

STATE OF NEW YORK

5248--A

2019-2020 Regular Sessions

IN ASSEMBLY

February 8, 2019

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

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

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

1 Section 1. Short title. This act shall be known and may be cited as
2 the "New York health act".
3 § 2. Legislative findings and intent. 1. The state constitution
4 states: "The protection and promotion of the health of the inhabitants
5 of the state are matters of public concern and provision therefor shall
6 be made by the state and by such of its subdivisions and in such manner,
7 and by such means as the legislature shall from time to time determine."
8 (Article XVII, §3.) The legislature finds and declares that all resi-
9 dents of the state have the right to health care. While the federal
10 Affordable Care Act brought many improvements in health care and health

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

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coverage, it still leaves many New Yorkers without coverage or with inadequate coverage. Millions of New Yorkers do not get the health care they need or face financial obstacles and hardships to get it. That is not acceptable. There is no plan other than the New York health act that will enable New York state to meet that need. New Yorkers - as individuals, employers, and taxpayers - have experienced a rise in the cost of health care and coverage in recent years, including rising premiums, deductibles and co-pays, restricted provider networks and high out-of-network charges. Many New Yorkers go without health care because they cannot afford it or suffer financial hardship to get it. Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely. Including long-term services and supports (LTSS) in New York Health is a major step forward for older adults, people with disabilities, and their families. Older adults and people with disabilities often cannot receive the services necessary to stay in the community or other LTSS. Even when older adults and people with disabilities receive LTSS, especially services in the community, it is often at the cost of unreasonable demands on unpaid family caregivers, depleting their own or family resources, or impoverishing themselves to qualify for public coverage. Health care providers are also affected by inadequate health coverage in New York state. A large portion of hospitals, health centers and other providers now experience substantial losses due to the provision of care that is uncompensated. Medicaid and Medicare often do not pay rates that are reasonably related to the cost of efficiently providing health care services and sufficient to assure an adequate and accessible supply of health care services, as guaranteed under the New York Health Act. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic interests rather than the individual's health care needs. To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided. Pursuant to the state constitution's charge to the legislature to provide for the health of New Yorkers, this legislation is an enactment of state concern for the purpose of establishing a comprehensive universal guaranteed health care coverage program and a health care cost control system for the benefit of all residents of the state of New York.

2. (a) It is the intent of the Legislature to create the New York Health program to provide a universal single payer health plan for every New Yorker, funded by broad-based revenue based on ability to pay. The legislature intends that federal waivers and approvals be sought where they will improve the administration of the New York Health program, but the legislature intends that the program be implemented even in the absence of such waivers or approvals. The state shall work to obtain waivers and other approvals relating to Medicaid, Child Health Plus, Medicare, the Affordable Care Act, and any other appropriate federal programs, under which federal funds and other subsidies that would otherwise be paid to New York State, New Yorkers, and health care providers for health coverage that will be equaled or exceeded by New York Health will be paid by the federal government to New York State and deposited in the New York Health trust fund, or paid to health care providers and individuals in combination with New York Health trust fund payments, and for other program modifications (including elimination of cost sharing and insurance premiums). Under such waivers and approvals,

1 health coverage under those programs will, to the maximum extent possi-
2 ble, be replaced and merged into New York Health, which will operate as
3 a true single-payer program.

4 (b) If any necessary waiver or approval is not obtained, the state
5 shall use state plan amendments and seek waivers and approvals to maxi-
6 mize, and make as seamless as possible, the use of federally-matched
7 health programs and federal health programs in New York Health. Thus,
8 even where other programs such as Medicaid or Medicare may contribute to
9 paying for care, it is the goal of this legislation that the coverage
10 will be delivered by New York Health and, as much as possible, the
11 multiple sources of funding will be pooled with other New York Health
12 funds and not be apparent to New York Health members or participating
13 providers.

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

20 (d) The program shall promote the use of clinical data to improve the
21 quality of health care and public health, consistent with protection of
22 patient confidentiality. The program shall maximize patient autonomy in
23 choice of health care providers and health care decision making. Care
24 coordination within the program shall ensure management and coordination
25 among a patient's health care services, consistent with patient autonomy
26 and person-centered service planning, rather than acting as a gatekeeper
27 to needed services.

28 (e) The program shall operate with care, skill, prudence, diligence,
29 and professionalism, and for the best interests primarily of the members
30 and health care providers.

31 3. This act does not create or relate to any employment benefit or
32 employment benefit plan, nor does it require, prohibit, or limit the
33 providing of any employment benefit or employment benefit plan.

34 4. In order to promote improved quality of, and access to, health care
35 services and promote improved clinical outcomes, it is the policy of the
36 state to encourage cooperative, collaborative and integrative arrange-
37 ments among health care providers who might otherwise be competitors,
38 under the active supervision of the commissioner of health. It is the
39 intent of the state to supplant competition with such arrangements and
40 regulation only to the extent necessary to accomplish the purposes of
41 this act, and to provide state action immunity under the state and
42 federal antitrust laws to health care providers, particularly with
43 respect to their relations with the single-payer New York Health plan
44 created by this act.

