

STATE OF NEW YORK

4738

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, GJONAJ, HIKIND, HUNTER, HYNDMAN, JAFFEE, JENNE, JOYNER, KAVANAGH, KIM, LAVINE, LIFTON, LUPARDO, MAYER, M. G. MILLER, MOSLEY, MOYA, PAULIN, PEOPLES-STOKES, PERRY, PICHARDO, RAMOS, RICHARDSON, RIVERA, RODRIGUEZ, ROSENTHAL, SEAWRIGHT, SEPULVEDA, SIMOTAS, STECK, STIRPE, THIELE, TITONE, TITUS, WALKER, WEINSTEIN, WEPRIN -- Multi-Sponsored by -- M. of A. ABBATE, ARROYO, AUBRY, CAHILL, DAVILA, FAHY, FARRELL, GLICK, GUNTHER, HOOPER, LENTOL, MAGEE, MAGNARELLI, O'DONNELL, ORTIZ, PRETLOW, QUART, ROZIC, SIMON, SKARTADOS, SOLAGES -- read once and referred 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.

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

LBD09305-01-7

1 Businesses have also experienced increases in the costs of health care
2 benefits for their employees, and many employers are shifting a larger
3 share of the cost of coverage to their employees or dropping coverage
4 entirely. Health care providers are also affected by inadequate health
5 coverage in New York state. A large portion of voluntary and public
6 hospitals, health centers and other providers now experience substantial
7 losses due to the provision of care that is uncompensated. Individuals
8 often find that they are deprived of affordable care and choice because
9 of decisions by health plans guided by the plan's economic needs rather
10 than their health care needs. To address the fiscal crisis facing the
11 health care system and the state and to assure New Yorkers can exercise
12 their right to health care, affordable and comprehensive health coverage
13 must be provided. Pursuant to the state constitution's charge to the
14 legislature to provide for the health of New Yorkers, this legislation
15 is an enactment of state concern for the purpose of establishing a
16 comprehensive universal single-payer health care coverage program and a
17 health care cost control system for the benefit of all residents of the
18 state of New York.

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

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

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

50 4. In order to promote improved quality of, and access to, health care
51 services and promote improved clinical outcomes, it is the policy of the
52 state to encourage cooperative, collaborative and integrative arrange-
53 ments among health care providers who might otherwise be competitors,
54 under the active supervision of the commissioner of health. It is the
55 intent of the state to supplant competition with such arrangements and
56 regulation only to the extent necessary to accomplish the purposes of

1 this act, and to provide state action immunity under the state and
2 federal antitrust laws to health care providers, particularly with
3 respect to their relations with the single-payer New York Health plan
4 created by this act.

5 § 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public
6 health law are renumbered article 80 and sections 8000, 8001, 8002 and
7 8003, respectively, and a new article 51 is added to read as follows:

8 ARTICLE 51
9 NEW YORK HEALTH

10 Section 5100. Definitions.

11 5101. Program created.

12 5102. Board of trustees.

13 5103. Eligibility and enrollment.

14 5104. Benefits.

15 5105. Health care providers; care coordination; payment method-
16 ologies.

17 5106. Health care organizations.

18 5107. Program standards.

19 5108. Regulations.

20 5109. Provisions relating to federal health programs.

21 5110. Additional provisions.

22 5111. Regional advisory councils.

23 § 5100. Definitions. As used in this article, the following terms
24 shall have the following meanings, unless the context clearly requires
25 otherwise:

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

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

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

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

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

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

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

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

51 9. "Medicaid" or "medical assistance" means title eleven of article
52 five of the social services law and the program thereunder. "Child
53 health plus" means title one-A of article twenty-five of this chapter
54 and the program thereunder. "Medicare" means title XVIII of the federal
55 social security act and the programs thereunder. "Basic health program"

1 means section three hundred sixty-nine-gg of the social services law and
2 the program thereunder.

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

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

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

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

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

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

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

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

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

38 § 5101. Program created. 1. The New York Health program is hereby
39 created in the department. The commissioner shall establish and imple-
40 ment the program under this article. The program shall provide compre-
41 hensive health coverage to every resident who enrolls in the program.

