

# STATE OF NEW YORK

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4371

2017-2018 Regular Sessions

## IN SENATE

February 10, 2017

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

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

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

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  
14 coverage in recent years, including rising premiums, deductibles and  
15 co-pays, restricted provider networks and high out-of-network charges.  
16 Businesses have also experienced increases in the costs of health care  
17 benefits for their employees, and many employers are shifting a larger  
18 share of the cost of coverage to their employees or dropping coverage  
19 entirely. Health care providers are also affected by inadequate health  
20 coverage in New York state. A large portion of voluntary and public  
21 hospitals, health centers and other providers now experience substantial

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

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

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

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

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

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

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

ARTICLE 51

NEW YORK HEALTH

Section 5100. Definitions.

5101. Program created.

5102. Board of trustees.

5103. Eligibility and enrollment.

5104. Benefits.

5105. Health care providers; care coordination; payment methodologies.

5106. Health care organizations.

5107. Program standards.

5108. Regulations.

5109. Provisions relating to federal health programs.

5110. Additional provisions.

5111. Regional advisory councils.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 § 5102. Board of trustees. 1. The New York Health board of trustees is  
27 hereby created in the department. The board of trustees shall, at the  
28 request of the commissioner, consider any matter to effectuate the  
29 provisions and purposes of this article, and may advise the commissioner  
30 thereon; and it may, from time to time, submit to the commissioner any  
31 recommendations to effectuate the provisions and purposes of this arti-  
32 cle. The commissioner may propose regulations under this article and  
33 amendments thereto for consideration by the board. The board of trustees  
34 shall have no executive, administrative or appointive duties except as  
35 otherwise provided by law. The board of trustees shall have power to  
36 establish, and from time to time, amend regulations to effectuate the  
37 provisions and purposes of this article, subject to approval by the  
38 commissioner.

39 2. The board shall be composed of:

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

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

43 (i) six of whom shall be representatives of health care consumer advoca-  
44 cacy organizations which have a statewide or regional constituency, who  
45 have been involved in activities related to health care consumer advoca-  
46 cy, including issues of interest to low- and moderate-income individ-  
47 uals;

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

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

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

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

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

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

3 (viii) two of whom shall be representatives of health care organiza-  
4 tions;

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

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

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

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

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

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

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

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

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

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

46 (a) The board shall develop a proposal, consistent with the principles  
47 of this article, for provision by the program of long-term care cover-  
48 age, including the development of a proposal, consistent with the prin-  
49 ciples of this article, for its funding. In developing the proposal,  
50 the board shall consult with an advisory committee, appointed by the  
51 chair of the board, including representatives of consumers and potential  
52 consumers of long-term care, providers of long-term care, labor, and  
53 other interested parties. The board shall present its proposal to the  
54 governor and the legislature.

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



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

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

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

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

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

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

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

(a) child health plus;

(b) Medicaid;

(c) Medicare;

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

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

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

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

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

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

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

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

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

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

2. Care coordination.

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

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

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

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

(iii) a health care organization;

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

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

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

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

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



1 applicable laws. Nothing in this subdivision shall authorize any indi-  
2 vidual to engage in any act in violation of title eight of the education  
3 law.

4 (f) The commissioner shall develop and implement procedures and stand-  
5 ards for an individual or entity to be approved to be a care coordinator  
6 in the program, including but not limited to procedures and standards  
7 relating to the revocation, suspension, limitation, or annulment of  
8 approval on a determination that the individual or entity is incompetent  
9 to be a care coordinator or has exhibited a course of conduct which is  
10 either inconsistent with program standards and regulations or which  
11 exhibits an unwillingness to meet such standards and regulations, or is  
12 a potential threat to the public health or safety. Such procedures and  
13 standards shall not limit approval to be a care coordinator in the  
14 program for economic purposes and shall be consistent with good profes-  
15 sional practice. In developing the procedures and standards, the commis-  
16 sioner shall: (i) consider existing standards developed by national  
17 accrediting and professional organizations; and (ii) consult with  
18 national and local organizations working on care coordination or similar  
19 models, including health care practitioners, hospitals, clinics, and  
20 consumers and their representatives. When developing and implementing  
21 standards of approval of care coordinators for individuals receiving  
22 chronic mental health care services, the commissioner shall consult with  
23 the commissioner of mental health. An individual or entity may not be a  
24 care coordinator unless the services included in care coordination are  
25 within the individual's professional scope of practice or the entity's  
26 legal authority.