45 5. There have been numerous professional economic analyses of state
46 and national single-payer health proposals, including the New York
47 Health Act, by noted consulting firms and academic economists. They have
48 almost all come to similar conclusions of net savings in the cost of
49 health coverage and health care. These savings are driven by (a) elimi-
50 nating the administrative bureaucracy costs, marketing, and profit of
51 multiple health plans and replacing that with the dramatically lower
52 costs of running a single-payer system; (b) substantially reducing the
53 administrative costs borne by health care providers dealing with those
54 health plans; and (c) using the negotiating power of 20 million consum-
55 ers to achieve lower drug prices. These savings will more than offset
56 costs primarily from (a) relieving patients of deductibles, co-pays, and

1 out-of-network charges; (b) covering the uninsured; (c) increasing
2 provider payment rates above Medicare and Medicaid rates; and (d)
3 replacing uncompensated home health care with paid care. Unlike premiums
4 and out-of-pocket spending, the New York Health Act tax will be progres-
5 sively graduated based on ability to pay. The vast majority of New
6 Yorkers today spend dramatically more in premiums, deductibles and other
7 out-of-pocket costs than they will in New York Health Act taxes. They
8 will have broader coverage (including long-term care), no restricted
9 provider networks or out-of-network charges, and no deductibles or
10 co-pays.

11 § 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public
12 health law are renumbered article 80 and sections 8000, 8001, 8002 and
13 8003, respectively, and a new article 51 is added to read as follows:

14 ARTICLE 51

15 NEW YORK HEALTH

16 Section 5100. Definitions.

17 5101. Program created.

18 5102. Board of trustees.

19 5103. Eligibility and enrollment.

20 5104. Benefits.

21 5105. Health care providers; care coordination; payment method-
22 ologies.

23 5106. Health care organizations.

24 5107. Program standards.

25 5108. Regulations.

26 5109. Provisions relating to federal health programs.

27 5110. Additional provisions.

28 5111. Regional advisory councils.

29 § 5100. Definitions. As used in this article, the following terms
30 shall have the following meanings, unless the context clearly requires
31 otherwise:

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

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

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

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

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

53 6. "Health care provider" means any individual or entity legally
54 authorized to provide a health care service under Medicaid or Medicare
55 or this article. "Health care professional" means a health care provider
56 that is an individual licensed, certified, registered or otherwise

1 authorized to practice under title eight of the education law to provide
2 such health care service, acting within his or her lawful scope of prac-
3 tice.

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

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

10 9. "Medicaid" or "medical assistance" means title eleven of article
11 five of the social services law and the program thereunder. "Child
12 health plus" means title one-A of article twenty-five of this chapter
13 and the program thereunder. "Medicare" means title XVIII of the federal
14 social security act and the programs thereunder. "Affordable care act"
15 means the federal patient protection and affordable care act, public law
16 111-148, as amended by the health care and education reconciliation act
17 of 2010, public law 111-152, and as otherwise amended and any regu-
18 lations or guidance issued thereunder. "Basic health program" means
19 section three hundred sixty-nine-gg of the social services law and the
20 program thereunder.

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

22 11. "New York Health", "New York Health program", and "program" mean
23 the New York Health program created by section fifty-one hundred one of
24 this article.

25 12. "New York Health trust fund" means the New York Health trust fund
26 established under section eighty-nine-j of the state finance law.

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

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

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

47 16. "Prescription and non-prescription drugs" means prescription drugs
48 as defined in section two hundred seventy of this chapter, and non-pres-
49 cription smoking cessation products or devices.

50 17. "Resident" means an individual whose primary place of abode is in
51 the state or, in the case of an individual whose primary place of abode
52 is not in the state, who is employed or self-employed full-time in the
53 state, without regard to the individual's immigration status, as deter-
54 mined according to regulations of the commissioner. Such regulations
55 shall include a process for appealing denials of residency.

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

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

14 3. The commissioner shall determine when individuals may begin enroll-
15 ing in the program. There shall be an implementation period, which shall
16 begin on the date that individuals may begin enrolling in the program
17 and shall end as determined by the commissioner. Individuals may not
18 enroll in the New York Health program until the legislature has enacted
19 the revenue proposal, as amended, and as the legislature shall further
20 provide.

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

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

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

38 (a) is inconsistent with any provision of this article or the legisla-
39 tive intent of the New York Health Act, this article shall apply and
40 prevail, except where explicitly provided otherwise by this article; or
41 explicitly required by applicable federal law or regulations and

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

45 7. (a) (i) The program shall be deemed to be a health care plan for
46 purposes of external appeal under article forty-nine of this chapter
47 (referred to in this subdivision as "article forty-nine"), subject to
48 this subdivision and any other applicable provision of this article.

