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

S. 4884 A. 7854

2009-2010 Regular Sessions

S E N A T E - A S S E M B L Y

April 27, 2009

IN SENATE -- Introduced by Sen. DUANE -- read twice and ordered printed, and when printed to be committed to the Committee on Health

IN ASSEMBLY -- Introduced by M. of A. GOTTFRIED -- read once and referred to the Committee on Health

AN ACT to amend the public health law and the social services law, in relation to establishing New York health plus

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, respectively, and a new article 51 is added to read as follows:

ARTICLE 51
NEW YORK HEALTH PLUS

SECTION 5100. DEFINITIONS.
5101. PROGRAM CREATED.
5102. BOARD OF TRUSTEES.
5103. ELIGIBILITY AND ENROLLMENT.
5104. BENEFITS.
5105. HEALTH PLANS.
5106. PREMIUMS PAID TO HEALTH PLANS BY THE PROGRAM.
5107. PROGRAM STANDARDS.
5108. PHASE-IN PERIOD.
5109. REGULATIONS.
5110. OTHER PROVISIONS.

S 5100. DEFINITIONS. AS USED IN THIS ARTICLE, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS, UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE:

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

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1. "BOARD" MEANS THE BOARD OF TRUSTEES OF THE NEW YORK HEALTH PLUS PROGRAM CREATED BY SECTION FIVE THOUSAND ONE HUNDRED TWO OF THIS ARTICLE, AND "TRUSTEE" MEANS A TRUSTEE OF THE BOARD.

2. "PROGRAM" MEANS THE NEW YORK HEALTH PLUS PROGRAM CREATED BY SECTION FIVE THOUSAND ONE HUNDRED ONE OF THIS ARTICLE.

3. "MEMBER" MEANS AN INDIVIDUAL WHO IS ENROLLED IN A HEALTH PLAN UNDER THE PROGRAM.

4. "PARTICIPATING PROVIDER" MEANS ANY PERSON THAT IS A HEALTH CARE PROVIDER THAT PROVIDES HEALTH CARE SERVICES TO MEMBERS UNDER A HEALTH PLAN.

5. "HEALTH CARE SERVICE" MEANS ANY HEALTH CARE SERVICE INCLUDED AS A BENEFIT UNDER THE PROGRAM UNDER SECTION FIVE THOUSAND ONE HUNDRED FOUR OF THIS ARTICLE.

6. "RESIDENT" MEANS AN INDIVIDUAL WHOSE PRIMARY PLACE OF ABODE IS IN THE STATE, AS DETERMINED ACCORDING TO REGULATIONS OF THE COMMISSIONER.

7. "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.

8. "PHASE-IN PERIOD" MEANS THE PERIOD UNDER SECTION FIVE THOUSAND ONE HUNDRED EIGHT OF THIS ARTICLE DURING WHICH THE PROGRAM WILL BE SUBJECT TO SPECIAL ELIGIBILITY AND FINANCING PROVISIONS UNTIL IT IS FULLY IMPLEMENTED UNDER THAT SECTION.

9. "FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM" MEANS THE MEDICAL ASSISTANCE PROGRAM UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, THE FAMILY HEALTH PLUS PROGRAM UNDER TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, THE CHILD HEALTH PLUS PROGRAM UNDER TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER.

10. "HEALTH PLAN" MEANS (I) AN ENTITY THAT IS APPROVED BY THE COMMISSIONER UNDER THE PROGRAM TO ENROLL AND PROVIDE HEALTH CARE SERVICES TO MEMBERS UNDER THE PROGRAM AND (II) THE FEE-FOR-SERVICE HEALTH PLAN UNDER SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS ARTICLE.

11. "MEDICAID" OR "MEDICAL ASSISTANCE" MEANS TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER. "FAMILY HEALTH PLUS" MEANS TITLE ELEVEN-D 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.

12. "THRESHOLD INCOME LEVEL" MEANS THE AMOUNT OF INCOME ABOVE WHICH A PREMIUM CONTRIBUTION MAY BE CHARGED DURING THE PHASE-IN PERIOD.

13. "INCOME" MEANS NET HOUSEHOLD INCOME, OR THE GROSS EQUIVALENT OF THAT NET INCOME.

14. "CARE MANAGEMENT" MEANS SERVICES PROVIDED BY A CARE MANAGER UNDER PARAGRAPH (B) OF SUBDIVISION THREE OF SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS ARTICLE.

15. "CARE MANAGER" MEANS AN INDIVIDUAL OR ENTITY APPROVED TO PROVIDE CARE MANAGEMENT UNDER PARAGRAPH (B) OF SUBDIVISION THREE OF SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS ARTICLE.

S 5101. PROGRAM CREATED. 1. THE NEW YORK HEALTH PLUS PROGRAM IS HEREBY CREATED IN THE DEPARTMENT. THE PROGRAM SHALL PROVIDE COMPREHENSIVE HEALTH COVERAGE TO EVERY RESIDENT WHO ENROLLS AS A MEMBER OF A HEALTH PLAN. HOWEVER, DURING THE PHASE-IN PERIOD, THE PROGRAM SHALL BE SUBJECT TO THE PROVISIONS OF SECTION FIVE THOUSAND ONE HUNDRED EIGHT OF THIS ARTICLE.

2. HEALTH COVERAGE UNDER THE PROGRAM SHALL BE PROVIDED THROUGH TITLES ELEVEN AND ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND TITLE

ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER. EXCEPT WHERE INCONSISTENT WITH THE PROVISIONS OF THIS ARTICLE, THE PROVISIONS OF TITLES ELEVEN AND ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER SHALL APPLY TO THE PROGRAM.

3. THE COMMISSIONER SHALL, TO THE MAXIMUM EXTENT POSSIBLE, ORGANIZE, ADMINISTER AND MARKET THE PROGRAM AND SERVICES UNDER TITLES ELEVEN AND ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER AS A SINGLE PROGRAM UNDER THE NAME "NEW YORK HEALTH PLUS" OR SUCH OTHER NAME AS THE COMMISSIONER SHALL DETERMINE. 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.

S 5102. BOARD OF TRUSTEES. 1. THE NEW YORK HEALTH PLUS 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 AND AMENDMENTS THERETO FOR CONSIDERATION BY THE BOARD. THE BOARD OF TRUSTEES MAY APPOINT ONE OR MORE ADVISORY COMMITTEES. MEMBERS OF ADVISORY COMMITTEES NEED NOT BE MEMBERS OF THE BOARD OF TRUSTEES. 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 AND THE SUPERINTENDENT OF INSURANCE, AND THE DIRECTOR OF THE BUDGET, OR THEIR DESIGNEES, AS EX OFFICIO MEMBERS;

(B) SEVENTEEN TRUSTEES APPOINTED BY THE GOVERNOR:

(I) TWO 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 HOSPITALS, ONE OF WHOM SHALL BE A REPRESENTATIVE OF PUBLIC HOSPITALS;

(V) ONE OF WHOM SHALL BE REPRESENTATIVE OF COMMUNITY HEALTH CENTERS OR OTHER HEALTH CARE PROVIDER ENTITIES;

(VI) TWO OF WHOM SHALL BE REPRESENTATIVES OF LOCAL GOVERNMENTS;

(VII) TWO OF WHOM SHALL BE REPRESENTATIVES BUSINESS;

(VIII) TWO OF WHOM SHALL BE REPRESENTATIVES OF ORGANIZED LABOR;

(IX) ONE OF WHOM SHALL BE REPRESENTATIVE OF PLANS;

(C) THREE TRUSTEES APPOINTED BY THE SPEAKER OF THE ASSEMBLY; THREE TRUSTEES APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE; ONE TRUSTEE APPOINTED BY THE MINORITY LEADER OF THE ASSEMBLY; AND ONE TRUSTEE APPOINTED BY THE MINORITY LEADER OF THE SENATE.

BEGINNING ONE YEAR AFTER THE END OF THE PHASE-IN PERIOD, NO PERSON SHALL BE A TRUSTEE UNLESS HE OR SHE IS A MEMBER OF A HEALTH PLAN, EXCEPT

THE EX OFFICIO TRUSTEES. EACH TRUSTEE SHALL SERVE AT THE PLEASURE OF THE APPOINTING OFFICER, EXCEPT THE EX OFFICIO TRUSTEES.

