

STATE OF NEW YORK

4738--A

2017-2018 Regular Sessions

IN ASSEMBLY

February 3, 2017

Introduced by M. of A. GOTTFRIED, ABINANTI, BARRON, BENEDETTO, BICHOTTE, BLAKE, BRONSON, CARROLL, COLTON, COOK, CRESPO, CYMBROWITZ, DILAN, DINOWITZ, ENGLEBRIGHT, GANTT, HIKIND, HUNTER, HYNDMAN, JAFFEE, JENNE, JOYNER, KIM, LAVINE, LIFTON, LUPARDO, MAYER, M. G. MILLER, MOSLEY, PAULIN, PEOPLES-STOKES, PERRY, PICHARDO, RAMOS, RICHARDSON, RIVERA, RODRIGUEZ, L. ROSENTHAL, SEAWRIGHT, SEPULVEDA, SIMOTAS, STECK, STIRPE, THIELE, TITONE, TITUS, WALKER, WEINSTEIN, WEPRIN, DE LA ROSA, D'URSO, JEAN-PIERRE, WRIGHT, HARRIS, WILLIAMS, VANEL, SOLAGES, WALLACE, BARRETT, PHEFFER AMATO, NIOU, ORTIZ, DICKENS, TAYLOR -- Multi-Sponsored by -- M. of A. ABBATE, ARROYO, AUBRY, CAHILL, DAVILA, FAHY, GLICK, GUNTHER, HOOPER, LENTOL, MAGEE, MAGNARELLI, O'DONNELL, PRETLOW, QUART, ROZIC, SIMON, SKARTADOS -- read once and referred to the Committee on Health -- recommitted to the Committee on Health in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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

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

1 Section 1. Short title. This act shall be known and may be cited as
2 the "New York health act".
3 § 2. Legislative findings and intent. 1. The state constitution
4 states: "The protection and promotion of the health of the inhabitants
5 of the state are matters of public concern and provision therefor shall
6 be made by the state and by such of its subdivisions and in such manner,
7 and by such means as the legislature shall from time to time determine."
8 (Article XVII, §3.) The legislature finds and declares that all resi-
9 dents of the state have the right to health care. While the federal
10 Affordable Care Act brought many improvements in health care and health
11 coverage, it still leaves many New Yorkers without coverage or with
12 inadequate coverage. New Yorkers - as individuals, employers, and
13 taxpayers - have experienced a rise in the cost of health care and

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

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1 coverage in recent years, including rising premiums, deductibles and
2 co-pays, restricted provider networks and high out-of-network charges.
3 Many New Yorkers go without health care because they cannot afford it or
4 suffer financial hardship to get it. Businesses have also experienced
5 increases in the costs of health care benefits for their employees, and
6 many employers are shifting a larger share of the cost of coverage to
7 their employees or dropping coverage entirely. Health care providers
8 are also affected by inadequate health coverage in New York state. A
9 large portion of hospitals, health centers and other providers now experi-
10 ence substantial losses due to the provision of care that is uncompen-
11 sated. Individuals often find that they are deprived of affordable care
12 and choice because of decisions by health plans guided by the plan's
13 economic interests rather than the individual's health care needs. To
14 address the fiscal crisis facing the health care system and the state
15 and to assure New Yorkers can exercise their right to health care,
16 affordable and comprehensive health coverage must be provided. Pursuant
17 to the state constitution's charge to the legislature to provide for the
18 health of New Yorkers, this legislation is an enactment of state concern
19 for the purpose of establishing a comprehensive universal guaranteed
20 health care coverage program and a health care cost control system for
21 the benefit of all residents of the state of New York.

22 2. (a) It is the intent of the Legislature to create the New York
23 Health program to provide a universal single payer health plan for every
24 New Yorker, funded by broad-based revenue based on ability to pay. The
25 state shall work to obtain waivers and other approvals relating to Medi-
26 caid, Child Health Plus, Medicare, the Affordable Care Act, and any
27 other appropriate federal programs, under which federal funds and other
28 subsidies that would otherwise be paid to New York State, New Yorkers,
29 and health care providers for health coverage that will be equaled or
30 exceeded by New York Health will be paid by the federal government to
31 New York State and deposited in the New York Health trust fund, or paid
32 to health care providers and individuals in combination with New York
33 Health trust fund payments, and for other program modifications (includ-
34 ing elimination of cost sharing and insurance premiums). Under such
35 waivers and approvals, health coverage under those programs will, to the
36 maximum extent possible, be replaced and merged into New York Health,
37 which will operate as a true single-payer program.

38 (b) If any necessary waiver or approval is not obtained, the state
39 shall use state plan amendments and seek waivers and approvals to maxi-
40 mize, and make as seamless as possible, the use of federally-matched
41 health programs and federal health programs in New York Health. Thus,
42 even where other programs such as Medicaid or Medicare may contribute to
43 paying for care, it is the goal of this legislation that the coverage
44 will be delivered by New York Health and, as much as possible, the
45 multiple sources of funding will be pooled with other New York Health
46 funds and not be apparent to New York Health members or participating
47 providers.