49 (ii) An external appeal shall not require utilization review or an
50 adverse determination under title one of article forty-nine of this
51 chapter. Any reference in article forty-nine to utilization review or a
52 universal review agent shall mean the program. Where the program makes
53 an adverse determination, an external appeal shall be automatic unless
54 specifically waived or withdrawn by the member or the member's designee.
55 Services, including services provided for a chronic condition, will
56 continue unchanged until the outcome of the external appeal decision is

1 issued. Where an external appeal is initiated or pursued by the
2 patient's health care provider, the provider shall notify the member or
3 the member's designee, and it shall be subject to the member's or
4 member's designee's right to waive or withdraw the external appeal. No
5 fee shall be required to be paid by any party to an external appeal,
6 including the member's health care provider.

7 (iii) Where an external appeal is denied, the external appeal agent
8 shall notify the member or the member's designee and, where appropriate,
9 the member's health care provider, within two business days of the
10 determination. The notice shall include a statement that the member,
11 member's designee or health care provider has the right to appeal the
12 determination to a fair hearing under this subdivision and seek judicial
13 review.

14 (iv) An enrollee may designate a person or entity, including, but not
15 limited to, the enrollee's family member, care coordinator, a health
16 care organization providing the service under review or appeal, or a
17 labor union or an entity affiliated with and designated by a labor union
18 of which the enrollee or enrollee's family member is a member, to serve
19 as the enrollee's designee for purposes of that article, if the person
20 or entity agrees to be the designee.

21 (b) (i) This paragraph applies where an external appeal is denied in
22 whole or in part; or the program denies coverage for a health care
23 service on any grounds other than under article forty-nine; or the
24 program makes any other determination as to a member or individual seek-
25 ing to become a member, contrary to the interest of the member or indi-
26 vidual (including but not limited to a denial of eligibility for lack of
27 residence).

28 (ii) The program shall notify the member or individual, member's
29 designee or health care provider, as appropriate, that the person has
30 the right to appeal the determination to a fair hearing under this
31 subdivision or seek judicial review.

32 (iii) The commissioner shall establish by regulation a process for
33 fair hearings under this subdivision. The process shall at a minimum
34 conform to the standards for fair hearings under section twenty-two of
35 the social services law.

36 (c) Article seventy-eight of the civil practice law and rules shall
37 apply to any matter under this article.

38 8. (a) No member shall be required to receive any health care service
39 through any entity organized, certified or operating under guidelines
40 under article forty-four of this chapter, or specified under section
41 three hundred sixty-four-j of the social services law, the insurance law
42 or the elder law. No such entity shall receive payment for health care
43 services (other than care coordination) from the program.

44 (b) However, this subdivision shall not preclude the use of a Medicare
45 managed care ("Medicare advantage") entity or other entity created by or
46 under the direction of the program where reasonably necessary to maxi-
47 mize federal financial participation or other federal financial support
48 under any federally-matched public health program, Medicare or the
49 Affordable Care Act. Any entity under this paragraph shall, to the maxi-
50 mum extent feasible, operate in the background, without burden on or
51 interference with the member and health care provider, without depriving
52 the member or health care provider of any right or benefit under the
53 program and otherwise consistent with this article.

54 9. The program shall include provisions for an appropriate reserve
55 fund.

10. (a) This subdivision applies to every person who is a retiree of a public employer, as defined in section two hundred one of the civil service law, and any person who is a beneficiary of the retiree's public employee retiree health benefit. Any reference to the retiree shall mean and include any beneficiary of the retiree. This subdivision does not create or increase any eligibility for any public employee retiree health benefit that would not otherwise exist and does not diminish any public employee retiree health benefit.

(b) This paragraph applies to the retiree while he or she is a resident of New York state. The retiree shall enroll in the program. If, by the implementation date, the retiree has not enrolled in the program, the appropriate public employee retiree health benefit program and the commissioner shall enroll the retiree in the New York Health program. If the retiree's public employee retiree health benefit includes any service for which coverage is not offered under the New York Health program, the retiree shall continue to receive that benefit from the appropriate public employee retiree health benefit program.

(c) For every retiree, while he or she is not a resident of New York state, the appropriate public employee retiree health benefit program shall maintain the retiree's public employee retiree health benefit as if this article had not been enacted.

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

2. The board shall be composed of:

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

(b) twenty-nine trustees appointed by the governor;

(i) six of whom shall be representatives of health care consumer advocacy organizations which have a statewide or regional constituency, who have been involved in issues of interest to low- and moderate-income individuals, older adults, and people with disabilities; at least three of whom shall represent organizations led by consumers in those groups;

(ii) three of whom shall be representatives of professional organizations representing physicians;

(iii) three of whom shall be representatives of professional organizations representing licensed or registered health care professionals other than physicians;

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

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

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

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

1 (viii) two of whom shall be representatives of health care organiza-
2 tions;

3 (ix) three of whom shall be representatives of organized labor;

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

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

9 (c) sixteen trustees appointed by the governor; six of whom to be
10 appointed on the recommendation of the speaker of the assembly; six of
11 whom to be appointed on the recommendation of the temporary president of
12 the senate; two of whom to be appointed on the recommendation of the
13 minority leader of the assembly; and two of whom to be appointed on the
14 recommendation of the minority leader of the senate.

15 3. (a) After the end of the implementation period, no person shall be
16 a trustee unless he or she is a member of the program.

17 (b) Each trustee shall serve at the pleasure of the appointing offi-
18 cer, except the ex officio trustees.