3. 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 MAY ALSO ESTABLISH ADVISORY COMMITTEES CONSISTING OF INDIVIDUALS OTHER THAN TRUSTEES.

4. TRUSTEES SHALL SERVE WITHOUT COMPENSATION BUT SHALL BE REIMBURSED FOR THEIR NECESSARY AND ACTUAL EXPENSES INCURRED WHILE ENGAGED IN THE BUSINESS OF THE BOARD.

5. 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.

6. 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.

S 5103. ELIGIBILITY AND ENROLLMENT. 1. EVERY RESIDENT SHALL BE ELIGIBLE AND ENTITLED TO ENROLL AS A MEMBER OF A HEALTH PLAN UNDER THE PROGRAM; PROVIDED THAT NO PERSON SHALL AT ANY TIME BE A MEMBER OF MORE THAN ONE HEALTH PLAN.

2. NO MEMBER SHALL BE REQUIRED TO PAY ANY PREMIUM OR OTHER CHARGE FOR ENROLLING IN OR BEING A MEMBER OF A HEALTH PLAN, EXCEPT DURING THE PHASE-IN PERIOD AS PROVIDED IN SECTION FIVE THOUSAND ONE HUNDRED EIGHT OF THIS ARTICLE.

3. (A) 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 IF THE MEMBER IS ELIGIBLE FOR IT. THE COMMISSIONER SHALL PROVIDE MEMBERS WITH NOTIFICATION OF ANY ENHANCED BENEFITS IF THEY HAVE BEEN ENROLLED IN A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM; HOWEVER, ENROLLMENT IN A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM SHALL NOT CAUSE ANY MEMBER TO LOSE ANY HEALTH CARE SERVICE PROVIDED BY THE PROGRAM.

(B) THE COMMISSIONER MAY BY REGULATION INCREASE THE INCOME ELIGIBILITY LEVEL, INCREASE OR ELIMINATE THE RESOURCE TEST FOR ELIGIBILITY, AND SIMPLIFY ANY PROCEDURAL OR DOCUMENTATION REQUIREMENT FOR ENROLLMENT FOR ANY FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM, 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 ENROLL IN FEDERALLY-MATCHED PUBLIC HEALTH PROGRAMS; (II) WILL NOT DIMINISH ANY INDIVIDUAL'S ACCESS TO ANY HEALTH CARE SERVICE AND (III) 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 INDIVIDUALS SEEKING PAYMENT FOR LONG TERM CARE, TREATMENT, MAINTENANCE, OR SERVICES NOT COVERED UNDER FAMILY HEALTH PLUS OR CHILD HEALTH PLUS, AS APPROPRIATE, WITH THE EXCEPTION OF SHORT TERM REHABILITATION, AS DEFINED BY THE COMMISSIONER.

4. AS A CONDITION OF CONTINUED ELIGIBILITY FOR HEALTH CARE SERVICES UNDER THE PROGRAM, A MEMBER WHO IS ELIGIBLE FOR BENEFITS UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT (MEDICARE) SHALL ENROLL IN MEDICARE, INCLUDING PARTS A, B AND D.

(A) IF A MEMBER WHO IS ENROLLED IN MEDICARE DOES NOT ENROLL IN A MEDICARE MANAGED CARE PLAN OR ENROLLS IN A MANAGED CARE PROGRAM THAT IS NOT A MANAGED CARE PROVIDER IN THE PROGRAM, THAT MEMBER SHALL USE THE FEE-FOR-SERVICE HEALTH PLAN CREATED IN SUBDIVISION TWO OF SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS ARTICLE.

(B) IF A MEMBER ENROLLS IN A MEDICARE MANAGED CARE PLAN OFFERED BY AN ENTITY THAT IS ALSO A MANAGED CARE PROVIDER; THAT MEMBER SHALL HAVE THE OPTION OF RECEIVING HEALTH CARE SERVICES IN THE PROGRAM THROUGH THE SAME ENTITY'S MANAGED CARE PLAN OR THROUGH THE FEE FOR SERVICE OPTION OF THE PROGRAM AS CREATED IN SUBDIVISION TWO OF SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS ARTICLE, PROVIDED THAT:

(I) IF THE MEMBER CHANGES HIS OR HER MEDICARE MANAGED CARE PLAN AS AUTHORIZED BY MEDICARE AND ENROLLS IN ANOTHER MEDICARE MANAGED CARE PLAN THAT IS ALSO A MANAGED CARE PROVIDER, THE MEMBER SHALL BE ENROLLED IN THAT MANAGED CARE PROVIDER OR RECEIVE HEALTH CARE SERVICES THROUGH THE FEE-FOR-SERVICE HEALTH PLAN CREATED IN SUBDIVISION TWO OF SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS ARTICLE;

(II) IF THE MEMBER CHANGES HIS OR HER MEDICARE MANAGED CARE PLAN AS AUTHORIZED BY MEDICARE, BUT ENROLLS IN ANOTHER MEDICARE MANAGED CARE PLAN THAT IS NOT ALSO A MANAGED CARE PROVIDER, THE INDIVIDUAL SHALL RECEIVE HEALTH CARE BENEFITS PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION;

(III) IF THE MEMBER DISENROLLS FROM HIS OR HER MEDICARE MANAGED CARE PLAN AS AUTHORIZED BY TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, AND DOES NOT ENROLL IN ANOTHER MEDICARE MANAGED CARE PLAN, THE MEMBER SHALL RECEIVE HEALTH CARE BENEFITS PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION; AND

(IV) NOTHING HEREIN SHALL REQUIRE AN INDIVIDUAL ENROLLED IN A MANAGED LONG TERM CARE PLAN, PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-F OF THIS CHAPTER, TO DISENROLL FROM SUCH PROGRAM.

(C) 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 MINIMUS 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.

(D) 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.

(E) 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.

S 5104. BENEFITS. THE PROGRAM SHALL PROVIDE COMPREHENSIVE HEALTH COVERAGE TO EVERY MEMBER OF A HEALTH PLAN, WHICH SHALL INCLUDE BUT NOT BE LIMITED TO:

(A) ALL HEALTH CARE SERVICES UNDER FAMILY HEALTH PLUS; AND

(B) FOR EVERY MEMBER UNDER THE AGE OF TWENTY-ONE, ALL COVERED HEALTH CARE SERVICES UNDER CHILD HEALTH PLUS; AND

(C) FOR EVERY MEMBER WHO IS ELIGIBLE FOR MEDICAID, ALL MEDICAL CARE AND SERVICES UNDER MEDICAID, PROVIDED THAT THIS SHALL NOT INCLUDE LONG TERM CARE, TREATMENT, MAINTENANCE, OR SERVICES NOT COVERED UNDER FAMILY HEALTH PLUS OR CHILD HEALTH PLUS, AS APPROPRIATE.

S 5105. HEALTH PLANS. 1. (A) AN ENTITY SEEKING TO BE A HEALTH PLAN SHALL FILE AN APPLICATION WITH THE COMMISSIONER, IN THE FORM PROVIDED BY THE COMMISSIONER. THE APPLICATION SHALL PROVIDE INFORMATION TO DEMONSTRATE THAT THE ENTITY MEETS ALL REQUIREMENTS TO BE A HEALTH PLAN AND TO PROVIDE HEALTH CARE SERVICES AND COMPLY WITH ALL OTHER REQUIREMENTS OF THIS ARTICLE AND THE PROGRAM, AND ANY ADDITIONAL INFORMATION REQUIRED BY THE COMMISSIONER. UPON APPROVAL BY THE COMMISSIONER, THE ENTITY SHALL BE A HEALTH PLAN UNDER THE PROGRAM. THE COMMISSIONER MAY, AT HIS OR HER DISCRETION, REQUIRE HEALTH PLANS TO RENEW THEIR APPLICATION, PROVIDED THAT THE FREQUENCY OF RENEWAL MAY NOT BE MORE THAN ANNUALLY.

(B) THE ENTITY OR HEALTH PLAN SHALL BE UNDER A CONTINUING DUTY TO REPORT TO THE COMMISSIONER ANY CHANGE IN FACTS OR CIRCUMSTANCES REFLECTED IN THE APPLICATION OR ANY NEWLY DISCOVERED OR OCCURRING FACT OR CIRCUMSTANCE WHICH IS REQUIRED TO BE INCLUDED IN THE APPLICATION.

