S T A T E O F N E W Y O R K

2370

2009-2010 Regular Sessions

I N S E N A T E

February 19, 2009

Introduced by Sen. SCHNEIDERMAN -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT to amend the public health law, the state finance law and the tax law, in relation to the establishment of the New York health plan and making an appropriation to the temporary commission on implementation of the New York health plan and providing for the repeal of certain provisions upon expiration thereof

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. 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 and a new article 51 is added to read as follows:

ARTICLE 51

NEW YORK HEALTH PLAN

SECTION 5100. LEGISLATIVE FINDINGS.
5101. SHORT TITLE.
5102. DEFINITIONS.
5103. PLAN CREATED.
5104. BOARD OF GOVERNORS.
5105. POWERS AND DUTIES OF THE BOARD.
5106. POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR.
5107. PLAN ELIGIBILITY.
5108. PLAN BENEFITS.
5109. PAYMENT FOR SERVICES.
5110. OUT-OF-STATE PARTICIPATION AND PAYMENTS.

S 5100. LEGISLATIVE FINDINGS. THE LEGISLATURE FINDS AND DECLARES THAT ALL RESIDENTS OF THE STATE OF NEW YORK HAVE THE RIGHT TO HEALTH SERVICES, YET AN INCREASING NUMBER OF NEW YORKERS ARE UNABLE TO EXERCISE THIS RIGHT BECAUSE OF A LACK OF HEALTH COVERAGE. NEW YORKERS HAVE EXPERIENCED A RAPID RISE IN THE COST OF HEALTH CARE IN RECENT YEARS. THIS INCREASE HAS RESULTED IN A LARGE NUMBER OF PEOPLE WHO HAVE HAD TO

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

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DISCONTINUE THEIR HEALTH COVERAGE. BUSINESSES HAVE ALSO EXPERIENCED EXTRAORDINARY INCREASES IN THE COSTS OF HEALTH CARE BENEFITS FOR THEIR EMPLOYEES. OVER THREE MILLION NEW YORKERS HAVE NO HEALTH COVERAGE, AND ANOTHER ESTIMATED THREE MILLION ARE SEVERELY UNDERINSURED. HOSPITALS AND OTHER HEALTH CARE PROVIDERS ARE ALSO AFFECTED BY INADEQUATE HEALTH INSURANCE COVERAGE IN NEW YORK STATE. A LARGE PORTION OF VOLUNTARY AND PUBLIC HOSPITALS, HEALTH CENTERS AND OTHER PROVIDERS NOW EXPERIENCE SUBSTANTIAL LOSSES DUE TO THE PROVISION OF CARE THAT IS UNCOMPENSATED. TO ADDRESS THE FISCAL CRISIS FACING THE HEALTH CARE SYSTEM 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 ARTICLE IS AN ENACTMENT OF STATE CONCERN FOR THE PURPOSE OF ESTABLISHING A COMPREHENSIVE UNIVERSAL HEALTH CARE COVERAGE PROGRAM AND A HEALTH CARE COST CONTROL SYSTEM FOR THE BENEFIT OF ALL RESIDENTS OF THE STATE OF NEW YORK.

S 5101. SHORT TITLE. THIS ARTICLE SHALL BE KNOWN AND MAY BE CITED AS THE "NEW YORK HEALTH PLAN".

S 5102. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE, UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE:

1. "BOARD" MEANS THE BOARD OF GOVERNORS OF THE NEW YORK HEALTH PLAN AS CREATED BY SECTION FIFTY-ONE HUNDRED FOUR OF THIS ARTICLE.

2. "PLAN" MEANS THE NEW YORK HEALTH PLAN AS CREATED BY SECTION FIFTY-ONE HUNDRED THREE OF THIS ARTICLE.

3. "PLAN MEMBER" MEANS ANY PERSON WHO QUALIFIES FOR BENEFITS UNDER THE PLAN UNDER SECTION FIFTY-ONE HUNDRED SEVEN OF THIS ARTICLE.

4. "PARTICIPATING PROVIDER" MEANS ANY PERSON, PARTNERSHIP, CORPORATION OR OTHER ENTITY, AUTHORIZED TO FURNISH COVERED SERVICES PURSUANT TO THIS ARTICLE.

5. "PLAN RATE" MEANS THE RATE OF PAYMENT FOR A COVERED SERVICE, UNDER THE PLAN, ESTABLISHED IN ACCORDANCE WITH THIS ARTICLE.

6. "GLOBAL BUDGET" MEANS AN INSTITUTION-WIDE BUDGET FOR THE FIXED AND OPERATING COSTS FOR THE PROVISION OF HEALTH CARE SERVICES, EXCLUSIVE OF CAPITAL EXPENDITURES COVERED UNDER SUBPARAGRAPH (III) OF PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION FIFTY-ONE HUNDRED FIVE OF THIS ARTICLE.

7. "RESIDENT" MEANS A PERSON WHO HAS ESTABLISHED THEIR PRIMARY PLACE OF ABODE IN THIS STATE, AS DETERMINED ACCORDING TO REGULATIONS OF THE BOARD.

S 5103. PLAN CREATED. THERE IS HEREBY ESTABLISHED THE NEW YORK HEALTH PLAN, TO PROVIDE, AS SET OUT IN THIS ARTICLE, AND RELATED LEGISLATION, UNIVERSAL HEALTH COVERAGE FOR ALL RESIDENTS OF THIS STATE, ACCESS TO AND CHOICE OF HEALTH CARE PROVIDERS, CONTROLS ON HEALTH CARE COSTS, DEVELOPMENT OF HEALTH CARE SERVICES, AND PUBLIC FINANCING FOR THE PROGRAM. SUCH PLAN SHALL BE A CORPORATE GOVERNMENTAL AGENCY CONSTITUTING A PUBLIC BENEFIT CORPORATION.

S 5104. BOARD OF GOVERNORS. 1. A BOARD OF GOVERNORS TO ADMINISTER THE PLAN IS HEREBY CREATED. THE BOARD SHALL BE COMPOSED OF EIGHTEEN MEMBERS, TO CONSIST OF THE CHAIR AND SEVENTEEN ADDITIONAL MEMBERS, APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE. THE COMMISSIONER, THE SUPERINTENDENT OF INSURANCE, AND THE COMMISSIONER OF TAXATION AND FINANCE SHALL SERVE AS NONVOTING EX OFFICIO MEMBERS OF THE BOARD.

OF THE SEVENTEEN ADDITIONAL MEMBERS APPOINTED BY THE GOVERNOR:

(A) FIVE SHALL BE REPRESENTATIVE 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;

(B) THREE SHALL BE REPRESENTATIVE OF LABOR ORGANIZATIONS;
(C) THREE SHALL BE REPRESENTATIVE OF BUSINESS AND INDUSTRY;
(D) TWO SHALL BE REPRESENTATIVE OF HOSPITALS;
(E) TWO SHALL BE REPRESENTATIVE OF PHYSICIANS; AND
(F) TWO SHALL BE REPRESENTATIVE OF LICENSED NON-PHYSICIAN HEALTH CARE PROFESSIONALS.

2. MEMBERS SHALL SERVE FOR A TERM OF FIVE YEARS; EACH TERM SHALL END ON DECEMBER THIRTY-FIRST. EACH MEMBER OF THE BOARD SHALL HOLD OFFICE FROM THE DATE OF QUALIFICATION FOR OFFICE UNTIL THE END OF THE TERM FOR WHICH THE MEMBER WAS APPOINTED. ANY MEMBER APPOINTED TO FILL A VACANCY OCCURRING PRIOR TO THE EXPIRATION OF A TERM, SHALL HOLD OFFICE FOR THE REMAINDER OF THAT TERM.