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

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

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

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

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

44 (a) The board shall develop proposals for: (i) incorporating retiree
45 health benefits into New York Health; (ii) accommodating employer reti-
46 ree health benefits for people who have been members of New York Health
47 but live as retirees out of the state; and (iii) accommodating employer
48 retiree health benefits for people who earned or accrued such benefits
49 while residing in the state prior to the implementation of New York
50 Health and live as retirees out of the state. The board shall present
51 its proposals to the governor and the legislature.

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

1 (c) The board shall develop a proposal for New York Health coverage,
2 for members, of health care services covered under paragraph one of
3 subsection (a) of section fifty-one hundred two of the insurance law
4 relating to motor vehicle insurance reparations, including whether and
5 how to continue funding for those services.

6 (d) The board shall develop a proposal for integration of federal
7 veterans health administration programs with New York Health coverage of
8 health care services; provided however that enrollment in or eligibility
9 for federal veterans health administration programs shall not affect a
10 resident's eligibility for New York Health coverage.

11 § 5103. Eligibility and enrollment. 1. Every resident of the state
12 shall be eligible and entitled to enroll as a member under the program.

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

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

18 § 5104. Benefits. 1. The program shall provide comprehensive health
19 coverage to every member, which shall include all health care services
20 required to be covered under any of the following, without regard to
21 whether the member would otherwise be eligible for or covered by the
22 program or source referred to:

23 (a) child health plus;

24 (b) Medicaid, including but not limited to services provided under
25 Medicaid waiver programs, including but not limited to those granted
26 under section 1915 of the federal social security act to persons with
27 traumatic brain injuries or qualifying for nursing home diversion and
28 transition services;

29 (c) Medicare;

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

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

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

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

40 (h) provided that where any state law or regulation related to any
41 federally-matched public health program states that a benefit is contin-
42 gent on federal financial participation, or words to that effect, the
43 benefit shall be included under the New York Health program without
44 regard to federal financial participation.

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

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

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

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

54 § 5105. Health care providers; care coordination; payment methodol-
55 ogies. 1. Choice of health care provider. (a) Any health care provider
56 qualified to participate under this section may provide health care

1 services under the program, provided that the health care provider is
2 otherwise legally authorized to perform the health care service for the
3 individual and under the circumstances involved.

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

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

12 (i) a health care practitioner who is: (A) the member's primary care
13 practitioner; (B) at the option of a female member, the member's provid-
14 er of primary gynecological care; or (C) at the option of a member who
15 has a chronic condition that requires specialty care, a specialist
16 health care practitioner who regularly and continually provides treat-
17 ment for that condition to the member;

18 (ii) an entity licensed under article twenty-eight of this chapter or
19 certified under article thirty-six of this chapter, or, with respect to
20 a member who receives chronic mental health care services, an entity
21 licensed under article thirty-one of the mental hygiene law or other
22 entity approved by the commissioner in consultation with the commission-
23 er of mental health;

24 (iii) a health care organization;

25 (iv) a labor union or an entity affiliated with and designated by a
26 labor union of which the enrollee or enrollee's family member is a
27 member, with respect to its members and their family members; provided
28 that this provision shall not preclude such an entity from becoming a
29 care coordinator under subparagraph (v) of this paragraph or a health
30 care organization under section fifty-one hundred six of this article;
31 or

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

33 (b)(i) Every member shall enroll with a care coordinator that agrees
34 to provide care coordination to the member prior to receiving health
35 care services to be paid for under the program. Health care services
36 provided to a member shall not be subject to payment under the program
37 unless the member is enrolled with a care coordinator at the time the
38 health care service is provided.

39 (ii) This paragraph shall not apply to health care services provided
40 under subdivision three of section fifty-one hundred four of this arti-
41 cle (certain emergency or temporary services).

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

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

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

(e) The commissioner shall develop and implement procedures and standards for an individual or entity to be approved to be a care coordinator in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is not qualified or competent to be a care coordinator or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a care coordinator in the program for criteria other than those under this section and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working on care coordination or similar models, including health care practitioners, hospitals, clinics, and consumers and their representatives. When developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the commissioner shall consult with the commissioner of mental health. An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

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

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

3. Health care providers. (a) The commissioner shall establish and maintain procedures and standards for health care providers to be qualified to participate in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of qualification to participate on a determination that the health care provider is not qualified or competent to be a provider of specific health care services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit health care provider participation in the program for criteria other than those under this section and shall be consistent with good professional practice. Such procedures and standards may be different for different types of health care providers and health care professionals. The commissioner may require that health care providers and health care professionals participate in Medicaid, child health plus, or Medicare to qualify to participate in the program. Any health care provider that is qualified to participate under Medicaid, child health plus or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified under this sentence shall follow the procedures to become qualified under the program by the end of the implementation period.

1 (b) The commissioner shall establish and maintain procedures and stan-
2 dards for recognizing health care providers located out of the state for
3 purposes of providing coverage under the program for out-of-state health
4 care services.