(C) THE PUBLIC HEALTH PLAN UNDER SUBDIVISION THREE OF THIS SECTION SHALL BE A HEALTH PLAN WITHOUT COMPLYING WITH THIS SUBDIVISION.

2. (A) IN ORDER TO BE A HEALTH PLAN, AN ENTITY SHALL BE A MANAGED CARE PROVIDER UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW (MEDICAID MANAGED CARE), AN APPROVED ORGANIZATION UNDER SECTION THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW (FAMILY HEALTH PLUS), AND AN APPROVED ORGANIZATION UNDER TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER (CHILD HEALTH PLUS). IF A HEALTH PLAN NO LONGER COMPLIES WITH THIS PARAGRAPH IT SHALL CEASE TO BE A HEALTH PLAN.

(B) IN ADDITION, THE COMMISSIONER SHALL PROVIDE, BY REGULATION, THAT A HEALTH PLAN ORGANIZED ON OTHER MODELS, INCLUDING BUT NOT LIMITED TO A PREFERRED PROVIDER ORGANIZATION, MAY BE A HEALTH PLAN. A HEALTH PLAN FORMED UNDER THIS PARAGRAPH MAY PROVIDE MEDICAID, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS, AS APPROPRIATE, TO MEMBERS IN THE PROGRAM, NOTWITHSTANDING ANY PROVISION OF MEDICAID, FAMILY HEALTH PLUS OR CHILD HEALTH PLUS TO THE CONTRARY.

3. FEE-FOR-SERVICE HEALTH PLAN. (A) GENERAL PROVISIONS. (I) THE COMMISSIONER SHALL ESTABLISH A FEE-FOR-SERVICE HEALTH PLAN UNDER THIS SUBDIVISION. ANY MEMBER WHO IS NOT A MEMBER OF ANOTHER HEALTH PLAN MAY BE A MEMBER OF THE FEE-FOR-SERVICE HEALTH PLAN.

(II) ANY HEALTH CARE PROVIDER QUALIFIED TO PARTICIPATE UNDER PARAGRAPH (C) OF THIS SUBDIVISION MAY PROVIDE HEALTH CARE SERVICES UNDER THE FEE-FOR-SERVICE HEALTH PLAN, PROVIDED THAT THE HEALTH CARE PROVIDER IS OTHERWISE LEGALLY AUTHORIZED TO PERFORM THE HEALTH CARE SERVICE FOR THE INDIVIDUAL AND UNDER THE CIRCUMSTANCES INVOLVED.

(III) HEALTH CARE SERVICES PROVIDED TO MEMBERS UNDER THE FEE-FOR-SERVICE HEALTH PLAN SHALL BE PAID FOR UNDER THIS SUBDIVISION ON A FEE-FOR-SERVICE BASIS, EXCEPT THAT CARE MANAGEMENT SHALL BE PAID FOR UNDER PARAGRAPH (B) OF THIS SUBDIVISION.

(IV) HEALTH CARE SERVICES PROVIDED TO A MEMBER SHALL NOT BE SUBJECT TO PAYMENT UNDER THIS SUBDIVISION UNLESS THE MEMBER IS ENROLLED WITH A CARE MANAGER UNDER PARAGRAPH (B) OF THIS SUBDIVISION AT THE TIME THE HEALTH CARE SERVICE IS PROVIDED.

(B) CARE MANAGEMENT. (I) EVERY MEMBER OF THE FEE-FOR-SERVICE HEALTH PLAN SHALL ENROLL WITH A CARE MANAGER THAT AGREES TO PROVIDE CARE MANAGEMENT TO THE MEMBER, PRIOR TO RECEIVING HEALTH CARE SERVICES TO BE PAID FOR UNDER THIS SUBDIVISION. THE MEMBER SHALL REMAIN ENROLLED WITH THAT CARE MANAGER UNTIL THE MEMBER BECOMES ENROLLED WITH A DIFFERENT CARE MANAGER OR CEASES TO BE A MEMBER OF THE FEE-FOR-SERVICE HEALTH PLAN. THE COMMISSIONER SHALL PROVIDE, BY REGULATION, THAT CARE MANAGEMENT MEMBERS HAVE THE RIGHT TO CHANGE THEIR CARE MANAGER 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.

(II) CARE MANAGEMENT SHALL BE PROVIDED TO THE MEMBER BY THE MEMBER'S CARE MANAGER. CARE MANAGEMENT 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. CARE MANAGEMENT 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.

(III) A CARE MANAGER MAY BE AN INDIVIDUAL OR ENTITY THAT IS APPROVED BY THE FEE-FOR-SERVICE HEALTH PLAN THAT IS:

(A) A HEALTH CARE PRACTITIONER WHO IS (I) THE MEMBER'S PRIMARY CARE PRACTITIONER; (II) AT THE OPTION OF A FEMALE MEMBER, THE MEMBER'S PROVIDER OF PRIMARY GYNECOLOGICAL CARE; OR (III) 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.

(B) AN ENTITY LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER OR CERTIFIED UNDER ARTICLE THIRTY-SIX OF THIS CHAPTER, 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.

(C) AN ENTITY AUTHORIZED TO BE A HEALTH PLAN;

(D) A TAFT-HARTLEY FUND, WITH RESPECT TO ITS MEMBERS AND THEIR FAMILY MEMBERS;

(E) ANY OTHER ENTITY APPROVED BY THE FEE-FOR-SERVICE HEALTH PLAN.

(IV) WHERE A MEMBER OF THE FEE-FOR-SERVICE HEALTH PLAN RECEIVES CHRONIC MENTAL HEALTH CARE SERVICES, CONSISTENT WITH STANDARDS ESTABLISHED BY THE FEE-FOR-SERVICE HEALTH PLAN, AT THE OPTION OF THE MEMBER, THE MEMBER MAY ENROLL WITH A CARE MANAGER FOR HIS OR HER MENTAL HEALTH CARE SERVICES AND ANOTHER CARE MANAGER APPROVED FOR HIS OR HER OTHER HEALTH CARE SERVICES. IN SUCH A CASE, THE TWO CARE MANAGERS SHALL WORK IN CLOSE CONSULTATION WITH EACH OTHER.

(V) THE COMMISSIONER SHALL DEVELOP AND IMPLEMENT PROCEDURES AND STANDARDS FOR AN INDIVIDUAL OR ENTITY TO BE APPROVED TO BE A CARE MANAGER IN THE FEE-FOR-SERVICE HEALTH PLAN, 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 MANAGER 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 MANAGER IN THE FEE-

FOR-SERVICE HEALTH PLAN FOR ECONOMIC PURPOSES AND SHALL BE CONSISTENT WITH GOOD PROFESSIONAL PRACTICE. IN DEVELOPING THE PROCEDURES AND STANDARDS, THE COMMISSIONER SHALL: (A) CONSIDER EXISTING STANDARDS DEVELOPED BY NATIONAL ACCREDITING AND PROFESSIONAL ORGANIZATIONS; AND (B) CONSULT WITH NATIONAL AND LOCAL ORGANIZATIONS WORKING ON CARE MANAGEMENT OR SIMILAR MODELS, INCLUDING HEALTH CARE PRACTITIONERS, HOSPITALS, CLINICS, AND CONSUMERS AND THEIR REPRESENTATIVES. WHEN DEVELOPING AND IMPLEMENTING STANDARDS OF APPROVAL OF CARE MANAGERS 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 MANAGER UNLESS THE SERVICES INCLUDED IN CARE MANAGEMENT ARE WITHIN THE INDIVIDUAL'S PROFESSIONAL SCOPE OF PRACTICE OR THE ENTITY'S LEGAL AUTHORITY.

(VI) TO MAINTAIN APPROVAL UNDER THE FEE-FOR-SERVICE HEALTH PLAN, A CARE MANAGER MUST: (A) RENEW ITS STATUS AT A FREQUENCY DETERMINED BY THE COMMISSIONER; AND (B) PROVIDE DATA TO THE DEPARTMENT AS REQUIRED BY THE COMMISSIONER TO ENABLE THE COMMISSIONER TO EVALUATE THE IMPACT OF CARE MANAGERS ON QUALITY, OUTCOMES AND COST.