48 (c) This program will promote movement away from fee-for-service
49 payment, which tends to reward quantity and requires excessive adminis-
50 trative expense, and towards alternate payment methodologies, such as
51 global or capitated payments to providers or health care organizations,
52 that promote quality, efficiency, investment in primary and preventive
53 care, and innovation and integration in the organizing of health care.

54 (d) The program shall promote the use of clinical data to improve the
55 quality of health care and public health, consistent with protection of

1 patient confidentiality. The program shall maximize patient autonomy in
2 choice of health care providers and health care decision making.

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

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

16 § 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public
17 health law are renumbered article 80 and sections 8000, 8001, 8002 and
18 8003, respectively, and a new article 51 is added to read as follows:

19 ARTICLE 51

20 NEW YORK HEALTH

21 Section 5100. Definitions.

22 5101. Program created.

23 5102. Board of trustees.

24 5103. Eligibility and enrollment.

25 5104. Benefits.

26 5105. Health care providers; care coordination; payment method-
27 ologies.

28 5106. Health care organizations.

29 5107. Program standards.

30 5108. Regulations.

31 5109. Provisions relating to federal health programs.

32 5110. Additional provisions.

33 5111. Regional advisory councils.

34 § 5100. Definitions. As used in this article, the following terms
35 shall have the following meanings, unless the context clearly requires
36 otherwise:

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

40 2. "Care coordination" means, but is not limited to, managing, refer-
41 ring to, locating, coordinating, and monitoring health care services for
42 the member to assure that all medically necessary health care services
43 are made available to and are effectively used by the member in a timely
44 manner, consistent with patient autonomy. Care coordination does not
45 include a requirement for prior authorization for health care services
46 or for referral for a member to receive a health care service.

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

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

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

4 6. "Health care provider" means any individual or entity legally
5 authorized to provide a health care service under Medicaid or Medicare
6 or this article. "Health care professional" means a health care provider
7 that is an individual licensed, certified, registered or otherwise
8 authorized to practice under title eight of the education law to provide
9 such health care service, acting within his or her lawful scope of prac-
10 tice.

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

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

17 9. "Long term care" means long term care, treatment, maintenance,
18 services and supports, with the exception of short term rehabilitation
19 and short term home care, as defined by the commissioner.

20 10. "Medicaid" or "medical assistance" means title eleven of article
21 five of the social services law and the program thereunder. "Child
22 health plus" means title one-A of article twenty-five of this chapter
23 and the program thereunder. "Medicare" means title XVIII of the federal
24 social security act and the programs thereunder. "Affordable care act"
25 means the federal patient protection and affordable care act, public law
26 111-148, as amended by the health care and education reconciliation act
27 of 2010, public law 111-152, and as otherwise amended and any regu-
28 lations or guidance issued thereunder. "Basic health program" means
29 section three hundred sixty-nine-gg of the social services law and the
30 program thereunder.

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

32 12. "New York Health", "New York Health program", and "program" mean
33 the New York Health program created by section fifty-one hundred one of
34 this article.

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

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

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

52 16. "Person" means any individual or natural person, trust, partner-
53 ship, association, unincorporated association, corporation, company,
54 limited liability company, proprietorship, joint venture, firm, joint
55 stock association, department, agency, authority, or other legal entity,
56 whether for-profit, not-for-profit or governmental.

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

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

7 § 5101. Program created. 1. The New York Health program is hereby
8 created in the department. The commissioner shall establish and imple-
9 ment the program under this article. The program shall provide compre-
10 hensive health coverage to every resident who enrolls in the program.

11 2. The commissioner shall, to the maximum extent possible, organize,
12 administer and market the program and services as a single program under
13 the name "New York Health" or such other name as the commissioner shall
14 determine, regardless of under which law or source the definition of a
15 benefit is found including (on a voluntary basis) retiree health bene-
16 fits. In implementing this article, the commissioner shall avoid jeop-
17 ardizing federal financial participation in these programs and shall
18 take care to promote public understanding and awareness of available
19 benefits and programs.

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

24 4. An insurer authorized to provide coverage pursuant to the insurance
25 law or a health maintenance organization certified under this chapter
26 may, if otherwise authorized, offer benefits that do not cover any
27 service for which coverage is offered to individuals under the program,
28 but may not offer benefits that cover any service for which coverage is
29 offered to individuals under the program. Provided, however, that this
30 subdivision shall not prohibit (a) the offering of any benefits to or
31 for individuals, including their families, who are employed or self-em-
32 ployed in the state but who are not residents of the state, or (b) the
33 offering of benefits during the implementation period to individuals who
34 enrolled or may enroll as members of the program, or (c) the offering of
35 retiree health benefits.

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

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

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

44 (b) is consistent with the provisions of this article and the legisla-
45 tive intent of the New York Health Act, the provision of that law shall
46 apply.

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

50 8. No member shall be required to receive any health care service
51 through any entity organized, certified or operating under guidelines
52 under article forty-four of this chapter, or specified under section
53 three hundred sixty-four-j of the social services law, the insurance law
54 or the elder law. No such entity shall receive payment for health care
55 services (other than care coordination) from the program. However, this
56 subdivision shall not preclude the use of a Medicare managed care

1 ("Medicare advantage") entity under the program and otherwise consistent
2 with this article.

