.

(g) The commissioner shall provide by regulation for payment methodologies and procedures for paying for out-of-state health care services.

§ 5106. Health care organizations. 1. A member may choose to enroll with and receive health care services under the program from a health care organization.

2. A health care organization shall be a not-for-profit or governmental entity that is approved by the commissioner that is:

(a) an accountable care organization under article twenty-nine-E of this chapter; or

(b) a Taft-Hartley fund (i) with respect to its members and their family members, and (ii) if allowed by applicable law and approved by

the commissioner, for other members of the program; provided that the commissioner shall provide by regulation that where a Taft-Hartley fund is acting under this subparagraph there are protections for health care providers and patients comparable to those applicable to accountable care organizations.

3. A health care organization may be responsible for all or part of the health care services to which its members are entitled under the program, consistent with the terms of its approval by the commissioner.

4. (a) The commissioner shall develop and implement procedures and standards for an entity to be approved to be a health care organization in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is incompetent to be a health care organization or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a health care organization in the program for economic purposes and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working in the field of health care organizations, including health care practitioners, hospitals, clinics, and consumers and their representatives. When developing and implementing standards of approval of health care organizations, the commissioner shall consult with the commissioner of mental health and the commissioner of developmental disabilities.

(b) To maintain approval under the program, a health care organization must: (i) renew its status at a frequency determined by the commissioner; and (ii) provide data to the department as required by the commissioner to enable the commissioner to evaluate the health care organization in relation to quality of health care services, health care outcomes, and cost.

5. The commissioner shall make regulations relating to health care organizations consistent with and to ensure compliance with this article.

6. The provision of health care services directly or indirectly by a health care organization through health care providers shall not be considered the practice of a profession under title eight of the education law by the health care organization.

§ 5107. Program standards. 1. The commissioner shall establish requirements and standards for the program and for health care organizations, care coordinators, and health care providers, consistent with this article, including requirements and standards for, as applicable:

(a) the scope, quality and accessibility of health care services;

(b) relations between health care organizations or health care providers and members; and

(c) relations between health care organizations and health care providers, including (i) credentialing and participation in the health care organization; and (ii) terms, methods and rates of payment.

2. Requirements and standards under the program shall include, but not be limited to, provisions to promote the following:

(a) simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organiza-

tion networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable;

(b) primary and preventive care, care coordination, efficient and effective health care services, quality assurance, coordination and integration of health care services, including use of appropriate technology, and promotion of public, environmental and occupational health;

(c) elimination of health care disparities;

(d) non-discrimination with respect to members and health care providers on the basis of race, ethnicity, national origin, religion, disability, age, sex, sexual orientation, gender identity or expression, or economic circumstances; provided that health care services provided under the program shall be appropriate to the patient's clinically-relevant circumstances; and

(e) accessibility of care coordination, health care organization services and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English, and the providing of care coordination, health care organization services and health care services in a culturally competent manner.

3. Any participating provider or care coordinator that is organized as a for-profit entity shall be required to meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to such entities shall not be calculated to accommodate the generation of profit or revenue for dividends or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

4. Every participating provider shall furnish to the program such information to, and permit examination of its records by, the program, as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, and cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental and occupational health.

5. In developing requirements and standards and making other policy determinations under this article, the commissioner shall consult with representatives of members, health care providers, care coordinators, health care organizations and other interested parties.

6. The program shall maintain the confidentiality of all data and other information collected under the program when such data would be normally considered confidential data between a patient and health care provider. Aggregate data of the program which is derived from confidential data but does not violate patient confidentiality shall be public information.

§ 5108. Regulations. The commissioner may approve regulations and amendments thereto, under subdivision one of section fifty-one hundred two of this article. The commissioner may make regulations or amendments thereto to effectuate the provisions and purposes of this article on an emergency basis under section two hundred two of the state administrative procedure act, provided that such regulations or amendments shall not become permanent unless adopted under subdivision one of section fifty-one hundred two of this article.