(VII) THE FEE-FOR-SERVICE HEALTH PLAN SHALL ESTABLISH METHODOLOGIES FOR PAYING CARE MANAGERS FOR CARE MANAGEMENT SERVICES. THE METHODOLOGIES MAY PROVIDE FOR CAPITATED OR OTHER FORMS OF PAYMENT.

(C) HEALTH CARE PROVIDERS. THE COMMISSIONER SHALL ESTABLISH AND MAINTAIN PROCEDURES AND STANDARDS FOR HEALTH CARE PROVIDERS TO BE QUALIFIED TO PARTICIPATE IN THE FEE-FOR-SERVICE HEALTH PLAN, 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 FEE-FOR-SERVICE HEALTH PLAN FOR ECONOMIC PURPOSES AND SHALL BE CONSISTENT WITH GOOD PROFESSIONAL PRACTICE. ANY HEALTH CARE PROVIDER WHO IS QUALIFIED TO PARTICIPATE UNDER MEDICAID, FAMILY HEALTH PLUS OR CHILD HEALTH PLUS SHALL BE DEEMED TO BE QUALIFIED TO PARTICIPATE IN THE FEE-FOR-SERVICE HEALTH PLAN, 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 FEE-FOR-SERVICE HEALTH PLAN.

S 5106. PREMIUMS PAID TO HEALTH PLANS BY THE PROGRAM. 1. THE PROGRAM SHALL PAY TO EVERY HEALTH PLAN A PREMIUM ON BEHALF OF EACH MEMBER OF THE HEALTH PLAN, FOR EACH MONTH THE MEMBER IS A MEMBER OF THE HEALTH PLAN.

2. THE PROGRAM SHALL, WHERE NOT INCONSISTENT WITH THE RATE SETTING AUTHORITY OF OTHER STATE AGENCIES AND SUBJECT TO APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, DEVELOP METHODOLOGIES FOR DETERMINING THE AMOUNT OF PREMIUMS TO BE PAID TO HEALTH PLANS UNDER THE PROGRAM.

3. THE PROGRAM, IN CONSULTATION WITH ORGANIZATIONS REPRESENTING HEALTH PLANS, SHALL SELECT AN INDEPENDENT ACTUARY TO REVIEW THE METHODOLOGIES AND PREMIUMS. THE INDEPENDENT ACTUARY SHALL REVIEW AND MAKE RECOMMENDATIONS CONCERNING APPROPRIATE ACTUARIAL ASSUMPTIONS RELEVANT TO THE ESTABLISHMENT OF METHODOLOGIES AND PREMIUMS, INCLUDING BUT NOT LIMITED, TO THE ADEQUACY OF THE METHODOLOGIES AND PREMIUMS IN RELATION TO THE POPULATION TO BE SERVED ADJUSTED FOR CASE MIX, THE SCOPE OF SERVICES THE PLANS MUST PROVIDE, THE UTILIZATION OF SERVICES AND THE NETWORK OF PROVIDERS NECESSARY TO MEET PROGRAM STANDARDS. THE INDEPENDENT ACTUARY

SHALL ISSUE AN ANNUAL REPORT, WHICH SHALL BE PROVIDED TO THE PROGRAM, THE GOVERNOR, THE TEMPORARY PRESIDENT AND THE MINORITY LEADER OF THE SENATE AND THE SPEAKER AND THE MINORITY LEADER OF THE ASSEMBLY. THE PROGRAM SHALL ASSESS HEALTH PLANS ON A PER ENROLLEE BASIS TO COVER THE COST OF THE REPORT.

S 5107. PROGRAM STANDARDS. 1. THE COMMISSIONER SHALL ESTABLISH REQUIREMENTS AND STANDARDS FOR THE PROGRAM AND FOR HEALTH PLANS, INCLUDING REQUIREMENTS AND STANDARDS FOR, AS APPLICABLE:

(A) THE SCOPE, QUALITY AND ACCESSIBILITY OF HEALTH CARE SERVICES;

(B) RELATIONS BETWEEN HEALTH PLANS AND MEMBERS, INCLUDING APPROVAL OF HEALTH CARE SERVICES; AND

(C) RELATIONS BETWEEN HEALTH PLANS AND HEALTH CARE PROVIDERS, INCLUDING (I) CREDENTIALING AND PARTICIPATION IN HEALTH PLAN NETWORKS; 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 PLAN NETWORKS, REFERRALS, PAYMENT PROCEDURES AND RATES, CLAIMS PROCESSING, AND APPROVAL OF HEALTH CARE SERVICES, AS APPLICABLE.

(B) PAYMENT RATES FOR HEALTH CARE SERVICES AND CARE MANAGEMENT THAT ARE REASONABLE AND REASONABLY RELATED TO THE COST OF EFFICIENTLY PROVIDING THE HEALTH CARE SERVICE.

(C) PRIMARY AND PREVENTIVE CARE, CARE MANAGEMENT, EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES, QUALITY ASSURANCE, AND COORDINATION AND INTEGRATION OF HEALTH CARE SERVICES, INCLUDING USE OF APPROPRIATE TECHNOLOGY.

(D) ELIMINATION OF HEALTH CARE DISPARITIES.

(E) 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; HEALTH CARE SERVICES PROVIDED UNDER THE PROGRAM SHALL BE APPROPRIATE TO THE PATIENT'S CIRCUMSTANCES.

(F) ACCESSIBILITY OF HEALTH PLAN 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 HEALTH PLAN SERVICES AND HEALTH CARE SERVICES IN A CULTURALLY COMPETENT MANNER.

3. ANY HEALTH PLAN THAT IS ORGANIZED AS A FOR-PROFIT ENTITY SHALL BE REQUIRED TO MEET THE SAME REQUIREMENTS AND STANDARDS AS HEALTH PLANS ORGANIZED AS NOT-FOR-PROFIT ENTITIES, AND THE PREMIUM PAID TO SUCH A PLAN 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. THE COMMISSIONER SHALL REQUIRE HEALTH PLANS TO COMPILE AND PERIODICALLY REPORT TO THE COMMISSIONER DATA AND INFORMATION ON THE HEALTH PLAN'S PERFORMANCE, INCLUDING THE AVAILABILITY AND QUALITY OF HEALTH CARE SERVICES AND RELEVANT CHARACTERISTICS OF THE HEALTH PLAN'S HEALTH CARE PROVIDERS AND MEMBERS. THE COMMISSIONER SHALL ANALYZE THE DATA AND INFORMATION RECEIVED UNDER THIS SUBDIVISION AND MAKE IT PUBLICLY AVAILABLE, INCLUDING ON THE PROGRAM'S WEBSITE, IN APPROPRIATE RISK-ADJUSTED FORM AND IN A MANNER DESIGNED TO FACILITATE EVALUATION AND COMPARISON OF HEALTH PLANS BY THE PUBLIC AND MEMBERS.

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, HEALTH PLANS AND OTHER INTERESTED PARTIES.

6. (A) FOR PURPOSES OF THIS SECTION, "INCOME-ELIGIBLE MEMBER" MEANS A MEMBER WHO IS ENROLLED IN A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM AND (I) THERE IS FEDERAL FINANCIAL PARTICIPATION IN THE INDIVIDUAL'S HEALTH COVERAGE, OR (II) THE MEMBER IS ELIGIBLE TO ENROLL IN THE FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM BY REASON OF INCOME, AGE, AND RESOURCES (WHERE APPLICABLE) UNDER STATE LAW IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION, BUT THERE IS NO FEDERAL FINANCIAL PARTICIPATION IN THE INDIVIDUAL'S HEALTH COVERAGE. A PERSON WHO IS ELIGIBLE TO ENROLL IN A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM SOLELY BY REASON OF SECTION THREE HUNDRED SIXTY-NINE-FF OF THE SOCIAL SERVICES LAW (EMPLOYER PARTNERSHIPS FOR FAMILY HEALTH PLUS) IS NOT AN INCOME-ELIGIBLE MEMBER.