3 9. The program shall include provision for an appropriate reserve
4 fund.

5 § 5102. Board of trustees. 1. The New York Health board of trustees is
6 hereby created in the department. The board of trustees shall, at the
7 request of the commissioner, consider any matter to effectuate the
8 provisions and purposes of this article, and may advise the commissioner
9 thereon; and it may, from time to time, submit to the commissioner any
10 recommendations to effectuate the provisions and purposes of this arti-
11 cle. The commissioner may propose regulations under this article and
12 amendments thereto for consideration by the board. The board of trustees
13 shall have no executive, administrative or appointive duties except as
14 otherwise provided by law. The board of trustees shall have power to
15 establish, and from time to time, amend regulations to effectuate the
16 provisions and purposes of this article, subject to approval by the
17 commissioner.

18 2. The board shall be composed of:

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

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

22 (i) six of whom shall be representatives of health care consumer advoca-
23 cy organizations which have a statewide or regional constituency, who
24 have been involved in activities related to health care consumer advoca-
25 cy, including issues of interest to low- and moderate-income individ-
26 uals;

27 (ii) two of whom shall be representatives of professional organiza-
28 tions representing physicians;

29 (iii) two of whom shall be representatives of professional organiza-
30 tions representing licensed or registered health care professionals
31 other than physicians;

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

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

35 (vi) two of whom shall be representatives of rehabilitation or home
36 care providers;

37 (vii) two of whom shall be representatives of behavioral or mental
38 health or disability service providers;

39 (viii) two of whom shall be representatives of health care organiza-
40 tions;

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

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

44 (xi) two of whom shall be employers or representatives of employers
45 who pay the payroll tax under this article, or, prior to the tax becom-
46 ing effective, will pay the tax;

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

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

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

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

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

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

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

26 (a) The board shall develop a proposal, consistent with the principles
27 of this article, for provision by the program of long-term care cover-
28 age, including the development of a proposal, consistent with the prin-
29 ciples of this article, for its funding. In developing the proposal,
30 the board shall consult with an advisory committee, appointed by the
31 chair of the board, including representatives of consumers and potential
32 consumers of long-term care, providers of long-term care, labor, and
33 other interested parties. The board shall present its proposal to the
34 governor and the legislature.

35 (b) The board shall develop proposals for: (i) incorporating retiree
36 health benefits into New York Health; (ii) accommodating employer reti-
37 ree health benefits for people who have been members of New York Health
38 but live as retirees out of the state; and (iii) accommodating employer
39 retiree health benefits for people who earned or accrued such benefits
40 while residing in the state prior to the implementation of New York
41 Health and live as retirees out of the state. The board shall present
42 its proposals to the governor and the legislature.

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

48 § 5103. Eligibility and enrollment. 1. Every resident of the state
49 shall be eligible and entitled to enroll as a member under the program.

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

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

55 § 5104. Benefits. 1. The program shall provide comprehensive health
56 coverage to every member, which shall include all health care services

1 required to be covered under any of the following, without regard to
2 whether the member would otherwise be eligible for or covered by the
3 program or source referred to:

4 (a) child health plus;

5 (b) Medicaid;

6 (c) Medicare;

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

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

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

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

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

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

22 3. The program shall provide for payment under the program for:

23 (a) emergency and temporary health care services provided to a member
24 or individual entitled to become a member who has not had a reasonable
25 opportunity to become a member or to enroll with a care coordinator; and

26 (b) health care services provided in an emergency to an individual who
27 is entitled to become a member or enrolled with a care coordinator,
28 regardless of having had an opportunity to do so.

29 § 5105. Health care providers; care coordination; payment methodol-
30 ogies. 1. Choice of health care provider. (a) Any health care provider
31 qualified to participate under this section may provide health care
32 services under the program, provided that the health care provider is
33 otherwise legally authorized to perform the health care service for the
34 individual and under the circumstances involved.

35 (b) A member may choose to receive health care services under the
36 program from any participating provider, consistent with provisions of
37 this article relating to care coordination and health care organiza-
38 tions, the willingness or availability of the provider (subject to
39 provisions of this article relating to discrimination), and the appro-
40 priate clinically-relevant circumstances.

41 2. Care coordination. (a) A care coordinator may be an individual or
42 entity that is approved by the program that is:

43 (i) a health care practitioner who is: (A) the member's primary care
44 practitioner; (B) at the option of a female member, the member's provid-
45 er of primary gynecological care; or (C) at the option of a member who
46 has a chronic condition that requires specialty care, a specialist
47 health care practitioner who regularly and continually provides treat-
48 ment for that condition to the member;

49 (ii) an entity licensed under article twenty-eight of this chapter or
50 certified under article thirty-six of this chapter, or, with respect to
51 a member who receives chronic mental health care services, an entity
52 licensed under article thirty-one of the mental hygiene law or other
53 entity approved by the commissioner in consultation with the commis-
54 ioner of mental health;

55 (iii) a health care organization;

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

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

7 (b)(i) Every member shall enroll with a care coordinator that agrees
8 to provide care coordination to the member prior to receiving health
9 care services to be paid for under the program. Health care services
10 provided to a member shall not be subject to payment under the program
11 unless the member is enrolled with a care coordinator at the time the
12 health care service is provided.