5 (c) Procedures and standards under this subdivision shall include
6 provisions for expedited temporary qualification to participate in the
7 program for health care professionals who are (i) temporarily authorized
8 to practice in the state or (ii) are recently arrived in the state or
9 recently authorized to practice in the state.

10 4. Payment for health care services. (a) (i) The commissioner may
11 establish by regulation payment methodologies for health care services
12 and care coordination provided to members under the program by partic-
13 ipating providers, care coordinators, and health care organizations.
14 There may be a variety of different payment methodologies, including
15 those established on a demonstration basis.

16 (ii) All payment methodologies and rates under the program shall be
17 reasonable and reasonably related to the cost of efficiently providing
18 the health care service and assuring an adequate and accessible supply
19 of the health care service.

20 (iii) In determining such payment methodologies and rates, the commis-
21 sioner shall consider factors including usual and customary rates imme-
22 diately prior to the implementation of the program, reported in a bench-
23 marking database maintained by a nonprofit organization specified by the
24 superintendent of financial services, under section six hundred three of
25 the financial services law; the level of training, education, and expe-
26 rience of the health care provider or providers involved; and the scope
27 of services, complexity, and circumstances of care including geographic
28 factors. Until and unless other applicable payment methodologies are
29 established, health care services provided to members under the program
30 shall be paid for on a fee-for-service basis, except for care coordi-
31 nation.

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

36 (c) (i) Prescription drugs eligible for reimbursement under this arti-
37 cle and dispensed by a pharmacy shall be provided and paid for under the
38 preferred drug program and the clinical drug review program under title
39 one of article two-A of this chapter, except as otherwise provided in
40 this paragraph. As used in this paragraph, "managed care provider"
41 means an entity under paragraph (b) of subdivision eight of section
42 fifty-one hundred one of this article that qualifies under the federal
43 Public Health Services Act (the "340B program").

44 (ii) Where the member is enrolled in a managed care provider and a
45 prescription for the member is made under section 340B of the federal
46 Public Health Service Act (the "340B program") and under a memorandum of
47 understanding relating to the 340B program between the New York Health
48 program and the relevant 340B program covered entity, the managed care
49 provider shall purchase, pay for and provide for the drugs under the
50 340B program. However, the prescription shall be subject to section two
51 hundred seventy-three (preferred drug program prior authorization) and
52 section two hundred seventy-four (clinical drug review program) of this
53 chapter.

54 (iii) The New York Health program shall enter into and maintain a
55 memorandum of understanding relating to the 340B program with each 340B
56 covered entity in the state that agrees to do so.

1 (iv) Where prescription drugs are not dispensed through a pharmacy,
2 payment shall be made as otherwise provided in this article, including
3 use of the 340B program as appropriate.

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

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

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

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

28 5. Prior authorization. The program shall not require prior authori-
29 zation for any health care service in any manner more restrictive of
30 access to or payment for the service than would be required for the
31 service under Medicare Part A or Part B. Prior authorization for
32 prescription drugs provided by pharmacies under the program shall be
33 under title one of article two-A of this chapter.

34 § 5106. Health care organizations. 1. A member may choose to enroll
35 with and receive health care services under the program from a health
36 care organization.

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

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

41 (b) a labor union or an entity affiliated with and designated by a
42 labor union of which the enrollee or enrollee's family member is a
43 member (i) with respect to its members and their family members, and
44 (ii) if allowed by applicable law and approved by the commissioner, for
45 other members of the program.

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

50 4. (a) The commissioner shall develop and implement procedures and
51 standards for an entity to be approved to be a health care organization
52 in the program, including but not limited to procedures and standards
53 relating to the revocation, suspension, limitation, or annulment of
54 approval on a determination that the entity is not competent to be a
55 health care organization or has exhibited a course of conduct which is
56 either inconsistent with program standards and regulations or which

1 exhibits an unwillingness to meet such standards and regulations, or is
2 a potential threat to the public health or safety. Such procedures and
3 standards shall not limit approval to be a health care organization in
4 the program for criteria other than those under this section and shall
5 be consistent with good professional practice. In developing the proce-
6 dures and standards, the commissioner shall: (i) consider existing stan-
7 dards developed by national accrediting and professional organizations;
8 and (ii) consult with national and local organizations working in the
9 field of health care organizations, including health care practitioners,
10 hospitals, clinics, long-term supports and service providers, consumers
11 and their representatives and labor organizations representing health
12 care workers. When developing and implementing standards of approval of
13 health care organizations, the commissioner shall consult with the
14 commissioner of mental health, the commissioner of developmental disa-
15 bilities, the director of the state office for the aging and the commis-
16 sioner of the office of alcoholism and substance abuse services.

17 (b) To maintain approval under the program, a health care organization
18 must: (i) renew its status at a frequency determined by the commis-
19 sioner; and (ii) provide data to the department as required by the commis-
20 sioner to enable the commissioner to evaluate the health care organiza-
21 tion in relation to quality of health care services, health care
22 outcomes, cost, and patient and provider satisfaction.

23 5. The commissioner shall make regulations relating to health care
24 organizations consistent with and to ensure compliance with this arti-
25 cle.