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

32 3. Health care providers. (a) The commissioner shall establish and  
33 maintain procedures and standards for health care providers to be quali-  
34 fied to participate in the program, including but not limited to proce-  
35 dures and standards relating to the revocation, suspension, limitation,  
36 or annulment of qualification to participate on a determination that the  
37 health care provider is an incompetent provider of specific health care  
38 services or has exhibited a course of conduct which is either inconsis-  
39 tent with program standards and regulations or which exhibits an unwill-  
40 ingness to meet such standards and regulations, or is a potential threat  
41 to the public health or safety. Such procedures and standards shall not  
42 limit health care provider participation in the program for economic  
43 purposes and shall be consistent with good professional practice. Any  
44 health care provider who is qualified to participate under Medicaid,  
45 child health plus or Medicare shall be deemed to be qualified to partic-  
46 ipate in the program, and any health care provider's revocation, suspen-  
47 sion, limitation, or annulment of qualification to participate in any of  
48 those programs shall apply to the health care provider's qualification  
49 to participate in the program; provided that a health care provider  
50 qualified under this sentence shall follow the procedures to become  
51 qualified under the program by the end of the implementation period.

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

1 4. Payment for health care services. (a) The commissioner may estab-  
2 lish by regulation payment methodologies for health care services and  
3 care coordination provided to members under the program by participating  
4 providers, care coordinators, and health care organizations. There may  
5 be a variety of different payment methodologies, including those estab-  
6 lished on a demonstration basis. All payment rates under the program  
7 shall be reasonable and reasonably related to the cost of efficiently  
8 providing the health care service and assuring an adequate and accessi-  
9 ble supply of health care service. Until and unless another payment  
10 methodology is established, health care services provided to members  
11 under the program shall be paid for on a fee-for-service basis, except  
12 for care coordination.

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

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

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

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

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

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

48 § 5106. Health care organizations. 1. A member may choose to enroll  
49 with and receive health care services under the program from a health  
50 care organization.

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

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

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

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

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

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

29 (b) To maintain approval under the program, a health care organization  
30 must: (i) renew its status at a frequency determined by the commission-  
31 er; and (ii) provide data to the department as required by the commis-  
32 sioner to enable the commissioner to evaluate the health care organiza-  
33 tion in relation to quality of health care services, health care  
34 outcomes, and cost.

35 5. The commissioner shall make regulations relating to health care  
36 organizations consistent with and to ensure compliance with this arti-  
37 cle.

38 6. The provision of health care services directly or indirectly by a  
39 health care organization through health care providers shall not be  
40 considered the practice of a profession under title eight of the educa-  
41 tion law by the health care organization.

42 § 5107. Program standards. 1. The commissioner shall establish  
43 requirements and standards for the program and for health care organiza-  
44 tions, care coordinators, and health care providers, consistent with  
45 this article, including requirements and standards for, as applicable:

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

47 (b) relations between health care organizations or health care provid-  
48 ers and members; and

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

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

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

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

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

(c) elimination of health care disparities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



1 under the program, with respect to participating in a health care organ-  
2 ization and dealing with a health care organization; and

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

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

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

19 4. The commissioner shall, directly and through grants to not-for-pro-  
20 fit entities, conduct programs using data collected through the New York  
21 Health program, to promote and protect public, environmental and occupa-  
22 tional health, including cooperation with other data collection and  
23 research programs of the department, consistent with this article and  
24 otherwise applicable law.