13 (ii) This paragraph shall not apply to health care services provided
14 under subdivision three of section fifty-one hundred four of this arti-
15 cle.

16 (iii) The member shall remain enrolled with that care coordinator
17 until the member becomes enrolled with a different care coordinator or
18 ceases to be a member. Members have the right to change their care coor-
19 dinator on terms at least as permissive as the provisions of section
20 three hundred sixty-four-j of the social services law relating to an
21 individual changing his or her primary care provider or managed care
22 provider.

23 (c) Care coordination shall be provided to the member by the member's
24 care coordinator. A care coordinator may employ or utilize the services
25 of other individuals or entities to assist in providing care coordi-
26 nation for the member, consistent with regulations of the commissioner.

27 (d) A health care organization may establish rules relating to care
28 coordination for members in the health care organization, different from
29 this subdivision but otherwise consistent with this article and other
30 applicable laws.

31 (e) The commissioner shall develop and implement procedures and stand-
32 ards for an individual or entity to be approved to be a care coordinator
33 in the program, including but not limited to procedures and standards
34 relating to the revocation, suspension, limitation, or annulment of
35 approval on a determination that the individual or entity is not compe-
36 tent to be a care coordinator or has exhibited a course of conduct which
37 is either inconsistent with program standards and regulations or which
38 exhibits an unwillingness to meet such standards and regulations, or is
39 a potential threat to the public health or safety. Such procedures and
40 standards shall not limit approval to be a care coordinator in the
41 program for economic purposes and shall be consistent with good profes-
42 sional practice. In developing the procedures and standards, the commis-
43 sioner shall: (i) consider existing standards developed by national
44 accrediting and professional organizations; and (ii) consult with
45 national and local organizations working on care coordination or similar
46 models, including health care practitioners, hospitals, clinics, and
47 consumers and their representatives. When developing and implementing
48 standards of approval of care coordinators for individuals receiving
49 chronic mental health care services, the commissioner shall consult with
50 the commissioner of mental health. An individual or entity may not be a
51 care coordinator unless the services included in care coordination are
52 within the individual's professional scope of practice or the entity's
53 legal authority.

54 (f) To maintain approval under the program, a care coordinator must:

55 (i) renew its status at a frequency determined by the commissioner; and
56 (ii) provide data to the department as required by the commissioner to

1 enable the commissioner to evaluate the impact of care coordinators on
2 quality, outcomes and cost.

3 (g) Nothing in this subdivision shall authorize any individual to
4 engage in any act in violation of title eight of the education law.

5 3. Health care providers. (a) The commissioner shall establish and
6 maintain procedures and standards for health care providers to be quali-
7 fied to participate in the program, including but not limited to proce-
8 dures and standards relating to the revocation, suspension, limitation,
9 or annulment of qualification to participate on a determination that the
10 health care provider is not competent to be a provider of specific
11 health care services or has exhibited a course of conduct which is
12 either inconsistent with program standards and regulations or which
13 exhibits an unwillingness to meet such standards and regulations, or is
14 a potential threat to the public health or safety. Such procedures and
15 standards shall not limit health care provider participation in the
16 program for economic purposes and shall be consistent with good profes-
17 sional practice. Such procedures and standards may be different for
18 different types of health care providers and health care professionals.
19 Any health care provider who is qualified to participate under Medicaid,
20 child health plus or Medicare shall be deemed to be qualified to partici-
21 ipate in the program, and any health care provider's revocation, suspen-
22 sion, limitation, or annulment of qualification to participate in any of
23 those programs shall apply to the health care provider's qualification
24 to participate in the program; provided that a health care provider
25 qualified under this sentence shall follow the procedures to become
26 qualified under the program by the end of the implementation period.

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

31 (c) Procedures and standards under this subdivision shall include
32 provisions for expedited temporary qualification to participate in the
33 program for health care professionals who are (i) temporarily authorized
34 to practice in the state or (ii) are recently arrived in the state or
35 recently authorized to practice in the state.

36 4. Payment for health care services. (a) The commissioner may estab-
37 lish by regulation payment methodologies for health care services and
38 care coordination provided to members under the program by participating
39 providers, care coordinators, and health care organizations. There may
40 be a variety of different payment methodologies, including those estab-
41 lished on a demonstration basis. All payment rates under the program
42 shall be reasonable and reasonably related to the cost of efficiently
43 providing the health care service and assuring an adequate and accessi-
44 ble supply of the health care service. Until and unless another payment
45 methodology is established, health care services provided to members
46 under the program shall be paid for on a fee-for-service basis, except
47 for care coordination.

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

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

1 drugs provided by health care providers other than pharmacies shall be
2 pursuant to other provisions of this article.

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

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

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

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

27 § 5106. Health care organizations. 1. A member may choose to enroll
28 with and receive health care services under the program from a health
29 care organization.

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

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

34 (b) a Taft-Hartley fund (i) with respect to its members and their
35 family members, and (ii) if allowed by applicable law and approved by
36 the commissioner, for other members of the program.