26 6. The provision of health care services directly or indirectly by a
27 health care organization through health care providers shall not be
28 considered the practice of a profession under title eight of the educa-
29 tion law by the health care organization.

30 § 5107. Program standards. 1. The commissioner shall establish
31 requirements and standards for the program and for health care organiza-
32 tions, care coordinators, and health care providers, consistent with
33 this article, including requirements and standards for, as applicable:

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

35 (b) relations between health care organizations or health care provid-
36 ers and members; and

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

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

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

46 (b) primary and preventive care, care coordination, efficient and
47 effective health care services, quality assurance, coordination and
48 integration of health care services, including use of appropriate tech-
49 nology, and promotion of public, environmental and occupational health;

50 (c) elimination of health care disparities;

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

1 (e) accessibility of care coordination, health care organization
2 services and health care services, including accessibility for people
3 with disabilities and people with limited ability to speak or understand
4 English, and the providing of care coordination, health care organiza-
5 tion services and health care services in a culturally competent manner;
6 and

7 (f) especially in relation to long-term supports and services, the
8 maximization and prioritization of the most integrated community-based
9 supports and services.

10 3. Any participating provider or care coordinator that is organized as
11 a for-profit entity (other than a professional practice of one or more
12 health care professionals) shall be required to meet the same require-
13 ments and standards as entities organized as not-for-profit entities,
14 and payments under the program paid to such entities shall not be calcu-
15 lated to accommodate the generation of profit or revenue for dividends
16 or other return on investment or the payment of taxes that would not be
17 paid by a not-for-profit entity.

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

26 5. In developing requirements and standards and making other policy
27 determinations under this article, the commissioner shall consult with
28 representatives of members, health care providers, care coordinators,
29 health care organizations employers, organized labor including repre-
30 sentatives of health care workers, and other interested parties.

31 6. The program shall maintain the security and confidentiality of all
32 data and other information collected under the program when such data
33 would be normally considered confidential patient data. Aggregate data
34 of the program which is derived from confidential data but does not
35 violate patient confidentiality shall be public information including
36 for purposes of article six of the public officers law.

37 § 5108. Regulations. The commissioner shall make regulations under
38 this article by approving regulations and amendments thereto, under
39 subdivision one of section fifty-one hundred two of this article. The
40 commissioner may make regulations or amendments thereto under this arti-
41 cle on an emergency basis under section two hundred two of the state
42 administrative procedure act, provided that such regulations or amend-
43 ments shall not become permanent unless adopted under subdivision one of
44 section fifty-one hundred two of this article.

45 § 5109. Provisions relating to federal health programs. 1. The commis-
46 sioner shall seek all federal waivers and other federal approvals and
47 arrangements and submit state plan amendments necessary to operate the
48 program consistent with this article to the maximum extent possible. No
49 provision of this article and no action under the program shall diminish
50 any right or benefit the member would otherwise have under any federal-
51 ly-matched program or Medicare.

52 2. (a) The commissioner shall apply to the secretary of health and
53 human services or other appropriate federal official for all waivers of
54 requirements, and make other arrangements, under Medicare, any federal-
55 ly-matched public health program, the affordable care act, and any other
56 federal programs that provide federal funds for payment for health care

1 services, that are necessary to enable all New York Health members to
2 receive all benefits under the program through the program to enable the
3 state to implement this article and to receive and deposit all federal
4 payments under those programs (including funds that may be provided in
5 lieu of premium tax credits, cost-sharing subsidies, and small business
6 tax credits) in the state treasury to the credit of the New York Health
7 trust fund and to use those funds for the New York Health program and
8 other provisions under this article. To the extent possible, the commis-
9 sioner shall negotiate arrangements with the federal government in which
10 bulk or lump-sum federal payments are paid to New York Health in place
11 of federal spending or tax benefits for federally-matched health
12 programs or federal health programs. The commissioner shall take
13 actions under paragraph (b) of subdivision eight of section fifty-one
14 hundred one of this article as reasonably necessary.

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

18 3. (a) The commissioner may take actions consistent with this article
19 to enable New York Health to administer Medicare in New York state, to
20 create a Medicare managed care plan ("Medicare Advantage") that would
21 operate consistent with this article, and to be a provider of drug
22 coverage under Medicare part D for eligible members of New York Health.

23 (b) The commissioner may waive or modify the applicability of
24 provisions of this section relating to any federally-matched public
25 health program or Medicare as necessary to implement any waiver or
26 arrangement under this section or to maximize the benefit to the New
27 York Health program under this section, provided that the commissioner,
28 in consultation with the director of the budget, shall determine that
29 such waiver or modification is in the best interests of the members
30 affected by the action and the state, and provided further that no
31 action under this paragraph shall diminish any right or benefit the
32 member would otherwise have under the program or any federally-matched
33 public health program or Medicare.