3. EACH MEMBER SHALL CONTINUE IN OFFICE SUBSEQUENT TO THE EXPIRATION DATE OF THE TERM UNTIL A SUCCESSOR TAKES OFFICE.

4. THE GOVERNOR MAY REMOVE THE CHAIR OF THE BOARD FOR GOOD CAUSE PRIOR TO THE EXPIRATION OF HIS OR HER TERM. IN THE EVENT OF A VACANCY IN THE CHAIR, THE GOVERNOR MAY APPOINT A PERSON TO BE ACTING CHAIR UNTIL A CHAIR SHALL BE CONFIRMED BY THE SENATE.

5. THE BOARD SHALL MEET AT LEAST FOUR TIMES IN A CALENDAR YEAR.

6. MEETINGS SHALL BE HELD UPON THE CALL OF THE CHAIR AND AS PROVIDED BY THE BOARD.

7. TEN MEMBERS OF THE BOARD SHALL CONSTITUTE A QUORUM, AND THE AFFIRMATIVE VOTE OF TEN MEMBERS SHALL BE NECESSARY FOR ANY ACTION TO BE TAKEN BY THE BOARD.

8. THE BOARD MAY ESTABLISH AN EXECUTIVE COMMITTEE TO CARRY OUT 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 BE THE CHAIR OF THE EXECUTIVE COMMITTEE AND SHALL APPOINT THE CHAIRS OF OTHER COMMITTEES. THE BOARD MAY ALSO ESTABLISH ADVISORY COMMITTEES, CONSISTING OF PERSONS OTHER THAN MEMBERS OF THE BOARD.

9. MEMBERS OF THE BOARD, WITH THE EXCEPTION OF THE CHAIR, SHALL SERVE WITHOUT COMPENSATION, BUT SHALL BE REIMBURSED FOR THEIR NECESSARY AND ACTUAL EXPENSES INCURRED WHILE ENGAGED IN THE BUSINESS OF THE BOARD.

10. NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF LAW, GENERAL, SPECIAL OR LOCAL, NO OFFICER OR EMPLOYEE OF THE STATE OR OF ANY CIVIL DIVISION THEREOF SHALL BE DEEMED TO HAVE FORFEITED OR SHALL FORFEIT HIS OR HER OFFICE OR EMPLOYMENT BY REASON OF BEING A MEMBER OF THE BOARD.

S 5105. POWERS AND DUTIES OF THE BOARD. 1. EXCEPT AS OTHERWISE LIMITED BY THIS ARTICLE, THE BOARD SHALL HAVE THE FOLLOWING CORPORATE POWERS:
(A) TO SUE AND BE SUED;
(B) TO HAVE A SEAL AND ALTER THE SAME AT PLEASURE;
(C) TO MAKE AND EXECUTE CONTRACTS AND ALL OTHER INSTRUMENTS NECESSARY OR CONVENIENT FOR THE EXERCISE OF ITS POWERS AND FUNCTIONS UNDER THIS ARTICLE;
(D) TO MAKE AND ALTER BY-LAWS FOR ITS ORGANIZATION AND INTERNAL MANAGEMENT;
(E) TO ACQUIRE, HOLD AND DISPOSE OF PERSONAL PROPERTY FOR ITS CORPORATE PURPOSES;
(F) TO APPOINT OFFICERS, AGENTS AND EMPLOYEES, PRESCRIBE THEIR DUTIES AND QUALIFICATIONS AND FIX THEIR COMPENSATION;
(G) TO BORROW MONEY AND ISSUE NEGOTIABLE NOTES, BONDS OR OTHER OBLIGATIONS FOR ITS CORPORATE PURPOSES AND TO PROVIDE FOR THE RIGHTS OF THE HOLDERS THEREOF;
(H) TO INVEST ANY FUNDS HELD IN RESERVE OR SINKING FUNDS, OR ANY MONIES NOT REQUIRED FOR THE IMMEDIATE USE OR DISBURSEMENT, AT THE DISCRETION OF THE PLAN, IN OBLIGATIONS OF THE STATE OR THE UNITED STATES

GOVERNMENT, OR IN ANY OTHER OBLIGATIONS IN WHICH THE COMPTROLLER OF THE STATE OF NEW YORK IS AUTHORIZED TO INVEST PURSUANT TO SECTION NINETY-EIGHT OF THE STATE FINANCE LAW;

(I) TO ACCEPT ANY GIFTS OR GRANTS OR LOANS OF FUNDS OR PROPERTY OR FINANCIAL OR OTHER AID IN ANY FORM FROM THE FEDERAL GOVERNMENT OR ANY AGENCY OR INSTRUMENTALITY THEREOF OR FROM THE STATE OR FROM ANY OTHER SOURCE AND TO COMPLY, SUBJECT TO THE PROVISIONS OF THIS ARTICLE, WITH THE TERMS AND CONDITIONS THEREOF; AND

(J) TO DO ANY AND ALL THINGS NECESSARY OR CONVENIENT TO CARRY OUT ITS PURPOSES AND EXERCISE THE POWERS EXPRESSLY GIVEN AND GRANTED IN THIS ARTICLE.

2. THE BOARD SHALL HAVE THE ADDITIONAL POWER TO DO THE FOLLOWING:

(A) (I) ESTABLISH A BUDGET TO INCLUDE ALL HEALTH CARE EXPENDITURES MADE BY THE PLAN, INCLUDING THE ESTABLISHMENT OF AGGREGATE EXPENDITURE TARGETS APPLICABLE TO CATEGORIES OF HEALTH SERVICES. (II) IN ESTABLISHING THE BUDGET, THE BOARD SHALL LIMIT THE ANNUAL AGGREGATE LEVEL OF EXPENDITURES FOR ANY YEAR TO A SUM EQUIVALENT TO THE LEVEL OF EXPENDITURES IN THE PRECEDING YEAR INCREASED BY ONE HUNDRED TWENTY PERCENT OF THE ANNUAL INCREASE IN THE CONSUMER PRICE INDEX - URBAN AS DEVELOPED BY THE UNITED STATES DEPARTMENT OF COMMERCE. (III) IN ESTABLISHING THE BUDGET, GLOBAL BUDGETS, ALLOCATIONS FOR CAPITAL EXPENDITURES, AND OTHER BUDGET AND EXPENDITURE ACTIONS, THE BOARD SHALL CONSIDER REGIONAL NEEDS AND RESOURCES, FOR REGIONS THAT ARE GEOGRAPHICAL AREAS REASONABLY RELATED TO THE NEED FOR, AND DELIVERY AND USE OF, PARTICULAR HEALTH CARE FACILITIES AND SERVICES, AND SHALL ENCOURAGE THE SHARING AND COOPERATIVE USE OF FACILITIES AND SERVICES BY HEALTH CARE PROVIDERS.