37 3. A health care organization may be responsible for providing all or
38 part of the health care services to which its members are entitled under
39 the program, consistent with the terms of its approval by the commis-
40 sioner.

41 4. (a) The commissioner shall develop and implement procedures and
42 standards for an entity to be approved to be a health care organization
43 in the program, including but not limited to procedures and standards
44 relating to the revocation, suspension, limitation, or annulment of
45 approval on a determination that the entity is not competent to be a
46 health care organization or has exhibited a course of conduct which is
47 either inconsistent with program standards and regulations or which
48 exhibits an unwillingness to meet such standards and regulations, or is
49 a potential threat to the public health or safety. Such procedures and
50 standards shall not limit approval to be a health care organization in
51 the program for economic purposes and shall be consistent with good
52 professional practice. In developing the procedures and standards, the
53 commissioner shall: (i) consider existing standards developed by
54 national accrediting and professional organizations; and (ii) consult
55 with national and local organizations working in the field of health
56 care organizations, including health care practitioners, hospitals,

1 clinics, and consumers and their representatives. When developing and
2 implementing standards of approval of health care organizations, the
3 commissioner shall consult with the commissioner of mental health, the
4 commissioner of developmental disabilities and the commissioner of the
5 office of alcoholism and substance abuse services.

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

12 5. The commissioner shall make regulations relating to health care
13 organizations consistent with and to ensure compliance with this arti-
14 cle.

15 6. The provision of health care services directly or indirectly by a
16 health care organization through health care providers shall not be
17 considered the practice of a profession under title eight of the educa-
18 tion law by the health care organization.

19 § 5107. Program standards. 1. The commissioner shall establish
20 requirements and standards for the program and for health care organiza-
21 tions, care coordinators, and health care providers, consistent with
22 this article, including requirements and standards for, as applicable:

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

24 (b) relations between health care organizations or health care provid-
25 ers and members; and

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

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

31 (a) simplification, transparency, uniformity, and fairness in health
32 care provider credentialing and participation in health care organiza-
33 tion networks, referrals, payment procedures and rates, claims process-
34 ing, and approval of health care services, as applicable;

35 (b) primary and preventive care, care coordination, efficient and
36 effective health care services, quality assurance, coordination and
37 integration of health care services, including use of appropriate tech-
38 nology, and promotion of public, environmental and occupational health;

39 (c) elimination of health care disparities;

40 (d) non-discrimination with respect to members and health care provid-
41 ers on the basis of race, ethnicity, national origin, religion, disabil-
42 ity, age, sex, sexual orientation, gender identity or expression, or
43 economic circumstances; provided that health care services provided
44 under the program shall be appropriate to the patient's clinically-rele-
45 vant circumstances; and

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

51 3. Any participating provider or care coordinator that is organized as
52 a for-profit entity (other than a professional practice of one or more
53 health care professionals) shall be required to meet the same require-
54 ments and standards as entities organized as not-for-profit entities,
55 and payments under the program paid to such entities shall not be calcu-
56 lated to accommodate the generation of profit or revenue for dividends

1 or other return on investment or the payment of taxes that would not be
2 paid by a not-for-profit entity.

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

11 5. In developing requirements and standards and making other policy
12 determinations under this article, the commissioner shall consult with
13 representatives of members, health care providers, care coordinators,
14 health care organizations employers, organized labor, and other inter-
15 ested parties.

16 6. The program shall maintain the security and confidentiality of all
17 data and other information collected under the program when such data
18 would be normally considered confidential patient data. Aggregate data
19 of the program which is derived from confidential data but does not
20 violate patient confidentiality shall be public information including
21 for purposes of article six of the public officers law.

22 § 5108. Regulations. The commissioner may make regulations under this
23 article by approving regulations and amendments thereto, under subdivi-
24 sion one of section fifty-one hundred two of this article. The commis-
25 sioner may make regulations or amendments thereto under this article on
26 an emergency basis under section two hundred two of the state adminis-
27 trative procedure act, provided that such regulations or amendments
28 shall not become permanent unless adopted under subdivision one of
29 section fifty-one hundred two of this article.

30 § 5109. Provisions relating to federal health programs. 1. The commis-
31 sioner shall seek all federal waivers and other federal approvals and
32 arrangements and submit state plan amendments necessary to operate the
33 program consistent with this article to the maximum extent possible.

34 2. (a) The commissioner shall apply to the secretary of health and
35 human services or other appropriate federal official for all waivers of
36 requirements, and make other arrangements, under Medicare, any federal-
37 ly-matched public health program, the affordable care act, and any other
38 federal programs that provide federal funds for payment for health care
39 services, that are necessary to enable all New York Health members to
40 receive all benefits under the program through the program to enable the
41 state to implement this article and to receive and deposit all federal
42 payments under those programs (including funds that may be provided in
43 lieu of premium tax credits, cost-sharing subsidies, and small business
44 tax credits) in the state treasury to the credit of the New York Health
45 trust fund and to use those funds for the New York Health program and
46 other provisions under this article. To the extent possible, the commis-
47 sioner shall negotiate arrangements with the federal government in which
48 bulk or lump-sum federal payments are paid to New York Health in place
49 of federal spending or tax benefits for federally-matched health
50 programs or federal health programs.