(B) A HEALTH PLAN, WITH RESPECT TO THOSE MEMBERS WHO ARE NOT INCOME-ELIGIBLE MEMBERS, SHALL NOT BE CONSIDERED A FEDERALLY-MATCHED PUBLIC HEALTH PROGRAM OR GOVERNMENTAL PAYOR UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER WITH RESPECT TO:

(I) PATIENT SERVICES PAYMENTS IN ACCORDANCE WITH SECTION TWENTY-EIGHT HUNDRED SEVEN-J OF THIS CHAPTER;

(II) PROFESSIONAL EDUCATION POOL FUNDING UNDER SECTION TWENTY-EIGHT HUNDRED SEVEN-S OF THIS CHAPTER; OR

(III) ASSESSMENTS ON COVERED LIVES UNDER SECTION TWENTY-EIGHT HUNDRED SEVEN-T OF THIS CHAPTER.

S 5108. PHASE-IN PERIOD. 1. THE COMMISSIONER SHALL DETERMINE WHEN INDIVIDUALS MAY BEGIN ENROLLING IN HEALTH PLANS UNDER THE PROGRAM AND WHEN HEALTH PLANS MAY BEGIN PROVIDING HEALTH CARE SERVICES TO MEMBERS UNDER THE PROGRAM. THE PHASE-IN PERIOD SHALL BEGIN ON THE DATE WHEN HEALTH PLANS MAY BEGIN PROVIDING HEALTH CARE SERVICES TO MEMBERS. THE PHASE-IN PERIOD SHALL CONSIST OF ANNUAL PERIODS, PROVIDED THAT THE FIRST ANNUAL PERIOD MAY BE LESS THAN ONE YEAR, AS DETERMINED BY THE COMMISSIONER. THE PHASE-IN PERIOD SHALL END AS DETERMINED BY THE COMMISSIONER.

2. (A) DURING THE PHASE-IN PERIOD, THE COMMISSIONER MAY REQUIRE MEMBERS WHOSE INCOMES ARE ABOVE THE THRESHOLD INCOME LEVEL TO PAY A PREMIUM CONTRIBUTION TO THE PROGRAM. ANOTHER PERSON MAY PAY ALL OR PART OF A MEMBER'S PREMIUM CONTRIBUTION ON THE MEMBER'S BEHALF. THE PREMIUM CONTRIBUTION SHALL BE ON A SLIDING SCALE FOR INCOME BRACKETS AND HOUSEHOLD SIZES DETERMINED BY THE COMMISSIONER AT AND ABOVE THE THRESHOLD INCOME LEVEL.

(B) THE PREMIUM CONTRIBUTION FOR AN INCOME BRACKET AND HOUSEHOLD SIZE SHALL NOT EXCEED FIVE PERCENT FOR AN INDIVIDUAL, NOT TO EXCEED A TOTAL OF EIGHT PERCENT FOR ALL THE INDIVIDUALS IN A HOUSEHOLD, OF THE INCOME FOR A HOUSEHOLD IN THE INCOME BRACKET. IN THE CASE OF A MEMBER UNDER THE AGE OF NINETEEN, THE PREMIUM CONTRIBUTION ATTRIBUTABLE TO THE MEMBER SHALL NOT EXCEED THE APPLICABLE ALLOWABLE PREMIUM PAYMENT UNDER CHILD HEALTH PLUS. NO INDIVIDUAL WHO IS ELIGIBLE FOR MEDICAID OR FAMILY HEALTH PLUS (OTHER THAN UNDER SECTION THREE HUNDRED SIXTY-NINE-FF OF THE SOCIAL SERVICES LAW) SHALL BE REQUIRED TO PAY ANY PREMIUM CONTRIBUTION. NO MEMBER'S PREMIUM CONTRIBUTION SHALL EXCEED EIGHTY PERCENT OF THE AVERAGE PER-MEMBER PREMIUM PAID BY THE PROGRAM IN THE MEMBER'S REGION, AS DETERMINED BY THE COMMISSIONER.

(C) FOR EACH ANNUAL PERIOD AFTER THE FIRST ANNUAL PERIOD, THE COMMISSIONER SHALL RAISE THE THRESHOLD LEVEL AND INCOME BRACKETS AND DETERMINE THE APPROPRIATE PREMIUM CONTRIBUTION LEVELS.

(D) (I) IN ORDER TO DETERMINE A MEMBER'S INCOME BRACKET FOR PURPOSES OF THIS SUBDIVISION, A MEMBER OR AN INDIVIDUAL SEEKING TO ENROLL AS A MEMBER SHALL, AT THE TIME OF THE INITIAL APPLICATION, AND MAY AT ANY

TIME THEREAFTER, ATTEST TO ALL INFORMATION REGARDING INCOME THAT IS NECESSARY AND SUFFICIENT TO DETERMINE THE INDIVIDUAL'S INCOME BRACKET AND PROVIDE HIS OR HER SOCIAL SECURITY ACCOUNT NUMBER, AS WELL AS THE SOCIAL SECURITY ACCOUNT NUMBER FOR EACH LEGALLY RESPONSIBLE RELATIVE WHO IS A MEMBER OF THE HOUSEHOLD AND WHOSE INCOME IS AVAILABLE TO THE APPLICANT. EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE ATTESTATION OF THE INDIVIDUAL TO ALL INFORMATION NECESSARY TO ESTABLISH THE INDIVIDUAL'S INCOME BRACKET SHALL BE SUFFICIENT TO DO SO. UPON THE RECEIPT OF SUCH INFORMATION, THE COMMISSIONER MAY, IN HIS OR HER DISCRETION, VERIFY THE ACCURACY OF THE INCOME INFORMATION PROVIDED BY THE INDIVIDUAL BY MATCHING IT AGAINST INFORMATION TO WHICH THE COMMISSIONER HAS ACCESS, INCLUDING THE STATE'S WAGES REPORTING SYSTEM OR BY INQUIRY TO THE INDIVIDUAL'S EMPLOYER.

(II) IN THE EVENT THERE IS AN INCONSISTENCY BETWEEN THE INFORMATION REPORTED BY THE INDIVIDUAL UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH AND ANY INFORMATION OBTAINED BY THE COMMISSIONER FROM OTHER SOURCES PURSUANT TO THIS PARAGRAPH AND SUCH INCONSISTENCY IS MATERIAL TO THE INDIVIDUAL'S INCOME BRACKET, THE COMMISSIONER MAY REQUIRE THAT THE INDIVIDUAL PROVIDE ADEQUATE DOCUMENTATION TO VERIFY HIS OR HER INCOME BRACKET. SUCH DOCUMENTATION MAY INCLUDE, BUT NOT BE LIMITED TO THE FOLLOWING:

(A) PAYCHECK STUBS; OR

(B) WRITTEN DOCUMENTATION OF INCOME FROM ALL EMPLOYERS; OR

(C) OTHER DOCUMENTATION OF INCOME (EARNED OR UNEARNED) AS DETERMINED BY THE COMMISSIONER, PROVIDED HOWEVER, SUCH DOCUMENTATION SHALL SET FORTH THE SOURCE OF SUCH INCOME; AND

(D) PROOF OF IDENTITY AND RESIDENCE AS DETERMINED BY THE COMMISSIONER.

IN THE EVENT AN INDIVIDUAL IS NOT REQUIRED AND ELECTS NOT TO PROVIDE HIS OR HER SOCIAL SECURITY ACCOUNT NUMBER OR THE SOCIAL SECURITY ACCOUNT NUMBERS OF EACH LEGALLY RESPONSIBLE RELATIVE WHO IS A MEMBER OF THE HOUSEHOLD AND WHOSE INCOME IS AVAILABLE TO THE INDIVIDUAL, THE INDIVIDUAL SHALL PROVIDE ADEQUATE DOCUMENTATION TO VERIFY HIS OR HER INCOME BRACKET. IN THE EVENT THAT AN INCONSISTENCY IS FOUND, AND IT IS DUE TO INACCURATE REPORTING ON BEHALF OF AN EMPLOYER, THE INDIVIDUAL SHALL NOT BE HELD LIABLE FOR THE ERROR, UNLESS IT CAN BE DETERMINED THAT THE INDIVIDUAL WAS A WILLFUL PARTICIPANT IN MISLEADING THE DEPARTMENT.