(B) ESTABLISH PLAN RATES, IN ACCORDANCE WITH SECTION FIFTY-ONE HUNDRED NINE OF THIS ARTICLE;

(C) ESTABLISH GLOBAL BUDGETS, AND DEVELOP RULES AND REGULATIONS CONCERNING ALLOWABLE EXPENDITURES TO BE INCLUDED IN GLOBAL BUDGETS, FOR INSTITUTIONAL PROVIDERS OF SERVICES, IN ACCORDANCE WITH SECTION FIFTY-ONE HUNDRED NINE OF THIS ARTICLE;

(D) ADMINISTER, IMPLEMENT AND MONITOR THE OPERATION OF THE PLAN;

(E) ADMINISTER THE NEW YORK HEALTH TRUST FUND CREATED PURSUANT TO SECTION EIGHTY-NINE-H OF THE STATE FINANCE LAW, AND INCLUDE WITHIN THE FUND ALLOCATIONS FOR THE FOLLOWING PURPOSES:

(I) HEALTH PROMOTION AND PRIMARY PREVENTION PROGRAMS, INCLUDING PROGRAMS WHICH UTILIZE COMMUNITY SETTINGS, SCHOOLS AND PLACES OF WORK, TO PROMOTE HEALTHY LIFESTYLES, ENABLE CONSUMERS TO MAKE INFORMED HEALTH DECISIONS AND PROVIDE SCREENING TESTS NOT PERFORMED AS PART OF ROUTINE CARE. MONEY ALLOCATED FOR THIS PURPOSE SHALL EQUAL AT LEAST ONE-HALF OF ONE PERCENT OF THE MONIES IN THE TRUST FUND;

(II) PAYING PARTICIPATING PROVIDERS IN ACCORDANCE WITH SECTION FIFTY-ONE HUNDRED NINE OF THIS ARTICLE;

(III) CAPITAL EXPENDITURES FOR THE FOLLOWING PURPOSES:

(A) CONSTRUCTION, RENOVATION, AND EQUIPPING OF HEALTH CARE INSTITUTIONS, INCLUDING INSTITUTIONAL PROVIDERS OF INPATIENT CARE AND AMBULATORY FACILITIES FOR DIAGNOSIS, TREATMENT AND SURGERY, DIAGNOSTIC AND TREATMENT CENTERS PROVIDING A COMPREHENSIVE RANGE OF PRIMARY HEALTH CARE SERVICES, AND MAJOR MEDICAL EQUIPMENT ACQUIRED FOR USE IN PRIVATE PRACTITIONER OFFICES;

(B) A LOAN PROGRAM FOR FACILITIES AND EQUIPMENT FOR USE BY HEALTH CARE PROFESSIONALS WHO DESIRE TO ESTABLISH PRACTICES IN AREAS OF THIS STATE IN WHICH, ACCORDING TO CRITERIA ESTABLISHED BY THE BOARD, THE LEVEL OF DELIVERY OF HEALTH CARE SERVICES IS INADEQUATE;

(IV) TRANSPORTATION OF PLAN MEMBERS FROM ONE GLOBALLY-BUDGETED INSTITUTION TO ANOTHER FOR THE PROVISION OF COVERED SERVICES, AND OTHERWISE TO EFFECT COOPERATION AND COMMUNICATION BETWEEN INSTITUTIONS FOR THE DELIVERY OF HEALTH CARE SERVICES; AND

(V) EDUCATION AND TRAINING OF WORKERS IN THE HEALTH CARE FIELD, INCLUDING, BUT NOT LIMITED TO, RETRAINING OF WORKERS WHO EXPERIENCE JOB LOSS OR DISLOCATION ASSOCIATED WITH THE IMPLEMENTATION OF THE NEW YORK HEALTH PLAN; AND A PROGRAM OF LOAN REPAYMENTS OR OTHER INCENTIVES TO ENCOURAGE HEALTH CARE PRACTITIONERS TO SERVE IN UNDERSERVED AREAS, SPECIALTIES OR FACILITIES. MONIES ALLOCATED SHALL EQUAL AT LEAST ONE-QUARTER OF ONE PERCENT OF THE MONIES IN THE TRUST FUND.

(F) IN CARRYING OUT ITS POWERS AND DUTIES, ESTABLISH REASONABLE AND EFFECTIVE MEANS OF:

(I) COST CONTAINMENT, INCLUDING BUT NOT LIMITED TO: REDUCING INEFFICIENCIES IN HEALTH CARE DELIVERY; PROMOTING EFFECTIVE AND APPROPRIATE USE OF ADVANCEMENTS IN CLINICAL PRACTICE AND TECHNOLOGY; ENCOURAGING THE USE OF LESS COSTLY ALTERNATIVE PROVIDERS WHERE APPROPRIATE; AND ESTABLISHING TREATMENT NORMS FOR PROVIDERS TO REDUCE THE INAPPROPRIATE PROVISION OR USE OF SERVICES;

(II) QUALITY ASSURANCE, INCLUDING BUT NOT LIMITED TO: DEVELOPING CLINICAL PRACTICE GUIDELINES; AND PROMOTING SYSTEMS FOR REVIEW OF PATIENT OUTCOMES, AND QUALITY AND APPROPRIATENESS OF SERVICES;

(III) PROMOTING ACCESS TO SERVICES, INCLUDING BUT NOT LIMITED TO: AVAILABILITY OF PRIMARY, PREVENTIVE AND OTHER SERVICES FOR CONTINUITY OF CARE; ASSURING CONSUMERS FREEDOM TO SELECT AMONG QUALIFIED PROVIDERS FOR APPROPRIATE SERVICES WITHIN THEIR RECOGNIZED SCOPE OF PRACTICE; RESPECTING THE PROFESSIONAL JUDGMENT OF PROVIDERS AND THE RIGHTS OF PATIENTS, AND THEIR FAMILIES AND REPRESENTATIVES WHERE APPROPRIATE, TO PARTICIPATE IN DECISIONS AFFECTING THEIR CARE; AND ELIMINATING AND PREVENTING INEQUITIES IN, OR BARRIERS TO, ACCESS TO SERVICES BASED ON GEOGRAPHY, SOCIAL OR ECONOMIC STATUS, RACE, RELIGION, GENDER, AGE, ETHNICITY, LANGUAGE, SEXUAL ORIENTATION, FAMILY STATUS OR DEFINITION, AND HEALTH CONDITION;

(G) ESTABLISH, AS THE BOARD CONSIDERS IT NECESSARY, A SYSTEM TO PROMOTE CONTINUITY OF CARE;

(H) ESTABLISH AN INDEMNITY PLAN TO CARRY OUT THE PURPOSES SET FORTH IN SECTION FIFTY-ONE HUNDRED TEN OF THIS ARTICLE;

(I) ESTABLISH A PRESCRIPTION DRUG FORMULARY, IN ACCORDANCE WITH SECTION FIFTY-ONE HUNDRED EIGHT OF THIS ARTICLE;

(J) AWARD CONTRACTS TO ADMINISTER THE PAYMENT OF COVERED SERVICES TO PARTICIPATING PROVIDERS, AND OTHER ELEMENTS OF THE PLAN AS THE BOARD DEEMS APPROPRIATE;

(K) (I) STUDY AND EVALUATE THE OPERATION OF THE PLAN, INCLUDING BUT NOT LIMITED TO THE ADEQUACY AND QUALITY OF SERVICES COVERED UNDER THE PLAN, THE COST OF EACH TYPE OF SERVICE AND THE EFFECTIVENESS OF COST CONTAINMENT MEASURES UNDER THE PLAN; AND

(II) STUDY UTILIZATION OF HEALTH CARE SERVICES UNDER THE PLAN, ENROLLMENT OF NEW PLAN MEMBERS, EFFECT OF THE PLAN ON PROVIDERS AND PRACTITIONERS, INCLUDING RECRUITMENT AND RETENTION OF PRACTITIONERS, AND OTHER MATTERS RELATING TO PLAN EXPERIENCE, OPERATION AND IMPACT. THE BOARD SHALL ESPECIALLY EXAMINE THE PHENOMENON OF INDIVIDUALS BECOMING MEMBERS OF THE PLAN (OTHER THAN BY BIRTH) FOR THE PURPOSE OF OBTAINING PLAN BENEFITS FOR PRE-EXISTING CONDITIONS FOR WHICH THEY HAD INADEQUATE OR NO HEALTH CARE COVERAGE, AND ITS EXTENT, NATURE AND FINANCIAL AND HEALTH CARE SYSTEM IMPACTS. THE BOARD SHALL CONSIDER THE NEED FOR, AND PROBABLE EFFECTIVENESS, ADVANTAGES AND DISADVANTAGES OF, POSSIBLE CHANGES IN THE PLAN INCLUDING LIMITING PLAN BENEFITS FOR SUCH CONDITIONS FOR A