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

54 3. (a) The commissioner may take actions consistent with this article
55 to enable New York Health to administer Medicare in New York state, to
56 create a Medicare managed care plan ("Medicare Advantage") that would

1 operate consistent with this article, and to be a provider of drug
2 coverage under Medicare part D for eligible members of New York Health.

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

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

18 (d) The commissioner shall by regulation increase the income eligibil-
19 ity level, increase or eliminate the resource test for eligibility,
20 simplify any procedural or documentation requirement for enrollment, and
21 increase the benefits for any federally-matched public health program,
22 and for any program to reduce or eliminate an individual's coinsurance,
23 cost-sharing or premium obligations or increase an individual's eligi-
24 bility for any federal financial support related to Medicare or the
25 affordable care act notwithstanding any law or regulation to the contra-
26 ry. The commissioner may act under this paragraph upon a finding,
27 approved by the director of the budget, that the action (i) will help to
28 increase the number of members who are eligible for and enrolled in
29 federally-matched public health programs, or for any program to reduce
30 or eliminate an individual's coinsurance, cost-sharing or premium obli-
31 gations or increase an individual's eligibility for any federal finan-
32 cial support related to Medicare or the affordable care act; (ii) will
33 not diminish any individual's access to any health care service, benefit
34 or right the individual would otherwise have; (iii) is in the interest
35 of the program; and (iv) does not require or has received any necessary
36 federal waivers or approvals to ensure federal financial participation.
37 Actions under this paragraph shall not apply to eligibility for payment
38 for long term care.

39 (e) To enable the commissioner to apply for coverage under any feder-
40 ally-matched public health program or Medicare on behalf of any member
41 and enroll the member in the federally-matched public health program or
42 Medicare if the member is eligible for it, the commissioner may require
43 that every member or applicant to be a member shall provide information
44 to enable the commissioner to determine whether the applicant is eligi-
45 ble for a federally-matched public health program and for Medicare (and
46 any program or benefit under Medicare). The program shall make a reason-
47 able effort to notify members of their obligations under this paragraph.
48 After a reasonable effort has been made to contact the member, the
49 member shall be notified in writing that he or she has sixty days to
50 provide such required information. If such information is not provided
51 within the sixty day period, the member's coverage under the program may
52 be terminated.

53 (f) To the extent necessary for purposes of this section, as a condi-
54 tion of continued eligibility for health care services under the
55 program, a member who is eligible for benefits under Medicare shall
56 enroll in Medicare, including parts A, B and D.

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

10 (h) If the commissioner has reasonable grounds to believe that a
11 member could be eligible for an income-related subsidy under section
12 1860D-14 of Title XVIII of the federal social security act, the member
13 shall provide, and authorize the program to obtain, any information or
14 documentation required to establish the member's eligibility for such
15 subsidy, provided that the commissioner shall attempt to obtain as much
16 of the information and documentation as possible from records that are
17 available to him or her.

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

24 § 5110. Additional provisions. 1. The commissioner shall contract
25 with not-for-profit organizations to provide:

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

30 (b) health care provider assistance to health care providers providing
31 and seeking or considering whether to provide, health care services
32 under the program, with respect to participating in a health care organ-
33 ization and dealing with a health care organization; and

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

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

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

50 4. The commissioner shall, directly and through grants to not-for-pro-
51 fit entities, conduct programs using data collected through the New York
52 Health program, to promote and protect the quality of health care
53 services, patient outcomes, and public, environmental and occupational
54 health, including cooperation with other data collection and research
55 programs of the department, consistent with this article, the protection

1 of the security and confidentiality of individually identifiable patient
2 information, and otherwise applicable law.

3 § 5111. Regional advisory councils. 1. The New York Health regional
4 advisory councils (each referred to in this article as a "regional advi-
5 sory council") are hereby created in the department.

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

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

9 (b) New York City;

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

12 (d) Northern, consisting of Albany, Clinton, Columbia, Essex, Frank-
13 lin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga,
14 Schenectady, Schoharie, Warren, Washington counties;

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

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

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

27 4. Appointment of members of the regional advisory councils.

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

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

30 (ii) six members shall be appointed by the governor on the recommenda-
31 tion of the speaker of the assembly;

32 (iii) six members shall be appointed by the governor on the recommen-
33 dation of the temporary president of the senate;

34 (iv) three members shall be appointed by the governor on the recommen-
35 dation of the minority leader of the assembly; and

36 (v) three members shall be appointed by the governor on the recommen-
37 dation of the minority leader of the senate.

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

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

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

46 (ii) representatives of professional organizations representing physi-
47 cians;

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

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

51 (v) representatives of community health centers;

52 (vi) representatives of mental health, behavioral health (including
53 substance use), physical disability, developmental disability, rehabili-
54 tation, home care and other service providers;

55 (vii) representatives of women's health service providers;

56 (viii) representatives of health care organizations;

- (ix) representatives of organized labor;
- (x) representatives of employers; and
- (xi) representatives of municipal and county government.