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

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

55 4. An insurer authorized to provide coverage pursuant to the insurance
56 law or a health maintenance organization certified under this chapter

1 may, if otherwise authorized, offer benefits that do not cover any
2 service for which coverage is offered to individuals under the program,
3 but may not offer benefits that cover any service for which coverage is
4 offered to individuals under the program. Provided, however, that this
5 subdivision shall not prohibit (a) the offering of any benefits to or
6 for individuals, including their families, who are employed or self-em-
7 ployed in the state but who are not residents of the state, or (b) the
8 offering of benefits during the implementation period to individuals who
9 enrolled or may enroll as members of the program, or (c) the offering of
10 retiree health benefits.

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

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

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

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

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

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

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

44 2. The board shall be composed of:

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

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

48 (i) six of whom shall be representatives of health care consumer advoca-
49 cacy organizations which have a statewide or regional constituency, who
50 have been involved in activities related to health care consumer advoca-
51 cacy, including issues of interest to low- and moderate-income individ-
52 uals;

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

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

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

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

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

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

10 (viii) two of whom shall be representatives of health care organiza-
11 tions;

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

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

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

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

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

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

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

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

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

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

53 (a) The board shall develop a proposal, consistent with the principles
54 of this article, for provision by the program of long-term care cover-
55 age, including the development of a proposal, consistent with the prin-
56 ciples of this article, for its funding. In developing the proposal,

1 the board shall consult with an advisory committee, appointed by the
2 chair of the board, including representatives of consumers and potential
3 consumers of long-term care, providers of long-term care, labor, and
4 other interested parties. The board shall present its proposal to the
5 governor and the legislature.

6 (b) The board shall develop proposals for: (i) incorporating retiree
7 health benefits into New York Health; (ii) accommodating employer reti-
8 ree health benefits for people who have been members of New York Health
9 but live as retirees out of the state; and (iii) accommodating employer
10 retiree health benefits for people who earned or accrued such benefits
11 while residing in the state prior to the implementation of New York
12 Health and live as retirees out of the state.

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

18 § 5103. Eligibility and enrollment. 1. Every resident of the state
19 shall be eligible and entitled to enroll as a member under the program.

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

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

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

29 § 5104. Benefits. 1. The program shall provide comprehensive health
30 coverage to every member, which shall include all health care services
31 required to be covered under any of the following, without regard to
32 whether the member would otherwise be eligible for or covered by the
33 program or source referred to:

34 (a) child health plus;

35 (b) Medicaid;

36 (c) Medicare;

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

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

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

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

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

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

52 3. The program shall provide for payment under the program for emer-
53 gency and temporary health care services provided to members or individ-
54 uals entitled to become members who have not had a reasonable opportu-
55 nity to become a member or to enroll with a care coordinator.

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

7 (b) A member may choose to receive health care services under the
8 program from any participating provider, consistent with provisions of
9 this article relating to care coordination and health care organiza-
10 tions, the willingness or availability of the provider (subject to
11 provisions of this article relating to discrimination), and the appro-
12 priate clinically-relevant circumstances.

13 2. Care coordination.

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

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

24 (i) a health care practitioner who is: (A) the member's primary care
25 practitioner; (B) at the option of a female member, the member's provid-
26 er of primary gynecological care; or (C) at the option of a member who
27 has a chronic condition that requires specialty care, a specialist
28 health care practitioner who regularly and continually provides treat-
29 ment for that condition to the member;

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

38 (iii) a health care organization;

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

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

45 (c) Health care services provided to a member shall not be subject to
46 payment under the program unless the member is enrolled with a care
47 coordinator at the time the health care service is provided, except
48 where provided under subdivision three of section fifty-one hundred four
49 of this article. Every member shall enroll with a care coordinator that
50 agrees to provide care coordination to the member prior to receiving
51 health care services to be paid for under the program. The member shall
52 remain enrolled with that care coordinator until the member becomes
53 enrolled with a different care coordinator or ceases to be a member.
54 Members have the right to change their care coordinator on terms at
55 least as permissive as the provisions of section three hundred sixty-

1 four-j of the social services law relating to an individual changing his
2 or her primary care provider or managed care provider.

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

7 (e) A health care organization may establish rules relating to care
8 coordination for members in the health care organization, different from
9 this subdivision but otherwise consistent with this article and other
10 applicable laws. Nothing in this subdivision shall authorize any indi-
11 vidual to engage in any act in violation of title eight of the education
12 law.