(III) ONCE AN INDIVIDUAL'S INCOME BRACKET IS DETERMINED FOR PURPOSES OF THE PHASE-IN PERIOD, IT SHALL NOT BE NECESSARY FOR IT TO BE RE-DETERMINED EVEN IF THE INDIVIDUAL WOULD BE IN A HIGHER INCOME BRACKET. AN INDIVIDUAL SEEKING TO CHANGE HIS OR HER INCOME BRACKET MAY APPLY TO HAVE IT RE-DETERMINED IN ACCORDANCE WITH THIS PARAGRAPH. AN INDIVIDUAL MAY CHOOSE NOT TO HAVE HIS OR HER INCOME BRACKET DETERMINED, IN WHICH CASE THE INDIVIDUAL SHALL PAY THE MAXIMUM PREMIUM CONTRIBUTION, SUBJECT TO PARAGRAPH (B) OF THIS SUBDIVISION.

S 5109. REGULATIONS. THE COMMISSIONER MAY APPROVE REGULATIONS AND AMENDMENTS THERETO, UNDER SECTION FIVE THOUSAND 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 SECTION FIVE THOUSAND ONE HUNDRED TWO OF THIS ARTICLE.

S 5110. OTHER PROVISIONS. 1. THE COMMISSIONER SHALL SEEK ALL FEDERAL WAIVERS AND OTHER FEDERAL APPROVALS NECESSARY TO OPERATE THE PROGRAM CONSISTENT WITH THIS ARTICLE.

2. CONSUMER, HEALTH CARE PROVIDER, AND CARE MANAGER ASSISTANCE. THE COMMISSIONER SHALL CONTRACT WITH NOT-FOR-PROFIT ORGANIZATIONS TO PROVIDE:

(A) CONSUMER ASSISTANCE TO MEMBERS AND INDIVIDUALS SEEKING OR CONSIDERING WHETHER TO BECOME MEMBERS, WITH RESPECT TO SELECTION OF A HEALTH PLAN, 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 TO MEMBERS UNDER THE PROGRAM, WITH RESPECT TO PARTICIPATING IN A HEALTH PLAN AND DEALING WITH A HEALTH PLAN; AND

(C) CARE MANAGER ASSISTANCE TO INDIVIDUALS AND ENTITIES PROVIDING AND SEEKING OR CONSIDERING WHETHER TO PROVIDE, CARE MANAGEMENT TO MEMBERS UNDER THE FEE-FOR-SERVICE HEALTH PLAN.

S 2. Subdivision 3 of section 2510 of the public health law, as added by chapter 922 of the laws of 1990, is amended to read as follows:

3. "Eligible organization" means:

(a) a commercial insurer;

(b) a corporation or health maintenance organization licensed under article forty-three of the insurance law;

(c) a health maintenance organization certified under article forty-four of this chapter; or

(d) a comprehensive health services plan operating pursuant to regulations of the department of social services or the department [of health]; OR

(E) A HEALTH PLAN UNDER SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THIS CHAPTER, INCLUDING THE FEE-FOR-SERVICE HEALTH PLAN.

S 3. Paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 649 of the laws of 1996, subparagraphs (i) and (ii) as amended by chapter 433 of the laws of 1997, is amended to read as follows:

(b) "Managed care provider". An entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management; and:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis; or

(ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act; OR

(III) IS A HEALTH PLAN UNDER SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THE PUBLIC HEALTH LAW, INCLUDING THE FEE-FOR-SERVICE HEALTH PLAN.

S 4. Paragraph (b) of subdivision 1 of section 369-ee of the social services law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

(b) "Eligible organization" means an insurer licensed pursuant to article thirty-two or forty-two of the insurance law, a corporation or an organization under article forty-three of the insurance law, or an organization certified under article forty-four of the public health law, including providers certified under section forty-four hundred three-e of such article, OR A HEALTH PLAN UNDER SECTION FIVE THOUSAND ONE HUNDRED FIVE OF THE PUBLIC HEALTH LAW, INCLUDING THE FEE-FOR-SERVICE HEALTH PLAN.

S 5. Financing of New York health plus. 1. The governor shall submit to the legislature a 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 Plus program, as created by article 51 of the public health law (referred to in this section as the "program") to be enacted by this act. 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 majority leader 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) The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two assessments (referred to collectively in this section as the "assessments"). First, there shall be an assessment on all payroll and self-employed income (referred to in this section as the "payroll assessment"), paid by employers, employees and self-employed, similar to the Medicare tax. Higher brackets of income subject to this assessment shall be assessed at a higher marginal rate than lower brackets. Second, there shall be a progressively-graduated assessment on taxable income (such as interest, dividends, and capital gains) not subject to the payroll assessment (referred to in this section as the "non-payroll assessment"). The assessments will be set at levels anticipated to produce sufficient revenue to finance the program, to be scaled up as enrollment grows. Individuals and employers who choose to pay for private health coverage instead of participating in the program shall be allowed to take a limited credit against the assessments they pay. 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 assessment. The income to be subject to the payroll assessment shall be all income subject to the Medicare tax. The assessment shall be set at a particular 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 assessment and the employee shall pay twenty percent (unless the employer agrees to pay a higher percentage). A self-employed individual shall pay the full assessment.

(c) Non-payroll income assessment. There shall be a second assessment, on upper-bracket taxable income that is not subject to the payroll assessment. It shall be progressively graduated and structured as a percentage of personal income tax.

(d) Phased-in rates. Early in the program, when enrollment is low, the amount of the assessments shall be low, and shall be raised as enrollment grows, to cover the actual cost of the program. The revenue proposal shall include a mechanism for determining the rates of the assessments.

(e) Credit against the assessments. (i) Employers and individuals shall be able to take a credit against the assessments they would otherwise pay, for amounts they spend on health benefits that would otherwise be covered by 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. An employee may take the credit for his or her contribution to an employment-based health benefit. 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.

(ii) The amount of the total credit relating to an individual (whether taken by an employer, employee or individual) shall not exceed eighty percent of the total includable spending relating to that individual (including the individual's family as appropriate).

(iii) The credit may only be taken against the assessments. Any excess amount may not be applied to other tax liability.

(iv) 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 assessment.

(f) 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 assessment as if the employment were in the state and may take the credit against the payroll assessment. 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 assessment and may take the credit against the assessment or (B) the employee shall pay the assessment as if he or she were self-employed and may take the credit against the assessment.

(ii) Out-of-state residents employed in the state. The payroll assessment and the credit against the payroll assessment shall apply to any out-of-state resident who is employed or self-employed in the state.

3. 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.

S 6. 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 HEALTH CARE PLANS

SECTION 4920. DEFINITIONS.
4921. COLLECTIVE NEGOTIATION AUTHORIZED.
4922. LIMITATIONS ON COLLECTIVE NEGOTIATION.
4923. COLLECTIVE NEGOTIATION REQUIREMENTS.
4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE.
4925. CERTAIN COLLECTIVE ACTION PROHIBITED.
4926. FEES.
4927. CONFIDENTIALITY.
4928. SEVERABILITY AND CONSTRUCTION.

S 4920. DEFINITIONS. FOR PURPOSES OF THIS TITLE:

1. "HEALTH CARE PLAN" MEANS AN ENTITY (OTHER THAN A HEALTH CARE PROVIDER) THAT APPROVES, PROVIDES, ARRANGES FOR, OR PAYS FOR HEALTH CARE SERVICES, INCLUDING BUT NOT LIMITED TO:

(A) A HEALTH MAINTENANCE ORGANIZATION LICENSED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW OR CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER;