§ 5109. Provisions relating to federal health programs. 1. The commissioner shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments necessary to operate the program consistent with this article.

2. (a) The commissioner shall apply to the secretary of health and human services or other appropriate federal official for all waivers of

requirements, and make other arrangements, under Medicare, any federally-matched public health program, the affordable care act, and any other federal programs that provide federal funds for payment for health care services, that are necessary to enable all New York Health members to receive all benefits under the program through the program to enable the state to implement this article and to receive and deposit all federal payments under those programs (including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits) in the state treasury to the credit of the New York Health trust fund created under section eighty-nine-i of the state finance law and to use those funds for the New York Health program and other provisions under this article. To the extent possible, the commissioner shall negotiate arrangements with the federal government in which bulk or lump-sum federal payments are paid to New York Health in place of federal spending or tax benefits for federally-matched health programs or federal health programs.

(b) The commissioner may require members or applicants to be members to provide information necessary for the program to comply with any waiver or arrangement under this subdivision.

3. (a) If actions taken under subdivision two of this section do not accomplish all results intended under that subdivision, then this subdivision shall apply and shall authorize additional actions to effectively implement New York Health to the maximum extent possible as a single-payer program consistent with this article.

(b) The commissioner may take actions consistent with this article to enable New York Health to administer Medicare in New York state and to be a provider of drug coverage under Medicare part D for eligible members of New York Health.

(c) The commissioner may waive or modify the applicability of provisions of this section relating to any federally-matched public health program or Medicare as necessary to implement any waiver or arrangement under this section or to maximize the benefit to the New York Health program under this section, provided that the commissioner, in consultation with the director of the budget, shall determine that such waiver or modification is in the best interests of the members affected by the action and the state.

(d) The commissioner may apply for coverage under any federally-matched public health program on behalf of any member and enroll the member in the federally-matched public health program or Medicare if the member is eligible for it. Enrollment in a federally-matched public health program or Medicare shall not cause any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

(e) The commissioner shall by regulation increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally-matched public health program, and for any program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the affordable care act notwithstanding any law or regulation to the contrary. The commissioner may act under this paragraph upon a finding, approved by the director of the budget, that the action (i) will help to increase the number of members who are eligible for and enrolled in federally-matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obli-

gations or increase an individual's eligibility for any federal financial support related to Medicare or the affordable care act; (ii) will not diminish any individual's access to any health care service or right the individual would otherwise have; (iii) is in the interest of the program; and (iv) does not require or has received any necessary federal waivers or approvals to ensure federal financial participation. Actions under this paragraph shall not apply to eligibility for payment for long term care.

(f) To enable the commissioner to apply for coverage under any federally-matched public health program or Medicare on behalf of any member and enroll the member in the federally-matched public health program or Medicare if the member is eligible for it, the commissioner may require that every member or applicant to be a member shall provide information to enable the commissioner to determine whether the applicant is eligible for a federally-matched public health program and for Medicare (and any program or benefit under Medicare). The program shall make a reasonable effort to notify members of their obligations under this paragraph. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the member's coverage under the program may be terminated.

(g) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare shall enroll in Medicare, including parts A, B and D.

(h) The program shall provide premium assistance for all members enrolling in a Medicare part D drug coverage under section 1860D of Title XVIII of the federal social security act limited to the low-income benchmark premium amount established by the federal centers for Medicare and Medicaid services and any other amount which such agency establishes under its de minimis premium policy, except that such payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(i) If the commissioner has reasonable grounds to believe that a member could be eligible for an income-related subsidy under section 1860D-14 of Title XVIII of the federal social security act, the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for such subsidy, provided that the commissioner shall attempt to obtain as much of the information and documentation as possible from records that are available to him or her.

(j) The program shall make a reasonable effort to notify members of their obligations under this subdivision. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the member's coverage under the program may be terminated.