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

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

41 3. Health care providers. (a) The commissioner shall establish and
42 maintain procedures and standards for health care providers to be quali-
43 fied to participate in the program, including but not limited to proce-
44 dures and standards relating to the revocation, suspension, limitation,
45 or annulment of qualification to participate on a determination that the
46 health care provider is an incompetent provider of specific health care
47 services or has exhibited a course of conduct which is either inconsis-
48 tent with program standards and regulations or which exhibits an unwill-
49 ingness to meet such standards and regulations, or is a potential threat
50 to the public health or safety. Such procedures and standards shall not
51 limit health care provider participation in the program for economic
52 purposes and shall be consistent with good professional practice. Any
53 health care provider who is qualified to participate under Medicaid,
54 child health plus or Medicare shall be deemed to be qualified to partici-
55 ipate in the program, and any health care provider's revocation, suspen-
56 sion, limitation, or annulment of qualification to participate in any of

1 those programs shall apply to the health care provider's qualification
2 to participate in the program; provided that a health care provider
3 qualified under this sentence shall follow the procedures to become
4 qualified under the program by the end of the implementation period.

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

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

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

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

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

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

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

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

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

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

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

8 (b) a Taft-Hartley fund (i) with respect to its members and their
9 family members, and (ii) if allowed by applicable law and approved by
10 the commissioner, for other members of the program; provided that the
11 commissioner shall provide by regulation that where a Taft-Hartley fund
12 is acting under this subparagraph there are protections for health care
13 providers and patients comparable to those applicable to accountable
14 care organizations.

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

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

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

44 5. The commissioner shall make regulations relating to health care
45 organizations consistent with and to ensure compliance with this arti-
46 cle.

47 6. The provision of health care services directly or indirectly by a
48 health care organization through health care providers shall not be
49 considered the practice of a profession under title eight of the educa-
50 tion law by the health care organization.

51 § 5107. Program standards. 1. The commissioner shall establish
52 requirements and standards for the program and for health care organiza-
53 tions, care coordinators, and health care providers, consistent with
54 this article, including requirements and standards for, as applicable:

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

1 (b) relations between health care organizations or health care provid-
2 ers and members; and

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

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

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

12 (b) primary and preventive care, care coordination, efficient and
13 effective health care services, quality assurance, coordination and
14 integration of health care services, including use of appropriate tech-
15 nology, and promotion of public, environmental and occupational health;

16 (c) elimination of health care disparities;

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

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

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

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

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

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

52 § 5108. Regulations. The commissioner may approve regulations and
53 amendments thereto, under subdivision one of section fifty-one hundred
54 two of this article. The commissioner may make regulations or amendments
55 thereto to effectuate the provisions and purposes of this article on an
56 emergency basis under section two hundred two of the state administra-

1 tive procedure act, provided that such regulations or amendments shall
2 not become permanent unless adopted under subdivision one of section
3 fifty-one hundred two of this article.

4 § 5109. Provisions relating to federal health programs. 1. The commis-
5 sioner shall seek all federal waivers and other federal approvals and
6 arrangements and submit state plan amendments necessary to operate the
7 program consistent with this article.

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

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

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

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

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

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

53 (e) The commissioner shall by regulation increase the income eligibil-
54 ity level, increase or eliminate the resource test for eligibility,
55 simplify any procedural or documentation requirement for enrollment, and
56 increase the benefits for any federally-matched public health program,

1 and for any program to reduce or eliminate an individual's coinsurance,
2 cost-sharing or premium obligations or increase an individual's eligi-
3 bility for any federal financial support related to Medicare or the
4 affordable care act notwithstanding any law or regulation to the contra-
5 ry. The commissioner may act under this paragraph upon a finding,
6 approved by the director of the budget, that the action (i) will help to
7 increase the number of members who are eligible for and enrolled in
8 federally-matched public health programs, or for any program to reduce
9 or eliminate an individual's coinsurance, cost-sharing or premium obli-
10 gations or increase an individual's eligibility for any federal finan-
11 cial support related to Medicare or the affordable care act; (ii) will
12 not diminish any individual's access to any health care service or right
13 the individual would otherwise have; (iii) is in the interest of the
14 program; and (iv) does not require or has received any necessary federal
15 waivers or approvals to ensure federal financial participation. Actions
16 under this paragraph shall not apply to eligibility for payment for long
17 term care.