(B) ANY OTHER ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER;
(C) AN INSURER OR CORPORATION SUBJECT TO THE INSURANCE LAW;
(D) A MANAGED CARE PROVIDER LICENSED PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW; OR
(E) A HEALTH PLAN OPERATING 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 WHO IS AUTHORIZED BY HEALTH CARE PROVIDERS TO NEGOTIATE ON THEIR BEHALF WITH HEALTH CARE PLANS OVER CONTRACTUAL 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. "SUBSTANTIAL MARKET POWER IN A BUSINESS LINE" EXISTS IF A HEALTH CARE PLAN'S MARKET SHARE OF A BUSINESS LINE WITHIN A SERVICE AREA AS APPROVED BY THE COMMISSIONER, ALONE OR IN COMBINATION WITH THE MARKET SHARES OF AFFILIATES, EXCEEDS EITHER TEN PERCENT OF THE TOTAL NUMBER OF COVERED LIVES IN THAT SERVICE AREA FOR SUCH BUSINESS LINE OR TWENTY-FIVE THOUSAND LIVES, OR IF THE COMMISSIONER DETERMINES THE MARKET POWER OF THE INSURER IN THE RELEVANT INSURANCE PRODUCT AND GEOGRAPHIC MARKETS FOR THE SERVICES OF THE PROVIDERS SEEKING TO COLLECTIVELY NEGOTIATE SIGNIFICANTLY EXCEEDS THE COUNTERVAILING MARKET POWER OF THE PROVIDERS ACTING INDIVIDUALLY.
6. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED, OR REGISTERED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW AND WHO PRACTICES AS A HEALTH CARE PROVIDER AS AN INDEPENDENT CONTRACTOR AND/OR WHO IS AN OWNER, OFFICER, SHAREHOLDER, OR PROPRIETOR OF A HEALTH CARE PROVIDER. 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.
S 4921. COLLECTIVE NEGOTIATION AUTHORIZED. 1. HEALTH CARE PROVIDERS PRACTICING WITHIN THE SERVICE AREA OF A HEALTH CARE PLAN MAY MEET AND COMMUNICATE FOR THE PURPOSE OF COLLECTIVELY NEGOTIATING THE FOLLOWING TERMS AND CONDITIONS OF PROVIDER CONTRACTS WITH THE HEALTH CARE PLAN:
(A) THE DETAILS OF THE UTILIZATION REVIEW PLAN AS DEFINED PURSUANT TO SUBDIVISION TEN OF SECTION FORTY-NINE HUNDRED OF THIS ARTICLE;
(B) COVERAGE PROVISIONS; HEALTH CARE BENEFITS; BENEFIT MAXIMUMS, INCLUDING BENEFIT LIMITATIONS; AND EXCLUSIONS OF COVERAGE;
(C) THE DEFINITION OF MEDICAL NECESSITY;
(D) THE CLINICAL PRACTICE GUIDELINES USED TO MAKE MEDICAL NECESSITY AND UTILIZATION REVIEW DETERMINATIONS;
(E) PREVENTIVE CARE AND OTHER MEDICAL MANAGEMENT PRACTICES;
(F) DRUG FORMULARIES AND STANDARDS AND PROCEDURES FOR PRESCRIBING OFF-FORMULARY DRUGS;
(G) RESPECTIVE PHYSICIAN LIABILITY FOR THE TREATMENT OR LACK OF TREATMENT OF COVERED PERSONS;
(H) THE DETAILS OF HEALTH CARE PLAN RISK TRANSFER ARRANGEMENTS WITH PROVIDERS;
(I) PLAN ADMINISTRATIVE PROCEDURES, INCLUDING METHODS AND TIMING OF HEALTH CARE PROVIDER PAYMENT FOR SERVICES PURSUANT TO SECTION FORTY-FOUR HUNDRED SIX-C OF THIS CHAPTER;
(J) PROCEDURES TO BE UTILIZED TO RESOLVE DISPUTES BETWEEN THE HEALTH CARE PLAN AND HEALTH CARE PROVIDERS;

(K) PATIENT REFERRAL PROCEDURES INCLUDING, BUT NOT LIMITED TO, THOSE APPLICABLE TO OUT-OF-POCKET NETWORK REFERRALS;

(L) THE FORMULATION AND APPLICATION OF HEALTH CARE PROVIDER REIMBURSEMENT PROCEDURES;

(M) QUALITY ASSURANCE PROGRAMS;

(N) THE PROCESS FOR RENDERING UTILIZATION REVIEW DETERMINATIONS INCLUDING: ESTABLISHMENT OF A PROCESS FOR RENDERING UTILIZATION REVIEW DETERMINATIONS WHICH SHALL, AT A MINIMUM, INCLUDE: WRITTEN PROCEDURES TO ASSURE THAT UTILIZATION REVIEWS AND DETERMINATIONS ARE CONDUCTED WITHIN THE TIMEFRAMES ESTABLISHED IN THIS ARTICLE; PROCEDURES TO NOTIFY AN ENROLLEE, AN ENROLLEE'S DESIGNEE AND/OR AN ENROLLEE'S HEALTH CARE PROVIDER OF ADVERSE DETERMINATIONS; AND PROCEDURES FOR APPEAL OF ADVERSE DETERMINATIONS, INCLUDING THE ESTABLISHMENT OF AN EXPEDITED APPEALS PROCESS FOR DENIALS OF CONTINUED INPATIENT CARE OR WHERE THERE IS IMMINENT OR SERIOUS THREAT TO THE HEALTH OF THE ENROLLEE; AND

(O) HEALTH CARE PROVIDER SELECTION AND TERMINATION CRITERIA USED BY THE HEALTH CARE PLAN.

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 A HEALTH CARE PLAN BY HEALTH CARE PROVIDERS OR PLANS AS OTHERWISE SET FORTH IN THE LAWS OF THIS STATE.

4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW OR AUTHORIZE TERMS OR CONDITIONS WHICH WOULD IMPEDE THE ABILITY OF A HEALTH CARE PLAN TO OBTAIN OR RETAIN ACCREDITATION BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE OR A SIMILAR BODY.

S 4922. LIMITATIONS ON COLLECTIVE NEGOTIATION. 1. IF THE HEALTH CARE PLAN HAS SUBSTANTIAL MARKET POWER IN A BUSINESS LINE IN ANY SERVICE AREA, HEALTH CARE PROVIDERS PRACTICING WITHIN THAT SERVICE AREA MAY COLLECTIVELY NEGOTIATE THE FOLLOWING TERMS AND CONDITIONS RELATING TO THAT BUSINESS LINE WITH THE HEALTH CARE PLAN:

(A) THE FEES ASSESSED BY THE HEALTH CARE PLAN FOR SERVICES, INCLUDING FEES ESTABLISHED THROUGH THE APPLICATION OF REIMBURSEMENT PROCEDURES;

(B) THE CONVERSION FACTORS USED BY THE HEALTH CARE PLAN IN A RESOURCE-BASED RELATIVE VALUE SCALE REIMBURSEMENT METHODOLOGY OR OTHER SIMILAR METHODOLOGY; PROVIDED THE SAME ARE NOT OTHERWISE ESTABLISHED BY STATE OR FEDERAL LAW OR REGULATION;

(C) THE AMOUNT OF ANY DISCOUNT GRANTED BY THE HEALTH CARE PLAN ON THE FEE OF HEALTH CARE SERVICES TO BE RENDERED BY HEALTH CARE PROVIDERS;

(D) THE DOLLAR AMOUNT OF CAPITATION OR FIXED PAYMENT FOR HEALTH SERVICES RENDERED BY HEALTH CARE PROVIDERS TO HEALTH CARE PLAN ENROLLEES;

(E) THE PROCEDURE CODE OR OTHER DESCRIPTION OF A HEALTH CARE SERVICE COVERED BY A PAYMENT AND THE APPROPRIATE GROUPING OF THE PROCEDURE CODES; OR

(F) THE AMOUNT OF ANY OTHER COMPONENT OF THE REIMBURSEMENT METHODOLOGY FOR A HEALTH CARE SERVICE.

2. NOTHING IN THIS SECTION SHALL BE DEEMED TO 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.

S 4923. 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 CONTRACTUAL TERMS AND CONDITIONS TO BE NEGOTIATED WITH A HEALTH CARE PLAN;

(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 HEALTH CARE PLANS 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, A HEALTH CARE PLAN IS ENTITLED TO CONTRACT WITH OR OFFER DIFFERENT CONTRACT TERMS AND CONDITIONS TO INDIVIDUAL COMPETING HEALTH CARE PROVIDERS.

2. A HEALTH CARE PROVIDERS' REPRESENTATIVE MAY NOT REPRESENT MORE THAN THIRTY PERCENT OF THE MARKET OF HEALTH CARE PROVIDERS OR OF A PARTICULAR HEALTH CARE PROVIDER TYPE OR SPECIALTY PRACTICING IN THE SERVICE AREA OR PROPOSED SERVICE AREA OF A HEALTH CARE PLAN THAT COVERS LESS THAN FIVE PERCENT OF THE ACTUAL NUMBER OF COVERED LIVES OF THE HEALTH CARE PLAN IN THE AREA, AS DETERMINED BY THE DEPARTMENT.

3. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT COLLECTIVE ACTION ON THE PART OF ANY HEALTH CARE PROVIDER WHO IS A MEMBER OF A COLLECTIVE BARGAINING UNIT RECOGNIZED PURSUANT TO THE NATIONAL LABOR RELATIONS ACT.