PERIOD OF TIME TO EXCLUDE SUCH CONDITIONS OR IMPOSE REQUIREMENTS SUCH AS DEDUCTIBLES, MAXIMUM BENEFITS OR CO-INSURANCE;

(L) REPORT ANNUALLY TO THE GOVERNOR AND THE LEGISLATURE ON ITS ACTIVITIES AND RECOMMEND ANY CHANGES IN LAWS TO IMPROVE ACCESS TO QUALITY HEALTH CARE AND TO MORE EFFECTIVELY CONTROL COSTS OF SERVICES PROVIDED UNDER THE PLAN, CONSISTENT WITH QUALITY HEALTH CARE;

(M) DISSEMINATE, TO PROVIDERS OF SERVICES AND TO THE PUBLIC, INFORMATION CONCERNING THE PLAN AND THE PERSONS ELIGIBLE TO RECEIVE THE BENEFITS UNDER THE PLAN;

(N) CONDUCT NECESSARY INVESTIGATIONS AND INQUIRIES AND REQUIRE THE SUBMISSION OF INFORMATION, DOCUMENTS AND RECORDS IT CONSIDERS NECESSARY TO CARRY OUT ITS DUTIES UNDER THIS ARTICLE;

(O) CREATE A PROGRAM FOR THE RESOLUTION OF COMPLAINTS BROUGHT BY PLAN MEMBERS OR PARTICIPATING PROVIDERS REGARDING ANY MATTER ASSOCIATED WITH COVERAGE UNDER THE PLAN, OR THE OPERATION OF THE PLAN;

(P) NO LATER THAN FIVE YEARS AFTER THE EFFECTIVE DATE OF THE PLAN, DEVELOP A PROPOSAL FOR PROVISION BY THE PLAN OF LONG-TERM CARE COVERAGE, INCLUDING THE DEVELOPMENT OF A PROPOSAL 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, BUSINESS, LABOR, SOCIAL SERVICES DISTRICTS, AND OTHER INTERESTED PARTIES;

(Q) DEVELOP A PLAN TO COORDINATE ITS ACTIVITIES, INCLUDING PLANNING FOR THE ADEQUACY OF HEALTH CARE SERVICES AND THE APPROVAL OF CAPITAL EXPENDITURES, WITH APPROPRIATE STATE AND LOCAL BODIES, INCLUDING HEALTH SYSTEMS AGENCIES AND THE HOSPITAL REVIEW AND PLANNING COUNCIL;

(R) NO LATER THAN ONE YEAR AFTER THE EFFECTIVE DATE OF THE PLAN, RECOMMEND TO THE GOVERNOR AND STATE LEGISLATURE THE REORGANIZATION OF STATE GOVERNMENT AGENCIES TO MOST EFFECTIVELY CARRY OUT ACTIVITIES TO BE CONDUCTED BY THE BOARD; AND

(S) CONDUCT OTHER ACTIVITIES NECESSARY AND APPROPRIATE TO CARRY OUT THE PURPOSES OF THIS ARTICLE, INCLUDING THE EMPLOYMENT OF STAFF AND AN EXECUTIVE DIRECTOR.

3. THE BOARD, AFTER PROVIDING NOTICE TO THE PUBLIC AND INTERESTED PARTIES, MAY HOLD HEARINGS IN CONNECTION WITH ANY ACTIVITIES IT PROPOSES TO UNDERTAKE.

4. THE BOARD SHALL MAINTAIN THE CONFIDENTIALITY OF ALL DATA AND OTHER INFORMATION COLLECTED IN FULFILLING ITS DUTIES WHEN SUCH DATA WOULD BE NORMALLY CONSIDERED CONFIDENTIAL DATA BETWEEN A PATIENT AND HEALTH CARE PROVIDER. AGGREGATE DATA WHICH IS DERIVED FROM CONFIDENTIAL DATA BUT DOES NOT VIOLATE PATIENT CONFIDENTIALITY SHALL BE CONSIDERED PUBLIC INFORMATION.

S 5106. POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR. 1. THE EXECUTIVE DIRECTOR OF THE PLAN SHALL BE THE CHIEF EXECUTIVE OFFICER OF THE PLAN.

2. THE EXECUTIVE DIRECTOR SHALL PERFORM SUCH DUTIES IN THE ADMINISTRATION OF THE PLAN AS THE BOARD MAY ASSIGN, INCLUDING THE EMPLOYMENT AND SUPERVISION OF STAFF.

3. THE BOARD MAY DELEGATE TO THE EXECUTIVE DIRECTOR ANY OF ITS FUNCTIONS OR DUTIES UNDER THIS ARTICLE OTHER THAN THE ISSUANCE OF RULES AND REGULATIONS AND THE ESTABLISHMENT OF THE ANNUAL PLAN BUDGET.

S 5107. PLAN ELIGIBILITY. 1. EVERY PERSON WHO IS A RESIDENT OF THIS STATE IS ELIGIBLE TO RECEIVE BENEFITS FOR COVERED SERVICES UNDER THE PLAN AND SHALL BE A PLAN MEMBER.

2. EVERY PLAN MEMBER IS ENTITLED TO RECEIVE BENEFITS FOR ANY COVERED SERVICE FURNISHED WITHIN THIS STATE BY A PARTICIPATING PROVIDER, IF THE

SERVICE IS NECESSARY OR APPROPRIATE FOR THE MAINTENANCE OF HEALTH OR FOR THE DIAGNOSIS OR TREATMENT OF, OR REHABILITATION FOLLOWING, INJURY, DISABILITY OR DISEASE.

S 5108. PLAN BENEFITS. 1. COVERED SERVICES UNDER THE PLAN SHALL INCLUDE, BUT ARE NOT LIMITED TO, ALL OF THE FOLLOWING MEDICALLY NECESSARY INPATIENT AND OUTPATIENT SERVICES:

(A) HOSPITAL SERVICES;

(B) MEDICAL AND OTHER PROFESSIONAL SERVICES FURNISHED BY AUTHORIZED HEALTH CARE PROFESSIONALS WHO ARE AUTHORIZED TO PROVIDE SUCH SERVICES UNDER THE LAWS OF THIS STATE INCLUDING PRIMARY, PREVENTIVE AND SPECIALTY SERVICES;

(C) LABORATORY TESTS AND IMAGING PROCEDURES;

(D) SHORT-TERM HOME HEALTH SERVICES FOR PERSONS REQUIRING SERVICES PERFORMED BY OR UNDER THE SUPERVISION OF PROFESSIONAL OR TECHNICAL PERSONNEL;

(E) REHABILITATIVE SERVICES WHERE A PATIENT IS RECEIVING ACTIVE CARE WITH A THERAPEUTIC OUTCOME;

(F) PRESCRIPTION DRUGS AND DEVICES, PROVIDED, HOWEVER, THAT THE PLAN SHALL PARTIALLY COVER THE COST OF A DRUG DISPENSED IN A PACKAGE, OR FORM OF DOSAGE OR ADMINISTRATION, AS TO WHICH THE BOARD DETERMINES THAT A LESS EXPENSIVE PACKAGE, OR FORM OF DOSAGE OR ADMINISTRATION IS AVAILABLE THAT IS PHARMACEUTICALLY EQUIVALENT AND EQUIVALENT IN ITS THERAPEUTIC EFFECT. IF A PLAN MEMBER CHOOSES TO PURCHASE A MORE EXPENSIVE DRUG THAT HAS A PHARMACEUTICAL AND THERAPEUTIC EQUIVALENT, THE PLAN MEMBER SHALL BE FINANCIALLY RESPONSIBLE FOR PAYING THE AMOUNT EQUAL TO THE DIFFERENCE BETWEEN THE COST OF SUCH DRUG AND ITS EQUIVALENT UNLESS THE PRESCRIBING PRACTITIONER CERTIFIES THAT THE MORE EXPENSIVE DRUG IS MEDICALLY NECESSARY, IN WHICH CASE THE PLAN SHALL COVER THE FULL COST;

(G) MENTAL HEALTH SERVICES SUBJECT TO APPROPRIATENESS GUIDELINES AND REVIEW;

(H) SUBSTANCE ABUSE TREATMENT SERVICES;

(I) PRIMARY AND ACUTE DENTAL SERVICES;

(J) VISION APPLIANCES, INCLUDING LENSES, FRAMES AND CONTACT LENSES, ACCORDING TO A SCHEDULE ESTABLISHED BY THE BOARD;

(K) MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND SELECTED ASSISTIVE DEVICES; AND

(L) HOSPICE CARE.