§ 5110. Additional provisions. 1. The commissioner shall contract with not-for-profit organizations to provide:

(a) consumer assistance to individuals with respect to selection of a care coordinator or health care organization, enrolling, obtaining health care services, disenrolling, and other matters relating to the program;

(b) health care provider assistance to health care providers providing and seeking or considering whether to provide, health care services

under the program, with respect to participating in a health care organization and dealing with a health care organization; and

(c) care coordinator assistance to individuals and entities providing and seeking or considering whether to provide, care coordination to members.

2. The commissioner shall provide grants from funds in the New York Health trust fund or otherwise appropriated for this purpose, to health systems agencies under section twenty-nine hundred four-b of this chapter to support the operation of such health systems agencies.

3. The commissioner shall provide funds from the New York Health trust fund or otherwise appropriated for this purpose to the commissioner of labor for a program for retraining and assisting job transition for individuals employed or previously employed in the field of health insurance and other third-party payment for health care or providing services to health care providers to deal with third-party payers for health care, whose jobs may be or have been ended as a result of the implementation of the New York Health program, consistent with otherwise applicable law.

4. The commissioner shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the New York Health program, to promote and protect public, environmental and occupational health, including cooperation with other data collection and research programs of the department, consistent with this article and otherwise applicable law.

§ 5111. Regional advisory councils. 1. The New York Health regional advisory councils (each referred to in this article as a "regional advisory council") are hereby created in the department.

2. There shall be a regional advisory council established in each of the following regions:

(a) Long Island, consisting of Nassau and Suffolk counties;

(b) New York City;

(c) Hudson Valley, consisting of Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester counties;

(d) Northern, consisting of Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington counties;

(e) Central, consisting of Broome, Cayuga, Chemung, Chenango, Cortland, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Yates counties; and

(f) Western, consisting of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming counties.

3. Each regional advisory council shall be composed of not fewer than twenty-seven members, as determined by the commissioner and the board, as necessary to appropriately represent the diverse needs and concerns of the region. Members of a regional advisory council shall be residents of or have their principal place of business in the region served by the regional advisory council.

4. Appointment of members of the regional advisory councils.

(a) The twenty-seven members shall be appointed as follows:

(i) nine members shall be appointed by the governor;

(ii) six members shall be appointed by the governor on the recommendation of the speaker of the assembly;

(iii) six members shall be appointed by the governor on the recommendation of the temporary president of the senate;

(iv) three members shall be appointed by the governor on the recommendation of the minority leader of the assembly; and

(v) three members shall be appointed by the governor on the recommendation of the minority leader of the senate. Where a regional advisory council has more than twenty-seven members, the additional members shall be appointed and recommended by these officials in the same proportion as the twenty-seven members.

Where a regional advisory council has more than twenty-seven members, additional members shall be appointed and recommended by these officials in the same proportion as the twenty-seven members.

(b) Regional advisory council membership shall include but not be limited to:

(i) representatives of health care consumer advocacy organizations with a regional constituency, who shall represent at least one third of the membership of each regional council;

(ii) representatives of professional organizations representing physicians;

(iii) representatives of professional organizations representing health care professionals other than physicians;

(iv) representatives of general hospitals, including public hospitals;

(v) representatives of community health centers;

(vi) representatives of health care organizations;

(vii) representatives of organized labor; and

(viii) representatives of municipal and county government.

5. Members of a regional advisory council shall be appointed for terms of three years provided, however, that of the members first appointed, one-third shall be appointed for one year terms and one-third shall be appointed for two year terms. Vacancies shall be filled in the same manner as original appointments for the remainder of any unexpired term. No person shall be an appointed member of a regional advisory council for more than six years in any period of twelve consecutive years.

6. Members of the regional advisory councils shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the advisory councils. The program shall provide financial support for such expenses and other expenses of the regional advisory councils.