S 4924. REQUIREMENTS FOR HEALTH CARE PROVIDERS' REPRESENTATIVE. 1. BEFORE ENGAGING IN COLLECTIVE NEGOTIATIONS WITH A HEALTH CARE PLAN 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.

2. BEFORE ENGAGING IN THE COLLECTIVE NEGOTIATIONS, THE HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL ALSO SUBMIT TO THE COMMISSIONER FOR THE COMMISSIONER'S APPROVAL A REPORT IDENTIFYING THE PROPOSED SUBJECT MATTER OF THE NEGOTIATIONS OR DISCUSSIONS WITH THE HEALTH CARE PLAN AND THE EFFICIENCIES OR BENEFITS EXPECTED TO BE ACHIEVED THROUGH THE NEGOTIATIONS. THE COMMISSIONER SHALL NOT APPROVE THE REPORT IF THE COMMISSIONER DETERMINES THAT THE PROPOSED NEGOTIATIONS WOULD EXCEED THE AUTHORITY GRANTED UNDER THIS TITLE.

3. THE REPRESENTATIVE SHALL SUPPLEMENT THE INFORMATION IN THE REPORT ON A REGULAR BASIS OR AS NEW INFORMATION BECOMES AVAILABLE, INDICATING THAT THE SUBJECT MATTER OF THE NEGOTIATIONS WITH THE HEALTH CARE PLAN HAS CHANGED OR WILL CHANGE. IN NO EVENT SHALL THE REPORT BE LESS THAN EVERY THIRTY DAYS.

4. WITH THE ADVICE OF THE SUPERINTENDENT OF INSURANCE, THE COMMISSIONER SHALL APPROVE OR DISAPPROVE THE REPORT NOT LATER THAN THE TWENTIETH DAY AFTER THE DATE ON WHICH THE REPORT IS FILED. IF DISAPPROVED, THE COMMISSIONER SHALL FURNISH A WRITTEN EXPLANATION OF ANY DEFICIENCIES, ALONG WITH A STATEMENT OF SPECIFIC PROPOSALS FOR REMEDIAL MEASURES TO CURE THE DEFICIENCIES. IF THE COMMISSIONER DOES NOT SO ACT WITHIN THE TWENTY DAYS, THE REPORT SHALL BE DEEMED APPROVED.

5. A PERSON WHO ACTS AS A HEALTH CARE PROVIDERS' REPRESENTATIVE WITHOUT THE APPROVAL OF THE COMMISSIONER UNDER THIS SECTION SHALL BE DEEMED TO BE ACTING OUTSIDE THE AUTHORITY GRANTED UNDER THIS TITLE.

6. BEFORE REPORTING THE RESULTS OF NEGOTIATIONS WITH A HEALTH CARE PLAN OR PROVIDING TO THE AFFECTED HEALTH CARE PROVIDERS AN EVALUATION OF

ANY OFFER MADE BY A HEALTH CARE PLAN, THE HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL FURNISH FOR APPROVAL BY THE COMMISSIONER, BEFORE DISSEMINATION TO THE HEALTH CARE PROVIDERS, A COPY OF ALL COMMUNICATIONS TO BE MADE TO THE HEALTH CARE PROVIDERS RELATED TO NEGOTIATIONS, DISCUSSIONS, AND OFFERS MADE BY THE HEALTH CARE PLAN.

7. A HEALTH CARE PROVIDERS' REPRESENTATIVE SHALL REPORT THE END OF NEGOTIATIONS TO THE COMMISSIONER NOT LATER THAN THE FOURTEENTH DAY AFTER THE DATE OF A HEALTH CARE PLAN DECISION DECLINING NEGOTIATION, CANCELING NEGOTIATIONS, OR FAILING TO RESPOND TO A REQUEST FOR NEGOTIATION.

S 4925. CERTAIN COLLECTIVE ACTION PROHIBITED. 1. THIS TITLE IS NOT INTENDED TO AUTHORIZE COMPETING HEALTH CARE PROVIDERS TO ACT IN CONCERT IN RESPONSE TO A REPORT ISSUED BY THE HEALTH CARE PROVIDERS' REPRESENTATIVE RELATED TO THE REPRESENTATIVE'S DISCUSSIONS OR NEGOTIATIONS WITH HEALTH CARE PLANS.

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.

S 4926. FEES. EACH PERSON WHO ACTS AS THE REPRESENTATIVE OR 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. ANY FEE COLLECTED UNDER THIS SECTION SHALL BE DEPOSITED IN THE STATE TREASURY TO THE CREDIT OF THE GENERAL FUND/STATE OPERATIONS - 003 FOR THE NEW YORK STATE DEPARTMENT OF HEALTH FUND.

S 4927. 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.

S 4928. SEVERABILITY AND CONSTRUCTION. THE PROVISIONS OF THIS TITLE SHALL BE SEVERABLE, AND IF ANY COURT OF COMPETENT JURISDICTION DECLARES ANY PHRASE, CLAUSE, SENTENCE OR PROVISION OF THIS TITLE TO BE INVALID, OR ITS APPLICABILITY TO ANY GOVERNMENT, AGENCY, PERSON OR CIRCUMSTANCE IS DECLARED INVALID, THE REMAINDER OF THIS TITLE AND ITS RELEVANT APPLICABILITY SHALL NOT BE AFFECTED. THE PROVISIONS OF THIS TITLE SHALL BE LIBERALLY CONSTRUED TO GIVE EFFECT TO THE PURPOSES THEREOF.

S 7. Section 2510 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. "PRESCRIPTION AND NON-PRESCRIPTION DRUGS" SHALL MEAN PRESCRIPTION DRUGS AS DEFINED IN SECTION TWO HUNDRED SEVENTY OF THE PUBLIC HEALTH LAW, WHICH SHALL BE PROVIDED PURSUANT TO SUBDIVISION FOUR-B OF SECTION TWO THOUSAND FIVE HUNDRED ELEVEN OF THIS ARTICLE, AND NON-PRESCRIPTION SMOKING CESSATION PRODUCTS OR DEVICES.

S 8. Section 2511 of the public health law is amended by adding a new subdivision 4-b to read as follows:

4-B. PRESCRIPTION AND NON-PRESCRIPTION DRUG PAYMENTS. NOTWITHSTANDING SUBDIVISIONS THREE AND FOUR OF THIS SECTION, PAYMENT FOR DRUGS, EXCEPT FOR SUCH DRUGS PROVIDED BY MEDICAL PRACTITIONERS, AND FOR WHICH PAYMENT IS AUTHORIZED PURSUANT TO SUBDIVISION THIRTEEN OF SECTION TWO THOUSAND FIVE HUNDRED TEN OF THIS TITLE, SHALL BE MADE PURSUANT TO SUBDIVISION NINE OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THE SOCIAL SERVICES LAW, ARTICLE TWO-A OF THIS CHAPTER AND SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW. PAYMENT FOR SUCH DRUGS

PROVIDED BY MEDICAL PRACTITIONERS SHALL BE INCLUDED IN THE CAPITATION PAYMENT FOR SERVICES OR SUPPLIES PROVIDED TO PERSONS ELIGIBLE FOR HEALTH CARE SERVICES UNDER THIS TITLE.

S 9. 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-ee of the social services law to the extent that section provides that the program shall be subject to this article, THE CHILD HEALTH INSURANCE PROGRAM ESTABLISHED BY TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER, AND THE NEW YORK HEALTH PLUS PROGRAM ESTABLISHED BY ARTICLE FIFTY-ONE OF THIS CHAPTER.

S 10. Severability. If any provision of law enacted by this act or any application thereof shall be adjudged by any court of competent jurisdiction to be invalid, or ruled by any appropriate federal agency to violate or be inconsistent with any applicable federal law or regulation, the judgment or ruling shall not affect, impair or invalidate the remainder thereof or any other application thereof, but shall be confined in its operation to the provision or application thereof directly involved in the controversy or matter in which the judgment or ruling shall have been rendered.

S 11. This act shall take effect immediately; provided that the amendments made to section 364-j of the social services law by section three of this act and to section 270 of the public health law by section nine of this act shall not affect the expiration and repeal of such sections and shall expire and be deemed repealed therewith.