18 (f) To enable the commissioner to apply for coverage under any feder-
19 ally-matched public health program or Medicare on behalf of any member
20 and enroll the member in the federally-matched public health program or
21 Medicare if the member is eligible for it, the commissioner may require
22 that every member or applicant to be a member shall provide information
23 to enable the commissioner to determine whether the applicant is eligi-
24 ble for a federally-matched public health program and for Medicare (and
25 any program or benefit under Medicare). The program shall make a reason-
26 able effort to notify members of their obligations under this paragraph.
27 After a reasonable effort has been made to contact the member, the
28 member shall be notified in writing that he or she has sixty days to
29 provide such required information. If such information is not provided
30 within the sixty day period, the member's coverage under the program may
31 be terminated.

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

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

44 (i) If the commissioner has reasonable grounds to believe that a
45 member could be eligible for an income-related subsidy under section
46 1860D-14 of Title XVIII of the federal social security act, the member
47 shall provide, and authorize the program to obtain, any information or
48 documentation required to establish the member's eligibility for such
49 subsidy, provided that the commissioner shall attempt to obtain as much
50 of the information and documentation as possible from records that are
51 available to him or her.

52 (j) The program shall make a reasonable effort to notify members of
53 their obligations under this subdivision. After a reasonable effort has
54 been made to contact the member, the member shall be notified in writing
55 that he or she has sixty days to provide such required information. If

1 such information is not provided within the sixty day period, the
2 member's coverage under the program may be terminated.

3 § 5110. Additional provisions. 1. The commissioner shall contract
4 with not-for-profit organizations to provide:

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

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

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

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

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

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

35 § 5111. Regional advisory councils. 1. The New York Health regional
36 advisory councils (each referred to in this article as a "regional advi-
37 sory council") are hereby created in the department.

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

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

41 (b) New York City;

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

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

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

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

53 3. Each regional advisory council shall be composed of not fewer than
54 twenty-seven members, as determined by the commissioner and the board,
55 as necessary to appropriately represent the diverse needs and concerns
56 of the region. Members of a regional advisory council shall be residents

1 of or have their principal place of business in the region served by the
2 regional advisory council.

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

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

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

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

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

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

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

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

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

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

25 (ii) representatives of professional organizations representing physi-
26 cians;

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

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

30 (v) representatives of community health centers;

31 (vi) representatives of health care organizations;

32 (vii) representatives of organized labor; and

33 (viii) representatives of municipal and county government.

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

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

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

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

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

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

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

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

11 (d) promoting increased public knowledge and responsibility regarding
12 the availability and appropriate utilization of health care services.

13 Each community health improvement plan shall be submitted to the commis-
14 sioner and the board and shall be posted on the department's website.

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

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

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

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

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

1 are employed out-of-state, and non-residents (who are not eligible for
2 the program) who are employed in the state.

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

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

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

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

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

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

5 4. To the extent that the revenue proposal differs from the terms of
6 subdivision two of this section, the revenue proposal shall state how it
7 differs from those terms and reasons for and the effects of the differ-
8 ences.

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

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

13 TITLE III

14 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH
15 NEW YORK HEALTH

16 Section 4920. Definitions.

17 4921. Collective negotiation authorized.

18 4922. Collective negotiation requirements.

19 4923. Requirements for health care providers' representative.

20 4924. Certain collective action prohibited.

21 4925. Fees.

22 4926. Confidentiality.

23 4927. Severability and construction.

24 § 4920. Definitions. For purposes of this title:

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

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

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

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

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

48 § 4921. Collective negotiation authorized. 1. Health care providers
49 may meet and communicate for the purpose of collectively negotiating
50 with New York Health on any matter relating to New York Health, includ-
51 ing but not limited to rates of payment and payment methodologies.

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

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

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

6 § 4922. Collective negotiation requirements. 1. Collective negotiation
7 rights granted by this title must conform to the following requirements:

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

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

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

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

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

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

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

28 § 4923. Requirements for health care providers' representative. Before
29 engaging in collective negotiations with New York Health on behalf of
30 health care providers, a health care providers' representative shall
31 file with the commissioner, in the manner prescribed by the commis-
32 sioner, information identifying the representative, the representative's
33 plan of operation, and the representative's procedures to ensure compli-
34 ance with this title.