7. Each regional advisory council shall meet at least quarterly. Each regional advisory council may form committees to assist it in its work. Members of a committee need not be members of the regional advisory council. The New York City regional advisory council shall form a committee for each borough of New York City, to assist the regional advisory council in its work as it relates particularly to that borough.

8. Each regional advisory council shall advise the commissioner,the board, the governor and the legislature on all matters relating to the development and implementation of the New York Health program.

9. Each regional advisory council shall adopt, and from time to time revise, a community health improvement plan for its region for the purpose of:

(a) promoting the delivery of health care services in the region, improving the quality and accessibility of care, including cultural competency, clinical integration of care between service providers including but not limited to physical, mental, and behavioral health, physical and developmental disability services, and long-term care;

(b) facility and health services planning in the region;

(c) identifying gaps in regional health care services; and

(d) promoting increased public knowledge and responsibility regarding the availability and appropriate utilization of health care services. Each community health improvement plan shall be submitted to the commissioner and the board and shall be posted on the department's website.

10. Each regional advisory council shall hold at least four public hearings annually on matters relating to the New York Health program and the development and implementation of the community health improvement plan.

11. Each regional advisory council shall publish an annual report to the commissioner and the board on the progress of the community health improvement plan. These reports shall be posted on the department's website.

12. All meetings of the regional advisory councils and committees shall be subject to article six of the public officers law.

§ 4. Financing of New York Health. 1. The governor shall submit to the legislature a revenue plan and legislative bills to implement the plan (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance the New York Health program, as created by article 51 of the public health law (referred to in this section as the "program"), taking into consideration anticipated federal revenue available for the program. The revenue proposal shall be submitted to the legislature as part of the executive budget under article VII of the state constitution, for the fiscal year commencing on the first day of April in the calendar year after this act shall become a law. In developing the revenue proposal, the governor shall consult with appropriate officials of the executive branch; the temporary president of the senate; the speaker of the assembly; the chairs of the fiscal and health committees of the senate and assembly; and representatives of business, labor, consumers and local government.

2. (a) Basic structure. The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two premiums (referred to collectively in this section as the "premiums"). First, there shall be a progressively graduated premium on all payroll and self-employed income (referred to in this section as the "payroll premium"), paid by employers, employees and self-employed, similar to the Medicare tax. Higher brackets of income subject to this premium shall be assessed at a higher marginal rate than lower brackets. Second, there shall be a progressively graduated premium on taxable income (such as interest, dividends, and capital gains) not subject to the payroll premium (referred to in this section as the "non-payroll premium"). The premiums will be set at levels anticipated to produce sufficient revenue to finance the program and other provisions of article 51 of the public health law, to be scaled up as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provision shall be made for state residents (who are eligible for the program) who are employed out-of-state, and non-residents (who are not eligible for the program) who are employed in the state.

(b) Payroll premium. The income to be subject to the payroll premium shall be all income subject to the Medicare tax. The premium shall be set at a percentage of that income, which shall be progressively graduated, so the percentage is higher on higher brackets of income. For employed individuals, the employer shall pay eighty percent of the premium and the employee shall pay twenty percent of the premium, except that an employer may agree to pay all or part of the employee's share. A self-employed individual shall pay the full premium.

(c) Non-payroll income premium. There shall be a premium on upper-bracket taxable personal income that is not subject to the payroll premium. It shall be set at a percentage of that income, which shall be progressively graduated, so the percentage is higher on higher brackets of income.

(d) Phased-in rates. Early in the program, when enrollment is growing, the amount of the premiums shall be at an appropriate level, and shall be raised as anticipated enrollment grows, to cover the actual cost of the program and other provisions of article 51 of the public health law. The revenue proposal shall include a mechanism for determining the rates of the premiums.