2. COVERED SERVICES DO NOT INCLUDE ANY OF THE FOLLOWING:

(A) SURGERY FOR COSMETIC PURPOSES OTHER THAN FOR RECONSTRUCTIVE SURGERY;

(B) MEDICAL EXAMINATIONS CONDUCTED AND MEDICAL REPORTS PREPARED FOR ANY OF THE FOLLOWING PURPOSES:

(I) PURCHASING OR RENEWING LIFE INSURANCE;

(II) APPLICATIONS FOR EMPLOYMENT; OR

(III) PARTICIPATING AS A PLAINTIFF OR DEFENDANT IN A CIVIL ACTION FOR THE RECOVERY OR SETTLEMENT OF DAMAGES;

(C) BASIC OR CUSTODIAL CARE RENDERED IN A NURSING HOME;

(D) CUSTODIAL CARE RENDERED IN A FACILITY LICENSED UNDER THE MENTAL HYGIENE LAW; OR

(E) COSMETIC DENTAL SERVICES.

3. COINSURANCES, DEDUCTIBLES AND COPAYMENTS SHALL NOT BE APPLICABLE TO BENEFITS COVERED UNDER THE PLAN.

4. INSURERS AUTHORIZED TO UNDERWRITE COVERAGE PURSUANT TO THE INSURANCE LAW OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED IN ACCORDANCE WITH ARTICLE FORTY-FOUR OF THIS CHAPTER, MAY OFFER BENEFITS THAT DO NOT DUPLICATE COVERAGE THAT IS OFFERED UNDER THE PLAN BUT MAY NOT OFFER

BENEFITS THAT DUPLICATE COVERAGE THAT IS COVERED BY THE PLAN. PROVIDED, HOWEVER, THAT NOTHING IN THIS SUBDIVISION SHALL PROHIBIT THE OFFERING OF BENEFITS TO OR FOR PERSONS, INCLUDING THEIR FAMILIES, WHO ARE EMPLOYED OR SELF-EMPLOYED IN THIS STATE BUT ARE NOT RESIDENTS OF THE STATE.

5. NO PARTICIPATING PROVIDER SHALL REFUSE TO FURNISH SERVICES TO A PLAN MEMBER ON THE BASIS OF RACE, COLOR, CREED, AGE, NATIONAL ORIGIN, ALIENAGE OR CITIZENSHIP STATUS, GENDER, SEXUAL ORIENTATION, DISABILITY, MARITAL STATUS, OR ARREST RECORD, EXCEPT AS APPROPRIATE TO THE PROVIDER'S PROFESSIONAL SPECIALIZATION, OR OTHER MEDICALLY APPROPRIATE CIRCUMSTANCES.

6. A PLAN MEMBER MAY CHOOSE ANY PARTICIPATING PROVIDER, WHETHER PRACTICING ON AN INDEPENDENT BASIS, IN A SMALL GROUP, OR IN A CAPITATED PRACTICE. A PLAN MEMBER WHO ENROLLS IN A CAPITATED PRACTICE SHALL BE SUBJECT TO RULES AND REQUIREMENTS OF THE PLAN AS TO DISENROLLMENT, CHOICE OF PROVIDER, AND AVAILABILITY OF BENEFITS OUTSIDE THE CAPITATED PRACTICE.

S 5109. PAYMENT FOR SERVICES. 1. THE PLAN SHALL PAY THE EXPENSES OF INSTITUTIONAL PROVIDERS LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER FOR COVERED SERVICES ON THE BASIS OF GLOBAL BUDGETS THAT ARE APPROVED BY THE BOARD.

2. THE GLOBAL BUDGET OF EACH INSTITUTIONAL PROVIDER SHALL BE SET ANNUALLY BY THE PLAN AFTER CONSULTATION AND NEGOTIATION WITH THE INSTITUTIONAL PROVIDERS, AND SHALL COVER THE COSTS OF ITS ANTICIPATED SERVICES FOR THE NEXT YEAR, BASED ON PAST PERFORMANCE AND PROJECTED CHANGES IN FACTOR PRICES AND SERVICE LEVELS.

3. EVERY INDIVIDUAL HEALTH CARE PROVIDER EMPLOYED BY A GLOBALLY BUDGETED INSTITUTIONAL PROVIDER SHALL BE PAID THROUGH AND IN A MANNER DETERMINED BY THE INSTITUTIONAL PROVIDER.

4. THE BUDGETING PROCEDURE DESCRIBED IN SUBDIVISIONS ONE, TWO AND THREE OF THIS SECTION ALSO APPLIES TO INSTITUTIONS THAT PROVIDE PLAN SERVICES AND THAT ARE FUNDED BY ANY POLITICAL SUBDIVISION OR ANY AGENCY OR INSTRUMENTALITY OF A POLITICAL SUBDIVISION.

5. THE PLAN SHALL REIMBURSE NON-INSTITUTIONAL PARTICIPATING PROVIDERS ON A FEE-FOR-SERVICE BASIS, ESTABLISHED BY THE BOARD. THE FEE SCHEDULE SHALL VARY THE PAYMENT AMOUNT AMONG DIFFERENT SERVICES BASED ON THE RELATIVE VALUE OF THE INPUT FACTORS TO PROVIDE THE SERVICES.

6. FEE SCHEDULES MAY TAKE INTO ACCOUNT RECOGNIZED DIFFERENCES AMONG GEOGRAPHIC AREAS REGARDING COST OF PRACTICE.

7. TO THE GREATEST EXTENT FEASIBLE, FEE SCHEDULE CATEGORIES SHALL INCLUDE PAYMENT FOR ALL PROCEDURES ROUTINELY PERFORMED FOR A GIVEN DIAGNOSIS.

8. (A) A MULTI-SPECIALTY ORGANIZATION OF PROVIDERS MAY ELECT TO BE REIMBURSED ON A CAPITATION BASIS, IN LIEU OF A FEE-FOR-SERVICE BASIS.

(B) IF THE ORGANIZATION MEETS ENROLLMENT AND OTHER REQUIREMENTS ESTABLISHED BY THE BOARD, THE ORGANIZATION MAY ELECT TO HAVE INCLUDED IN ITS CAPITATION PAYMENTS, INPATIENT SERVICES PROVIDED BY INSTITUTIONS FUNDED UNDER A BUDGET DESCRIBED IN SUBDIVISION ONE OF THIS SECTION. UPON THAT ELECTION, THE INSTITUTIONAL BUDGETS OF SUCH INSTITUTIONS SHALL BE ADJUSTED ACCORDINGLY.