35 § 4924. Certain collective action prohibited. 1. This title is not
36 intended to authorize competing health care providers to act in concert
37 in response to a health care providers' representative's discussions or
38 negotiations with New York Health except as authorized by other law.

39 2. No health care providers' representative shall negotiate any agree-
40 ment that excludes, limits the participation or reimbursement of, or
41 otherwise limits the scope of services to be provided by any health care
42 provider or group of health care providers with respect to the perform-
43 ance of services that are within the health care provider's scope of
44 practice, license, registration, or certificate.

45 § 4925. Fees. Each person who acts as the representative of negotiat-
46 ing parties under this title shall pay to the department a fee to act as
47 a representative. The commissioner, by rule, shall set fees in amounts
48 deemed reasonable and necessary to cover the costs incurred by the
49 department in administering this title.

50 § 4926. Confidentiality. All reports and other information required to
51 be reported to the department under this title shall not be subject to
52 disclosure under article six of the public officers law or article thir-
53 ty-one of the civil practice law and rules.

54 § 4927. Severability and construction. If any provision or application
55 of this title shall be held to be invalid, or to violate or be incon-
56 sistent with any applicable federal law or regulation, that shall not

1 affect other provisions or applications of this title which can be given
2 effect without that provision or application; and to that end, the
3 provisions and applications of this title are severable. The provisions
4 of this title shall be liberally construed to give effect to the
5 purposes thereof.

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

9 11. "State public health plan" means the medical assistance program
10 established by title eleven of article five of the social services law
11 (referred to in this article as "Medicaid"), the elderly pharmaceutical
12 insurance coverage program established by title three of article two of
13 the elder law (referred to in this article as "EPIC"), and the [~~family~~
14 ~~health plus program established by section three hundred sixty-nine-ee~~
15 ~~of the social services law to the extent that section provides that the~~
16 ~~program shall be subject to this article] New York Health program estab-
17 lished by article fifty-one of this chapter.~~

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

20 § 89-i. New York Health trust fund. 1. There is hereby established in
21 the joint custody of the state comptroller and the commissioner of taxa-
22 tion and finance a special revenue fund to be known as the "New York
23 Health trust fund", hereinafter known as "the fund". The definitions in
24 section fifty-one hundred of the public health law shall apply to this
25 section.

26 2. The fund shall consist of:

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

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

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

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

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

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

52 § 8. Temporary commission on implementation. 1. There is hereby estab-
53 lished a temporary commission on implementation of the New York Health
54 program, hereinafter to be known as the commission, consisting of
55 fifteen members: five members, including the chair, shall be appointed
56 by the governor; four members shall be appointed by the temporary presi-

1 dent of the senate, one member shall be appointed by the senate minority
2 leader; four members shall be appointed by the speaker of the assembly,
3 and one member shall be appointed by the assembly minority leader. The
4 commissioner of health, the superintendent of financial services, and
5 the commissioner of taxation and finance, or their designees shall serve
6 as non-voting ex-officio members of the commission.

7 2. Members of the commission shall receive such assistance as may be
8 necessary from other state agencies and entities, and shall receive
9 necessary expenses incurred in the performance of their duties. The
10 commission may employ staff as needed, prescribe their duties, and fix
11 their compensation within amounts appropriated for the commission.

12 3. The commission shall examine the laws and regulations of the state
13 and make such recommendations as are necessary to conform the laws and
14 regulations of the state and article 51 of the public health law estab-
15 lishing the New York Health program and other provisions of law relating
16 to the New York Health program, and to improve and implement the
17 program. The commission shall report its recommendations to the governor
18 and the legislature. The commission shall immediately begin development
19 of proposals consistent with the principles of this article for
20 provision of long-term care coverage; health care services covered under
21 the workers' compensation law; and incorporation of retiree health bene-
22 fits, as described in paragraphs (a), (b) and (c) of subdivision 8 of
23 section 5102 of the public health law. The commission shall provide its
24 work product and assistance to the board established pursuant to section
25 5102 of the public health law upon completion of the appointment of the
26 board.

27 § 9. Severability. If any provision or application of this act shall
28 be held to be invalid, or to violate or be inconsistent with any appli-
29 cable federal law or regulation, that shall not affect other provisions
30 or applications of this act which can be given effect without that
31 provision or application; and to that end, the provisions and applica-
32 tions of this act are severable.

33 § 10. This act shall take effect immediately.