(e) Cross-border employees. (i) State residents employed out-of-state. If an individual is employed out-of-state by an employer that is subject to New York state law, the employer and employee shall be required to pay the payroll premium as to that employee as if the employment were in the state. If an individual is employed out-of-state by an employer that is not subject to New York state law, either (A) the employer and employee shall voluntarily comply with the premium or (B) the employee shall pay the premium as if he or she were self-employed.

(ii) Out-of-state residents employed in the state. (A) The payroll premium shall apply to any out-of-state resident who is employed or self-employed in the state. (B) In the case of an out-of-state resident who is employed or self-employed in the state, such individual and individual's employer shall be able to take a credit against the payroll premiums they would otherwise pay, as to the individual for amounts they spend on health benefits for the individual that would otherwise be covered by the program if the individual were a member of the program. For employers, the credit shall be available regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to make sure that the revenue proposal does not relate to employment benefits in violation of the federal ERISA. For non-employment-based spending by individuals, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll premiums. Any excess amount may not be applied to other tax liability. For employment-based health benefits, the credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit. The employer and employee may each apply their respective portion of the credit to their respective portion of the premium. If any provision of this clause or any application of it shall be ruled to violate federal ERISA, the provision or the application of it shall be null and void and the ruling shall not affect any other provision or application of this section or the act that enacted it.

3. The revenue proposal shall include a plan and legislative provisions for ending the requirement for local social services districts to pay part of the cost of Medicaid and replacing those payments with revenue from the premiums under the revenue proposal.

4. To the extent that the revenue proposal differs from the terms of subdivision two of this section, the revenue proposal shall state how it differs from those terms and reasons for and the effects of the differences.

5. All revenue from the premiums shall be deposited in the New York Health trust fund account under section 89-i of the state finance law.

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

TITLE III

COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH NEW YORK HEALTH

§ 4920. Definitions. For purposes of this title:

1. "New York Health" means the program under article fifty-one of this chapter.

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

3. "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with New York Health over terms and conditions affecting those health care providers.

4. "Strike" means a work stoppage in part or in whole, direct or indirect, by a body of workers to gain compliance with demands made on an employer.

5. "Health care provider" means a person who is licensed, certified, registered or authorized to practice a health care profession pursuant to title eight of the education law and who practices that profession as a health care provider as an independent contractor or who is an owner, officer, shareholder, or proprietor of a health care provider; or an entity that employs or utilizes health care providers to provide health care services, including but not limited to a hospital licensed under article twenty-eight of this chapter or an accountable care organization under article twenty-nine-E of this chapter. A health care provider under title eight of the education law who practices as an employee of a health care provider shall not be deemed a health care provider for purposes of this title.

§ 4921. Collective negotiation authorized. 1. Health care providers may meet and communicate for the purpose of collectively negotiating with New York Health on any matter relating to New York Health, including but not limited to rates of payment and payment methodologies.

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

3. Nothing in this section shall be construed to allow a strike of New York Health by health care providers.

4. Nothing in this section shall be construed to allow or authorize terms or conditions which would impede the ability of New York Health to obtain or retain accreditation by the national committee for quality assurance or a similar body or to comply with applicable state or federal law.

§ 4922. Collective negotiation requirements. 1. Collective negotiation rights granted by this title must conform to the following requirements:

(a) health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with New York Health;

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

(c) a health care providers' representative is the only party authorized to negotiate with New York Health on behalf of the health care providers as a group;

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

(e) in communicating or negotiating with the health care providers' representative, New York Health is entitled to offer and provide different terms and conditions to individual competing health care providers.

2. Nothing in this title shall affect or limit the right of a health care provider or group of health care providers to collectively petition a government entity for a change in a law, rule, or regulation.

3. Nothing in this title shall affect or limit collective action or collective bargaining on the part of any health care provider with his or her employer or any other lawful collective action or collective bargaining.

§ 4923. Requirements for health care providers' representative. Before engaging in collective negotiations with New York Health on behalf of health care providers, a health care providers' representative shall file with the commissioner, in the manner prescribed by the commissioner, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this title.