(C) IF THE ORGANIZATION ELECTS, AND MEETS REQUIREMENTS OF THE BOARD, THE BOARD MAY INCLUDE IN THE ORGANIZATION'S CAPITATION PAYMENTS FUNDS TO BE PASSED ON BY THE ORGANIZATION TO PLAN MEMBERS WHO ARE ITS ENROLLED MEMBERS AS A REBATE OR INCENTIVE TO ENCOURAGE MEMBERSHIP IN THE ORGANIZATION; PROVIDED THAT THE BOARD FINDS THAT THE REBATE OR INCENTIVE IS IN THE FINANCIAL INTERESTS OF THE PLAN.

9. EVERY PARTICIPATING PROVIDER SHALL FURNISH TO THE PLAN SUCH INFORMATION, AND PERMIT EXAMINATION OF ITS RECORDS BY THE PLAN, AS MAY BE REASONABLY REQUIRED FOR PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE AND COST CONTAINMENT, FOR THE MAKING OF PAYMENTS AND FOR STATISTICAL OR OTHER STUDIES OF THE OPERATION OF THE PLAN.

10. RATES OF PAYMENT ESTABLISHED UNDER THIS SECTION SHALL BE CONSIDERED PAYMENT IN FULL. A PROVIDER OF SERVICES SHALL NOT CHARGE RATES THAT ARE IN EXCESS OF SUCH REIMBURSEMENT LEVELS, NOR CHARGE SEPARATELY FOR COVERED SERVICES PROVIDED UNDER SECTION FIFTY-ONE HUNDRED EIGHT OF THIS ARTICLE. PROVIDED, HOWEVER, THE PROVISIONS OF THIS SUBDIVISION SHALL NOT APPLY TO SERVICES RENDERED OUTSIDE OF THIS STATE, OR TO SERVICES RENDERED TO PERSONS WHO ARE NOT PLAN MEMBERS.

S 5110. OUT-OF-STATE PARTICIPATION AND PAYMENTS. 1. (A) THE PLAN, IN ACCORDANCE WITH SUBDIVISION FOUR OF THIS SECTION AND EXCEPT AS PROVIDED IN PARAGRAPH (B) OF THIS SUBDIVISION, SHALL PAY FOR SERVICES RENDERED TO PLAN MEMBERS WHILE THEY ARE OUT OF THE STATE (I) WHILE THEY ARE TEMPORARILY OUT OF THE STATE FOR REASONS OTHER THAN TO OBTAIN THE SERVICES OR (II) WHERE THE PLAN MEMBER OBTAINS THE SERVICES OUT OF THE STATE FOR COMPELLING REASONS RELATING TO THE SUITABILITY OF SERVICES, THE NATURE OF THE CONDITION AND PERSONAL CIRCUMSTANCES.

(B) WHERE THE PLAN MEMBER IS ELIGIBLE FOR HEALTH BENEFITS UNDER TITLE XVIII OR TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT, THEN OUT-OF-STATE SERVICES FOR THE PLAN MEMBER SHALL, TO THE EXTENT ALLOWED BY LAW, BE PAID FOR UNDER THOSE TITLES.

2. WHERE AN EMPLOYEE OR SELF-EMPLOYED INDIVIDUAL IS NOT A RESIDENT OF NEW YORK STATE (AND THEREFORE NOT ELIGIBLE TO BE A PLAN MEMBER) BUT IS EMPLOYED OR SELF-EMPLOYED IN THE STATE, THE EMPLOYER OR THE EMPLOYEE, OR THE SELF-EMPLOYED INDIVIDUAL, MAY PURCHASE HEALTH COVERAGE FOR THE PERSON, INCLUDING THE PERSON'S FAMILY, FROM ANY ENTITY AUTHORIZED TO OFFER THAT COVERAGE OR FROM THE PLAN PURSUANT TO SUBDIVISION FIVE OF THIS SECTION.

3. ANY PRIVATE OR STATE COLLEGE, UNIVERSITY OR OTHER INSTITUTION OF HIGHER EDUCATION SITUATED IN THIS STATE MAY PURCHASE COVERAGE UNDER THE PLAN FOR ANY STUDENT, OR THEIR DEPENDENTS, WHO IS NOT A RESIDENT OF THIS STATE.

4. THE BOARD SHALL ESTABLISH AND OPERATE AN INDEMNITY PLAN TO PROVIDE PAYMENTS FOR SERVICES UNDER SUBDIVISION ONE OF THIS SECTION. THE PAYMENTS SHALL BE MADE AT THE RATES ESTABLISHED BY THE BOARD FOR BENEFITS FOR COMPARABLE SERVICES PROVIDED BY THE PLAN IN THIS STATE. CHARGES IN EXCESS OF THE PAYMENT RATES ESTABLISHED IN ACCORDANCE WITH THIS SECTION SHALL BE THE RESPONSIBILITY OF THE PLAN MEMBER.

5. THE BOARD SHALL ESTABLISH AND OPERATE AN INDEMNITY PLAN TO PROVIDE HEALTH COVERAGE FOR EMPLOYEES AND SELF-EMPLOYED INDIVIDUALS WHO ARE NOT RESIDENTS OF THIS STATE BUT ARE EMPLOYED OR SELF-EMPLOYED IN THE STATE, INCLUDING THEIR FAMILIES, TO BE OFFERED FOR PURCHASE BY THE EMPLOYER OR EMPLOYEE, OR SELF-EMPLOYED INDIVIDUALS, UNDER SUBDIVISION TWO OF THIS SECTION. THE INDEMNITY PLAN SHALL BE OFFERED ON A NOT-FOR-PROFIT BASIS. ITS SCOPE OF BENEFITS AND RATES OF PAYMENT SHALL BE ESTABLISHED BY THE BOARD AND SHALL, TO THE EXTENT PRACTICABLE, BE COMPARABLE TO THOSE UNDER THE NEW YORK HEALTH PLAN.

6. NOTHING IN THIS ARTICLE SHALL IMPACT THE EXISTING OR FUTURE OBLIGATIONS OF EMPLOYERS TO PROVIDE SUPPLEMENTARY HEALTH BENEFITS TO RETIREES WHO NO LONGER RESIDE IN THIS STATE.

S 2. The state finance law is amended by adding a new section 89-h to read as follows:

S 89-H. 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".

2. THE FUND SHALL CONSIST OF:

(A) ALL MONIES OBTAINED FROM PREMIUM PAYMENT REVENUES PURSUANT TO ARTICLE THIRTY-FIVE OF THE TAX LAW;

(B) FEDERAL PAYMENTS RECEIVED AS A RESULT OF ANY WAIVER OF REQUIREMENTS GRANTED BY THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES FOR HEALTH CARE PROGRAMS ESTABLISHED UNDER TITLES XVIII (MEDICARE) AND XIX (MEDICAL ASSISTANCE FOR NEEDY PERSONS) OF THE FEDERAL SOCIAL SECURITY ACT;

(C) THE AMOUNTS PAID BY THE DEPARTMENT OF HEALTH AND BY LOCAL SOCIAL SERVICES DISTRICTS THAT ARE EQUIVALENT TO THOSE AMOUNTS THAT ARE PAID ON BEHALF OF RESIDENTS OF THIS STATE UNDER TITLES XVIII (MEDICARE) AND XIX (MEDICAL ASSISTANCE FOR NEEDY PERSONS) OF THE FEDERAL SOCIAL SECURITY ACT, AND ARTICLE FIVE, TITLE ELEVEN OF THE SOCIAL SERVICES LAW FOR HEALTH BENEFITS WHICH ARE EQUIVALENT TO HEALTH BENEFITS COVERED UNDER ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW;

(D) ALL SURCHARGES THAT ARE IMPOSED ON RESIDENTS OF THIS STATE TO REPLACE PAYMENTS MADE BY THE RESIDENTS UNDER THE COST-SHARING PROVISIONS OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT;

(E) FEDERAL, STATE AND LOCAL 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

(F) STATE AND LOCAL GOVERNMENT 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 ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW. 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 IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW.