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

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

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

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

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

- (a) promoting the delivery of health care services in the region, improving the quality and accessibility of care, including cultural competency, clinical integration of care between service providers including but not limited to physical, mental, and behavioral health, physical and developmental disability services, and long-term care;
- (b) facility and health services planning in the region;
- (c) identifying gaps in regional health care services; and
- (d) promoting increased public knowledge and responsibility regarding the availability and appropriate utilization of health care services.

Each community health improvement plan shall be submitted to the commissioner and the board and shall be posted on the department's website.

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

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

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

§ 4. Financing of New York Health. 1. The governor shall submit to the legislature a revenue plan and legislative bills to implement the plan (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance the New York Health program, as created by article 51 of the public health law and all provisions of that article (referred to in this section as the "program"), taking into consideration anticipated federal revenue available for the program. The revenue proposal shall be submitted to the legislature as part of the

1 executive budget under article VII of the state constitution, for the
2 fiscal year commencing on the first day of April in the calendar year
3 after this act shall become a law. In developing the revenue proposal,
4 the governor shall consult with appropriate officials of the executive
5 branch; the temporary president of the senate; the speaker of the assem-
6 bly; the chairs of the fiscal and health committees of the senate and
7 assembly; and representatives of business, labor, consumers and local
8 government.

9 2. (a) Basic structure. The basic structure of the revenue proposal
10 shall be as follows: Revenue for the program shall come from two taxes
11 (referred to collectively in this section as the "taxes"). First, there
12 shall be a progressively graduated tax on all payroll and self-employed
13 income (referred to in this section as the "payroll tax"), paid by
14 employers, employees and self-employed individuals. Second, there shall
15 be a progressively graduated tax on taxable income (such as interest,
16 dividends, and capital gains) not subject to the payroll tax (referred
17 to in this section as the "non-payroll tax"). Higher brackets of income
18 subject to the taxes shall be assessed at a higher marginal rate than
19 lower brackets. The taxes shall be set at levels anticipated to produce
20 sufficient revenue to finance the program, to be scaled up as enrollment
21 grows, taking into consideration anticipated federal revenue available
22 for the program. Provision shall be made for state residents (who are
23 eligible for the program) who are employed out-of-state, and non-resi-
24 dents (who are not eligible for the program) who are employed in the
25 state.

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

34 (c) Non-payroll income tax. There shall be a tax on income that is
35 subject to the personal income tax under article 22 of the tax law and
36 is not subject to the payroll tax. It shall be set at a percentage of
37 that income, which shall be progressively graduated, so the percentage
38 is higher on higher brackets of income.

39 (d) Phased-in rates. Early in the program, when enrollment is growing,
40 the amount of the taxes shall be at an appropriate level, and shall be
41 changed as anticipated enrollment grows, to cover the actual cost of the
42 program. The revenue proposal shall include a mechanism for determining
43 the rates of the taxes.

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

52 (ii) Out-of-state residents employed in the state. (A) The payroll
53 tax shall apply to any out-of-state resident who is employed or self-em-
54 ployed in the state. (B) In the case of an out-of-state resident who is
55 employed or self-employed in the state, such individual and individual's
56 employer shall be able to take a credit against the payroll taxes each

1 would otherwise pay as to that individual for amounts they spend respec-
 2 tively on health benefits for the individual that would otherwise be
 3 covered by the program if the individual were a member of the program.
 4 For the employer, the credit shall be available regardless of the form
 5 of the health benefit (e.g., health insurance, a self-insured plan,
 6 direct services, or reimbursement for services), to make sure that the
 7 revenue proposal does not relate to employment benefits in violation of
 8 the federal ERISA. For non-employment-based spending by the individual,
 9 the credit shall be available for and limited to spending for health
 10 coverage (not out-of-pocket health spending). The credit shall be avail-
 11 able without regard to how little is spent or how sparse the benefit.
 12 The credit may only be taken against the payroll tax. Any excess amount
 13 may not be applied to other tax liability. The credit shall be distrib-
 14 uted between the employer and employee in the same proportion as the
 15 spending by each for the benefit and may be applied to their respective
 16 portion of the tax. (C) If any provision of this subparagraph or any
 17 application of it shall be ruled to violate federal ERISA, the provision
 18 or the application of it shall be null and void and the ruling shall not
 19 affect any other provision or application of this section or the act
 20 that enacted it.

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

25 (b) The taxes under this section shall not supplant the spending of
 26 other state revenue to pay for the Medicaid program as it exists as of
 27 the enactment of the revenue proposal as amended, unless the revenue
 28 proposal as amended provides otherwise.

29 4. To the extent that the revenue proposal differs from the terms of
 30 subdivision two or paragraph (b) of subdivision three of this section,
 31 the revenue proposal shall state how it differs from those terms and
 32 reasons for and the effects of the differences.

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

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

37 TITLE III

38 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH

39 NEW YORK HEALTH

40 Section 4920. Definitions.

41 4921. Collective negotiation authorized.

42 4922. Collective negotiation requirements.

43 4923. Requirements for health care providers' representative.

44 4924. Certain collective action prohibited.

45 4925. Fees.

46 4926. Confidentiality.

47 4927. Severability and construction.

48 § 4920. Definitions. For purposes of this title:

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

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

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

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

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

16 § 4921. Collective negotiation authorized. 1. Health care providers
17 may meet and communicate for the purpose of collectively negotiating
18 with New York Health on any matter relating to New York Health, includ-
19 ing but not limited to rates of payment and payment methodologies.