25 § 5111. Regional advisory councils. 1. The New York Health regional  
26 advisory councils (each referred to in this article as a "regional advi-  
27 sory council") are hereby created in the department.

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

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

31 (b) New York City;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (ii) representatives of professional organizations representing physi-  
17 cians;

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

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

21 (v) representatives of community health centers;

22 (vi) representatives of health care organizations;

23 (vii) representatives of organized labor; and

24 (viii) representatives of municipal and county government.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

50 4. To the extent that the revenue proposal differs from the terms of  
51 subdivision two of this section, the revenue proposal shall state how it  
52 differs from those terms and reasons for and the effects of the differ-  
53 ences.

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

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

TITLE III  
COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH  
NEW YORK HEALTH

Section 4920. Definitions.

4921. Collective negotiation authorized.

4922. Collective negotiation requirements.

4923. Requirements for health care providers' representative.

4924. Certain collective action prohibited.

4925. Fees.

4926. Confidentiality.

4927. Severability and construction.

§ 4920. Definitions. For purposes of this title:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 § 4923. Requirements for health care providers' representative. Before  
19 engaging in collective negotiations with New York Health on behalf of  
20 health care providers, a health care providers' representative shall  
21 file with the commissioner, in the manner prescribed by the commission-  
22 er, information identifying the representative, the representative's  
23 plan of operation, and the representative's procedures to ensure compli-  
24 ance with this title.

25 § 4924. Certain collective action prohibited. 1. This title is not  
26 intended to authorize competing health care providers to act in concert  
27 in response to a health care providers' representative's discussions or  
28 negotiations with New York Health except as authorized by other law.

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

35 § 4925. Fees. Each person who acts as the representative of negotiat-  
36 ing parties under this title shall pay to the department a fee to act as  
37 a representative. The commissioner, by rule, shall set fees in amounts  
38 deemed reasonable and necessary to cover the costs incurred by the  
39 department in administering this title.

40 § 4926. Confidentiality. All reports and other information required to  
41 be reported to the department under this title shall not be subject to  
42 disclosure under article six of the public officers law or article thir-  
43 ty-one of the civil practice law and rules.

44 § 4927. Severability and construction. If any provision or application  
45 of this title shall be held to be invalid, or to violate or be incon-  
46 sistent with any applicable federal law or regulation, that shall not  
47 affect other provisions or applications of this title which can be given  
48 effect without that provision or application; and to that end, the  
49 provisions and applications of this title are severable. The provisions  
50 of this title shall be liberally construed to give effect to the  
51 purposes thereof.

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

55 11. "State public health plan" means the medical assistance program  
56 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~~] New York Health program established by article fifty-one of this chapter.

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

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

2. The fund shall consist of:

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

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

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

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

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

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

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

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

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

3 3. The commission shall examine the laws and regulations of the state  
4 and make such recommendations as are necessary to conform the laws and  
5 regulations of the state and article 51 of the public health law estab-  
6 lishing the New York Health program and other provisions of law relating  
7 to the New York Health program, and to improve and implement the  
8 program. The commission shall report its recommendations to the governor  
9 and the legislature. The commission shall immediately begin development  
10 of proposals consistent with the principles of this article for  
11 provision of long-term care coverage; health care services covered under  
12 the workers' compensation law; and incorporation of retiree health bene-  
13 fits, as described in paragraphs (a), (b) and (c) of subdivision 8 of  
14 section 5102 of the public health law. The commission shall provide its  
15 work product and assistance to the board established pursuant to section  
16 5102 of the public health law upon completion of the appointment of the  
17 board.

18 § 9. Severability. If any provision or application of this act shall  
19 be held to be invalid, or to violate or be inconsistent with any appli-  
20 cable federal law or regulation, that shall not affect other provisions  
21 or applications of this act which can be given effect without that  
22 provision or application; and to that end, the provisions and applica-  
23 tions of this act are severable.

24 § 10. This act shall take effect immediately.