3. MONIES IN THE FUND SHALL ONLY BE USED FOR PURPOSES ESTABLISHED UNDER ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW.

4. REVENUES HELD IN THE FUND SHALL NOT BE SUBJECT TO APPROPRIATION OR ALLOTMENT BY THE STATE OR ANY POLITICAL SUBDIVISION THEREOF.

5. THE BOARD OF GOVERNORS OF THE NEW YORK HEALTH PLAN UNDER ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW SHALL:

(A) ADMINISTER THE FUND AND SHALL CONDUCT A QUARTERLY REVIEW OF THE EXPENDITURES FROM AND REVENUES RECEIVED BY THE FUND; AND

(B) INVEST THE FUND IN INVESTMENTS THAT ARE AUTHORIZED BY THE LAWS OF THIS STATE FOR THE INVESTMENT OF THE CAPITAL, SURPLUS AND ACCUMULATIONS OF DOMESTIC LIFE INSURANCE COMPANIES. THE LIMITATIONS SET FORTH IN THESE LAWS APPLY TO THE INVESTMENTS OF THE FUND.

S 3. The tax law is amended by adding a new article 35 to read as follows:

ARTICLE 35

NEW YORK HEALTH PLAN PREMIUM PAYMENTS

SECTION 1650. DEFINITIONS.
1651. PREMIUM PAYMENTS.
1652. PROCEDURAL PROVISIONS.

S 1650. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE, UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE:

1. "EMPLOY" MEANS TO SUFFER OR PERMIT TO WORK.

2. "EMPLOYER" MEANS AN INDIVIDUAL, PARTNERSHIP, ASSOCIATION, CORPORATION, BUSINESS TRUST, THE STATE OF NEW YORK, ITS INSTRUMENTALITIES AND ITS POLITICAL SUBDIVISIONS AND THEIR INSTRUMENTALITIES, OR ANY PERSON OR GROUP OF PERSONS, ACTING IN THE INTEREST OF AN EMPLOYER IN RELATION TO AN EMPLOYEE.

3. "EMPLOYEE" MEANS ANY INDIVIDUAL WHO WORKS FOR AN EMPLOYER.

S 1651. PREMIUM PAYMENTS. FOR THE PURPOSE OF PROVIDING REVENUE FOR THE NEW YORK HEALTH PLAN ESTABLISHED PURSUANT TO ARTICLE FIFTY-ONE OF THE PUBLIC HEALTH LAW, AND TO PAY THE EXPENSE OF PLAN ADMINISTRATION, THE FOLLOWING PREMIUM PAYMENTS ARE HEREBY LEVIED:

1. ON EACH EMPLOYER, A PREMIUM PAYMENT EQUAL TO TEN PERCENT OF THE EMPLOYER'S PAYROLL. THE EMPLOYER MAY CHOOSE, SUBJECT TO COLLECTIVE BARGAINING AGREEMENTS, TO DEDUCT TWO PERCENT OF EACH EMPLOYEE'S WAGES OR GROSS SALARY AS PARTIAL PAYMENT OF THIS PREMIUM PAYMENT.

2. ON EACH SELF-EMPLOYED INDIVIDUAL, A PREMIUM PAYMENT EQUAL TO TEN PERCENT OF THE INDIVIDUAL'S SELF-EMPLOYMENT INCOME, SUBJECT TO THE LIMIT ON TAXABLE SELF-EMPLOYMENT INCOME FOR MEDICARE HOSPITAL INSURANCE UNDER THE "FEDERAL INSURANCE CONTRIBUTIONS ACT", 68A STAT. 415 (1954), 26 U.S.C.A. 3101, AS AMENDED.

3. A PERSON SUBJECT TO TAXATION UNDER THIS CHAPTER, OTHER THAN A PERSON WHO IS ENTITLED TO COVERAGE UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, WHO HAS NOT HAD THE PREMIUM PAID ON FIFTY PERCENT OR MORE OF HIS OR HER ADJUSTED GROSS INCOME UNDER SUBDIVISION ONE OR TWO OF THIS SECTION, SHALL MAKE A PREMIUM PAYMENT EQUAL TO TEN PERCENT OF THE DIFFERENCE BETWEEN FIFTY PERCENT OF THE INDIVIDUAL'S ADJUSTED GROSS INCOME AND THE TOTAL AMOUNT OF INCOME ON WHICH THE INDIVIDUAL HAS HAD PREMIUMS PAID UNDER SUBDIVISIONS ONE AND TWO OF THIS SECTION; PROVIDED, HOWEVER, THAT THE TOTAL AMOUNT OF ADJUSTED GROSS INCOME SUBJECT TO PREMIUM PAYMENTS UNDER THIS SUBDIVISION SHALL NOT EXCEED THE LIMIT ON TAXABLE SELF-EMPLOYMENT INCOME FOR MEDICAL HOSPITAL INSURANCE UNDER THE "FEDERAL INSURANCE CONTRIBUTIONS ACT," 68A STAT. 415 (1954), 26 U.S.C.A. 3101, AS AMENDED.

4. (A) WHERE A NEW YORK STATE RESIDENT IS EMPLOYED OUTSIDE THE STATE BY AN EMPLOYER THAT DOES BUSINESS IN THE STATE, OR THAT ELECTS TO BE SUBJECT TO THIS SUBDIVISION, THEN THE EMPLOYER SHALL PAY THE PREMIUM UNDER SUBDIVISION ONE OF THIS SECTION, CALCULATED ON THE PRO RATA PORTION OF THE EMPLOYER'S PAYROLL ATTRIBUTABLE TO ALL NEW YORK STATE RESIDENTS EMPLOYED BY THE EMPLOYER.

(B) WHERE A NEW YORK RESIDENT IS EMPLOYED OUTSIDE THE STATE BY AN EMPLOYER THAT DOES NOT DO BUSINESS IN THE STATE AND THAT DOES NOT ELECT TO BE SUBJECT TO THIS SUBDIVISION, THEN THE EMPLOYEE SHALL PAY THE PREMIUM UNDER SUBDIVISION ONE OF THIS SECTION, AS IF THE EMPLOYEE'S INCOME FROM THE EMPLOYER WAS SELF-EMPLOYMENT INCOME.

5. WHERE AN EMPLOYEE IS NOT A RESIDENT OF NEW YORK STATE (AND THEREFORE NOT ELIGIBLE TO BE A NEW YORK HEALTH PLAN MEMBER), AND THE EMPLOYER PURCHASES HEALTH COVERAGE FOR THE EMPLOYEE, INCLUDING THE EMPLOYEE'S FAMILY, UNDER SUBDIVISION TWO OF SECTION FIFTY-ONE HUNDRED TEN OF THE PUBLIC HEALTH LAW, THE EMPLOYER MAY TAKE A CREDIT AGAINST THE PREMIUM PAID UNDER SUBDIVISION ONE OF THIS SECTION, UP TO THE PRO RATA PORTION OF THE EMPLOYER'S PREMIUM ATTRIBUTABLE TO THAT EMPLOYEE, FOR THE AMOUNT PAID BY THE EMPLOYER TO PURCHASE THAT COVERAGE. WHERE SUCH AN EMPLOYEE PURCHASES OR PAYS A PORTION OF THE COST OF SUCH COVERAGE, THE EMPLOYEE MAY TAKE A CREDIT FOR THE AMOUNT PAID BY HIM OR HER FOR THAT COVERAGE AGAINST ANY PREMIUM THE EMPLOYEE IS REQUIRED BY THE EMPLOYER TO PAY UNDER SUBDIVISION ONE OF THIS SECTION.