§ 4924. Certain collective action prohibited. 1. This title is not intended to authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with New York Health except as authorized by other law.

2. No health care providers' representative shall negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

§ 4925. Fees. Each person who acts as the representative of negotiating parties under this title shall pay to the department a fee to act as a representative. The commissioner, by rule, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the department in administering this title.

§ 4926. Confidentiality. All reports and other information required to be reported to the department under this title shall not be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules.

§ 4927. Severability and construction. If any provision or application of this title shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this title which can be given effect without that provision or application; and to that end, the provisions and applications of this title are severable. The provisions of this title shall be liberally construed to give effect to the purposes thereof.

§ 6. Subdivision 11 of section 270 of the public health law, as amended by section 2-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

11. "State public health plan" means the medical assistance program established by title eleven of article five of the social services law

(referred to in this article as "Medicaid"), the elderly pharmaceutical insurance coverage program established by title three of article two of the elder law (referred to in this article as "EPIC"), and the [~~family health plus program established by section three hundred sixty-nine-oo of the social services law to the extent that section provides that the program shall be subject to this article~~] New York Health program established by article fifty-one of this chapter.

§ 7. The state finance law is amended by adding a new section 89-i to read as follows:

§ 89-i. New York Health trust fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "New York Health trust fund", hereinafter known as "the fund". The definitions in section fifty-one hundred of the public health law shall apply to this section.

2. The fund shall consist of:

(a) all monies obtained from premiums pursuant to legislation enacted as proposed under section three of the New York Health act;

(b) federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States secretary of health and human services or other appropriate federal officials for health care programs established under Medicare, any federally-matched public health program, or the affordable care act;

(c) the amounts paid by the department of health that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally-matched public health program, or the affordable care act for health benefits which are equivalent to health benefits covered under New York Health;

(d) federal and state funds for purposes of the provision of services authorized under title XX of the federal social security act that would otherwise be covered under article fifty-one of the public health law; and

(e) state monies that would otherwise be appropriated to any governmental agency, office, program, instrumentality or institution which provides health services, for services and benefits covered under New York Health. Payments to the fund pursuant to this paragraph shall be in an amount equal to the money appropriated for such purposes in the fiscal year beginning immediately preceding the effective date of the New York Health act.

3. Monies in the fund shall only be used for purposes established under article fifty-one of the public health law.

§ 8. Temporary commission on implementation. 1. There is hereby established a temporary commission on implementation of the New York Health program, hereinafter to be known as the commission, consisting of fifteen members: five members, including the chair, shall be appointed by the governor; four members shall be appointed by the temporary president of the senate, one member shall be appointed by the senate minority leader; four members shall be appointed by the speaker of the assembly, and one member shall be appointed by the assembly minority leader. The commissioner of health, the superintendent of financial services, and the commissioner of taxation and finance, or their designees shall serve as non-voting ex-officio members of the commission.

2. Members of the commission shall receive such assistance as may be necessary from other state agencies and entities, and shall receive necessary expenses incurred in the performance of their duties. The

commission may employ staff as needed, prescribe their duties, and fix their compensation within amounts appropriated for the commission.

3. The commission shall examine the laws and regulations of the state and make such recommendations as are necessary to conform the laws and regulations of the state and article 51 of the public health law establishing the New York Health program and other provisions of law relating to the New York Health program, and to improve and implement the program. The commission shall report its recommendations to the governor and the legislature. The commission shall immediately begin development of proposals consistent with the principles of this article for provision of long-term care coverage; health care services covered under the workers' compensation law; and incorporation of retiree health benefits, as described in paragraphs (a), (b) and (c) of subdivision 8 of section 5102 of the public health law. The commission shall provide its work product and assistance to the board established pursuant to section 5102 of the public health law upon completion of the appointment of the board.

§ 9. Severability. If any provision or application of this act shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this act which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 10. This act shall take effect immediately.