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

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

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

30 § 4922. Collective negotiation requirements. 1. Collective negotiation
31 rights granted by this title must conform to the following requirements:

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

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

37 (c) a health care providers' representative is the only party author-
38 ized to negotiate with New York Health on behalf of the health care
39 providers as a group;

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

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

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

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

52 § 4923. Requirements for health care providers' representative. Before
53 engaging in collective negotiations with New York Health on behalf of
54 health care providers, a health care providers' representative shall
55 file with the commissioner, in the manner prescribed by the commis-
56 sioner, information identifying the representative, the representative's

1 plan of operation, and the representative's procedures to ensure compli-
2 ance with this title.

3 § 4924. Certain collective action prohibited. 1. This title is not
4 intended to authorize competing health care providers to act in concert
5 in response to a health care providers' representative's discussions or
6 negotiations with New York Health except as authorized by other law.

7 2. No health care providers' representative shall negotiate any agree-
8 ment that excludes, limits the participation or reimbursement of, or
9 otherwise limits the scope of services to be provided by any health care
10 provider or group of health care providers with respect to the perform-
11 ance of services that are within the health care provider's lawful scope
12 or terms of practice, license, registration, or certificate.

13 § 4925. Fees. Each person who acts as the representative of negotiat-
14 ing parties under this title shall pay to the department a fee to act as
15 a representative. The commissioner, by regulation, shall set fees in
16 amounts deemed reasonable and necessary to cover the costs incurred by
17 the department in administering this title.

18 § 4926. Confidentiality. All reports and other information required to
19 be reported to the department under this title shall not be subject to
20 disclosure under article six of the public officers law.

21 § 4927. Severability and construction. If any provision or application
22 of this title shall be held to be invalid, or to violate or be incon-
23 sistent with any applicable federal law or regulation, that shall not
24 affect other provisions or applications of this title which can be given
25 effect without that provision or application; and to that end, the
26 provisions and applications of this title are severable. The provisions
27 of this title shall be liberally construed to give effect to the
28 purposes thereof.

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

32 11. "State public health plan" means the medical assistance program
33 established by title eleven of article five of the social services law
34 (referred to in this article as "Medicaid"), the elderly pharmaceutical
35 insurance coverage program established by title three of article two of
36 the elder law (referred to in this article as "EPIC"), and the [~~family~~
37 ~~health plus program established by section three hundred sixty-nine-ee~~
38 ~~of the social services law to the extent that section provides that the~~
39 ~~program shall be subject to this article] New York Health program estab-
40 lished by article fifty-one of this chapter.~~

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

43 § 89-i. New York Health trust fund. 1. There is hereby established in
44 the joint custody of the state comptroller and the commissioner of taxa-
45 tion and finance a special revenue fund to be known as the "New York
46 Health trust fund", referred to in this section as "the fund". The defi-
47 nitions in section fifty-one hundred of the public health law shall
48 apply to this section.

49 2. The fund shall consist of:

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

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

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

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

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

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

19 § 8. Temporary commission on implementation. 1. There is hereby estab-
20 lished a temporary commission on implementation of the New York Health
21 program, referred to in this section as the commission, consisting of
22 fifteen members: five members, including the chair, shall be appointed
23 by the governor; four members shall be appointed by the temporary presi-
24 dent of the senate, one member shall be appointed by the senate minority
25 leader; four members shall be appointed by the speaker of the assembly,
26 and one member shall be appointed by the assembly minority leader. The
27 commissioner of health, the superintendent of financial services, and
28 the commissioner of taxation and finance, or their designees shall serve
29 as non-voting ex-officio members of the commission.

30 2. Members of the commission shall receive such assistance as may be
31 necessary from other state agencies and entities, and shall receive
32 reasonable and necessary expenses incurred in the performance of their
33 duties. The commission may employ staff as needed, prescribe their
34 duties, and fix their compensation within amounts appropriated for the
35 commission.

36 3. The commission shall examine the laws and regulations of the state
37 and make such recommendations as are necessary to conform the laws and
38 regulations of the state and article 51 of the public health law estab-
39 lishing the New York Health program and other provisions of law relating
40 to the New York Health program, and to improve and implement the
41 program. The commission shall report its recommendations to the governor
42 and the legislature. The commission shall immediately begin development
43 of proposals consistent with the principles of article 51 of the public
44 health law for provision of long-term care coverage; health care
45 services covered under the workers' compensation law; and incorporation
46 of retiree health benefits, as described in paragraphs (a), (b) and (c)
47 of subdivision 8 of section 5102 of the public health law. The commis-
48 sion shall provide its work product and assistance to the board estab-
49 lished pursuant to section 5102 of the public health law upon completion
50 of the appointment of the board.

51 § 9. Severability. If any provision or application of this act shall
52 be held to be invalid, or to violate or be inconsistent with any appli-
53 cable federal law or regulation, that shall not affect other provisions
54 or applications of this act which can be given effect without that
55 provision or application; and to that end, the provisions and applica-
56 tions of this act are severable.

1 § 10. This act shall take effect immediately.