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

41 (d) The commissioner shall by regulation increase the income eligibil-
42 ity level, increase or eliminate the resource test for eligibility,
43 simplify any procedural or documentation requirement for enrollment, and
44 increase the benefits for any federally-matched public health program,
45 and for any program to reduce or eliminate an individual's coinsurance,
46 cost-sharing or premium obligations or increase an individual's eligi-
47 bility for any federal financial support related to Medicare or the
48 affordable care act notwithstanding any law or regulation to the contra-
49 ry. The commissioner may act under this paragraph upon a finding,
50 approved by the director of the budget, that the action (i) will help to
51 increase the number of members who are eligible for and enrolled in
52 federally-matched public health programs, or for any program to reduce
53 or eliminate an individual's coinsurance, cost-sharing or premium obli-
54 gations or increase an individual's eligibility for any federal finan-
55 cial support related to Medicare or the affordable care act; (ii) will
56 not diminish any individual's access to any health care service, benefit

1 or right the individual would otherwise have; (iii) is in the interest
2 of the program; and (iv) does not require or has received any necessary
3 federal waivers or approvals to ensure federal financial participation.

4 (e) To enable the commissioner to apply for coverage or financial
5 support under any federally-matched public health program, the Afford-
6 able Care Act, or Medicare on behalf of any member and enroll the member
7 in any such program, including an entity under paragraph (b) of subdivi-
8 sion eight of section fifty-one hundred one of this article if the
9 member is eligible for it, the commissioner may require that every
10 member or applicant to be a member shall provide information to enable
11 the commissioner to determine whether the applicant is eligible for such
12 program. The program shall make a reasonable effort to notify members
13 of their obligations under this paragraph. After a reasonable effort has
14 been made to contact the member, the member shall be notified in writing
15 that he or she has sixty days to provide such required information. If
16 such information is not provided within the sixty day period, the
17 member's coverage under the program may be terminated.

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

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

31 (h) If the commissioner has reasonable grounds to believe that a
32 member could be eligible for an income-related subsidy under section
33 1860D-14 of Title XVIII of the federal social security act, the member
34 shall provide, and authorize the program to obtain, any information or
35 documentation required to establish the member's eligibility for such
36 subsidy, provided that the commissioner shall attempt to obtain as much
37 of the information and documentation as possible from records that are
38 available to him or her.

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

45 § 5110. Additional provisions. 1. The commissioner shall contract
46 with not-for-profit organizations to provide:

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

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

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

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

8 3. Retraining and re-employment of impacted employees. (a) As used in
9 this subdivision:

10 (i) "Third party payer" has its ordinary meaning and includes any
11 entity that provides or arranges reimbursement in whole or in part for
12 the purchase of health care services.

13 (ii) "Health care provider administrative employee" means an employee
14 of a health care provider primarily engaged in relations or dealings
15 with third party payers or seeking payment or reimbursement for health
16 care services from third party payers.

17 (iii) "Impacted employee" means an individual who, at any time from
18 the date this section becomes a law until two years after the end of the
19 implementation period, is employed by a third party payer or is a health
20 care provider administrative employee, and whose employment ends or is
21 reasonably anticipated to end as a result of the implementation of the
22 New York Health program.

23 (b) Within ninety days after this section shall become a law, the
24 commissioner of labor shall convene a retraining and re-employment task
25 force including but not limited to: representatives of potential
26 impacted employees, human resource departments of third party payers and
27 health care providers, individuals with experience and expertise in
28 retraining and re-employment programs relevant to the circumstances of
29 impacted employees, and representatives of the commissioner of labor.
30 The commissioner of labor and the task force shall review and provide:

31 (i) analysis of potential impacted employees by job title and
32 geography;

33 (ii) competency mapping and labor market analysis of impacted employee
34 occupations with job openings; and

35 (iii) establishment of regional retraining and re-employment systems,
36 including but not limited to job boards, outplacement services, job
37 search services, career advisement services, and retraining advisement,
38 to be coordinated with the regional advisory councils established under
39 section fifty-one hundred eleven of this article.

40 (c) (i) Three or more impacted employees, a recognized union of work-
41 ers including impacted employees, or an employer of impacted employees
42 may file a petition with the commissioner of labor to certify such
43 employees as being impacted employees.

44 (ii) Impacted employees shall be eligible for:

45 (A) up to two years of retraining at any training provider approved by
46 the commissioner of labor; and

47 (B) up to two years of unemployment benefits, provided that the
48 impacted employee is enrolled in a department of labor approved training
49 program, is actively seeking employment, and is not currently employed
50 full time; provided, however, that such impacted employee may maintain
51 unemployment benefits for up to two years even if he or she does not
52 meet the criteria set forth in this clause but is sixty-three years of
53 age or older at the time of loss of employment as an impacted employee.

54 (d) The commissioner shall provide funds from the New York Health
55 trust fund or otherwise appropriated for this purpose to the commission-

er of labor for retraining and re-employment programs for impacted employees under this subdivision.

(e) The commissioner of labor shall make regulations and take other actions reasonably necessary to implement this subdivision. This subdivision shall be implemented consistent with applicable law and regulations.

4. The commissioner shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the New York Health program, to promote and protect the quality of health care services, patient outcomes, and public, environmental and occupational health, including cooperation with other data collection and research programs of the department, consistent with this article, the protection of the security and confidentiality of individually identifiable patient information, and otherwise applicable law.