6. WHERE A SELF-EMPLOYED INDIVIDUAL IS NOT A RESIDENT OF NEW YORK STATE (AND THEREFORE NOT ELIGIBLE TO BE A NEW YORK HEALTH PLAN MEMBER), AND THE PERSON PURCHASES HEALTH COVERAGE UNDER SUBDIVISION TWO OF SECTION FIFTY-ONE HUNDRED TEN OF THE PUBLIC HEALTH LAW, THE SELF-EMPLOYED INDIVIDUAL MAY TAKE A CREDIT FOR THE AMOUNT PAID BY HIM OR HER FOR THAT COVERAGE AGAINST THE PREMIUM PAID BY THE SELF-EMPLOYED PERSON UNDER SUBDIVISION ONE OF THIS SECTION.

7. THE TOTAL AMOUNT OF CREDITS TAKEN UNDER SUBDIVISIONS FIVE AND SIX OF THIS SECTION, AGAINST PREMIUMS PAID UNDER THIS SECTION, FOR HEALTH COVERAGE FOR A PERSON, INCLUDING THAT PERSON'S FAMILY, SHALL NOT EXCEED THE TOTAL AMOUNT OF PREMIUM PAID BY OR ATTRIBUTABLE TO THAT PERSON, WHETHER PAID BY THAT PERSON OR BY AN EMPLOYER.

8. NEW YORK HEALTH PLAN MEMBERS ENTITLED TO COVERAGE UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, WHO ARE NOT ALSO ENTITLED TO COVERAGE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT, SHALL MAKE PREMIUM PAYMENTS EQUAL TO THE PREMIUM PAYMENT DEVELOPED BY THE FEDERAL SECRETARY OF HEALTH AND HUMAN SERVICES FOR COVERAGE UNDER PART B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT; PROVIDED, HOWEVER, THAT PLAN MEMBERS WHO MAKE PREMIUM PAYMENTS DIRECTLY TO THE SECRETARY OF HEALTH AND HUMAN SERVICES SHALL BE ENTITLED TO A CREDIT AGAINST THE AMOUNT PAID UNDER THIS SUBDIVISION.

S 1652. PROCEDURAL PROVISIONS. THE BOARD OF GOVERNORS OF THE NEW YORK HEALTH PLAN SHALL ADOPT RULES REGARDING THE LEVY AND COLLECTION OF THE PREMIUM PAYMENTS UNDER THIS ARTICLE AND MAY ENTER INTO CONTRACTS WITH THE DEPARTMENT FOR THE COLLECTION OF THE PREMIUM PAYMENTS LEVIED BY THIS ARTICLE. FOR PURPOSES OF ENFORCEMENT, PREMIUM PAYMENTS DUE UNDER THIS ARTICLE SHALL BE SUBJECT TO THE PROVISIONS OF THIS CHAPTER APPLICABLE TO INCOME TAXES DUE UNDER ARTICLE TWENTY-TWO OF THIS CHAPTER.

S 4. 1. There is hereby established a temporary commission on implementation of the New York health plan, hereinafter to be known as the commission, consisting of fifteen members: five members, including the chair, shall be appointed by the governor; five members shall be appointed by the temporary president of the senate, two of which shall be upon recommendation of the senate minority leader; and, five members shall be appointed by the speaker of the assembly, two of which shall be upon recommendation of the assembly minority leader. The commissioner of health, the superintendent of insurance, 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 duty. The commission may employ staff as needed, prescribe their duties, and fix their compensation within amounts appropriate for the commission.

3. The commission shall examine the statutes of this state and make such recommendations as are necessary to conform the laws of this state, and to eliminate any inconsistency between the laws of this state, and the provisions of article 51 of the public health law establishing the New York health plan as added by section one of this act, and other provisions of law relating to the New York health plan, and to improve and implement the plan.

4. On or before 270 days subsequent to the enactment of this act, the commission shall report to the governor and the legislature, with recommendations, as provided in subdivision three of this section.

S 5. The superintendent of insurance, in consultation with a technical advisory committee which shall include representation from insurers,

consumers, organized labor, and business, shall examine the premium rate structure for insurance underwritten and offered in this state by insurers licensed pursuant to the insurance law, and determine the extent to which such premiums reflect expenditures for health care services covered under the provisions of article 51 of the public health law establishing the New York health plan as added by section one of this act. On or before 270 days following the enactment of this act, the superintendent shall report to the governor and the legislature on the extent to which the premium rate structure for insurance, by line of insurance, underwritten and offered in this state reflects expenditures for health care services covered under article 51 of the public health law as added by section one of this act, and make such recommendations as are necessary for an adjustment in such premium rate structures to reflect a reduction in health care expenditures due to implementation of the New York health plan.

S 6. The sum of five hundred thousand dollars ($500,000), or so much thereof as may be necessary, is hereby appropriated to the temporary commission on implementation of the New York health plan created pursuant to section four of this act out of any moneys in the state treasury in the general fund to the credit of the state purposes account not otherwise appropriated. Such sum shall be payable on the audit and warrant of the state comptroller on vouchers certified or approved by the chair of the temporary commission on implementation of the New York health plan created pursuant to section four of this act.

S 7. (a) This act shall take effect on the first of January next succeeding the date on which it shall have become a law provided, however, that sections four and five of this act shall take effect immediately and shall remain in full force and effect until the first of January following the date upon which benefits under article 51 of the public health law as added by section one of this act begin whereupon such sections shall be deemed repealed. The commissioner of health shall notify the Legislative Bill Drafting Commission of such event.

(b) Not later than the thirty-first of March following the effective date of this act, the commissioner of health shall do both of the following:

1. Apply to the secretary of health and human services for all waivers of requirements under health care programs established under titles XVIII and XIX of the federal social security act that are necessary to enable this state to deposit all federal payments under those programs in the state treasury to the credit of the New York health trust fund created pursuant to section 89-h of the state finance law, as added by section two of this act;

2. Identify any other federal programs that provide federal funds for payment of health care services to individuals. The commissioner of health shall comply with any requirements under those programs and apply for any waivers of those requirements that are necessary to enable this state to deposit such federal funds to the credit of the New York health trust fund.

(c) No later than the thirty-first of December following the effective date of this act, the board of governors of the New York health plan and the commissioner of health shall explore and cooperate with, enter into any necessary contract or other arrangement with, and otherwise pursue any other reasonable course of action with, the secretary of health and human services to establish procedures, standards and conditions under which the commissioner of health shall pay to the New York health trust fund amounts equivalent to those amounts that, on the effective date of

this section, are paid on behalf of residents of this state for health benefits covered under the plan under titles XVIII and XIX of the federal social security act.

(d) Commencing on the first of January following the effective date of this act the following shall occur:

1. New York health premium payments that are authorized pursuant to article 35 of the tax law, as added by section three of this act, shall be levied.

2. Benefits under the New York health plan established pursuant to article 51 of the public health law, as added by section one of this act shall begin.

3. Payments into the New York health trust fund created pursuant to section 89-h of the state finance law shall begin.

(e) Not later than the twenty-eighth of February following the effective date of this act, the governor shall make the initial appointments to the board of governors of the New York health plan established pursuant to article 51 of the public health law, as added by section one of this act, provided, however, that of the initial appointments made by the governor, four shall be for a term of one year; four shall be for a term of two years; three shall be for a term of three years; three shall be for a term of four years; and four, including the chair, shall be for a term of five years. Thereafter, all appointments shall be for a term of five years, except in those instances where an appointment is to fill a vacancy occurring prior to the expiration of a term.