5. Settlements and judgments. This subdivision applies where any settlement, judgment or order in the course of litigation, or any contract or agreement made as an alternative to litigation, provides that one party shall pay for health care coverage for another party who is entitled to enroll in the program. Any party to the settlement, judgment, order, contract or agreement may apply to an appropriate court for modification of the judgment, order, contract or agreement. The modification may provide that the paying party, instead of paying for health care coverage, shall pay all or part of the New York Health tax that is owed by the other party, and may include other or further provisions. The modifications shall be appropriate, consistent with the program, and in the interest of justice. As used in this subdivision, "New York Health tax" means the tax or taxes enacted by the legislature as part of the revenue proposal, as amended, to fund the program.

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

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

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

(b) New York City;

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

(d) Northern, consisting of Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Warren, Washington counties;

(e) Central, consisting of Broome, Cayuga, Chemung, Chenango, Cortland, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates counties; and

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

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

4. Appointment of members of the regional advisory councils.

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

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

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

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

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

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

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

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

14 (i) representatives of organizations with a regional constituency that
15 advocate for health care consumers, older adults, and people with disa-
16 bilities including organizations led by members of those groups, who
17 shall constitute at least one third of the membership of each regional
18 council;

19 (ii) representatives of professional organizations representing physi-
20 cians;

21 (iii) representatives of professional organizations representing
22 health care professionals other than physicians;

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

24 (v) representatives of community health centers;

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

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

29 (viii) representatives of health care organizations;

30 (ix) representatives of organized labor including representatives of
31 health care workers;

32 (x) representatives of employers; and

33 (xi) 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 a member of a regional advisory council for more than
40 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 supports
9 and services;

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

11 (c) identifying gaps in regional health care services;

12 (d) promoting increased public knowledge and responsibility regarding
13 the availability and appropriate utilization of health care services.
14 Each community health improvement plan shall be submitted to the commis-
15 sioner and the board and shall be posted on the department's website;

16 (e) identifying needs in professional and service personnel required
17 to deliver health care services; and

18 (f) coordinating regional implementation of retraining and re-employ-
19 ment programs for impacted employees under subdivision three of section
20 fifty-one hundred ten of this article.

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

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

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

31 § 4. Financing of New York Health. 1. (a) As used in this section,
32 unless the context clearly requires otherwise:

33 (i) "New York Health program" and the "program" mean the New York
34 Health program, as created by article 51 of the public health law and
35 all provisions of that article.

36 (ii) "Revenue proposal" means the revenue plan and legislative bills,
37 as proposed and enacted under this section, to provide the revenue
38 necessary to finance the New York Health program.

39 (iii) "Tax" means the payroll tax or non-payroll tax to be enacted
40 under the revenue proposal. "Payroll tax" means the tax on payroll
41 income and self-employed income subject to the Medicare Part A tax,
42 provided for in subdivision two of this section. "Non-payroll tax" means
43 the tax on taxable income (such as interest, dividends, and capital
44 gains) not subject to the payroll tax, provided for in subdivision two
45 of this section.

46 (b) The governor shall submit to the legislature a revenue proposal.
47 The revenue proposal shall be submitted to the legislature as part of
48 the executive budget under article VII of the state constitution, for
49 the fiscal year commencing on the first day of April in the calendar
50 year after this act shall become a law. In developing the revenue
51 proposal, the governor shall consult with appropriate officials of the
52 executive branch; the temporary president of the senate; the speaker of
53 the assembly; the chairs of the fiscal and health committees of the
54 senate and assembly; and representatives of business, labor, consumers
55 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 taxes. First, there shall be a progressively graduated tax on all payroll and self-employed income, paid by employers, employees and self-employed individuals. Second, there shall be a progressively graduated tax on taxable income (such as interest, dividends, and capital gains) not subject to the payroll tax. Income in the bracket below twenty-five thousand dollars per year shall be exempt from the taxes; provided that for individuals enrolled in Medicare as defined in the program, income in the bracket below fifty thousand dollars per year shall be exempt from the taxes. Higher brackets of income subject to the taxes shall be assessed at a higher marginal rate than lower brackets. The taxes shall be set at levels anticipated to produce sufficient revenue to finance the program, 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 employed out-of-state, and non-residents who are employed in the state (including those employed less than full-time).

(b) Payroll tax. The income to be subject to the payroll tax shall be all income subject to the Medicare Part A tax. The payroll tax 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 payroll tax and the employee shall pay twenty percent of the tax, except that an employer may agree to pay all or part of the employee's share. A self-employed individual shall pay the full tax.

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

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

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

(ii) Out-of-state residents employed in the state. The payroll tax shall apply to any out-of-state resident who is employed or self-employed in the state. Such individual and individual's employer shall be able to take a credit against the payroll taxes each would otherwise pay as to that individual for amounts they spend respectively on health benefits (A) for the individual, if the individual is not eligible to be a member of the program, and (B) for any member of the individual's immediate family. For the employer, the credit shall be available regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to make sure that the revenue proposal does not relate to employment benefits in violation of any federal law. For non-employment-based spending

1 by the individual, the credit shall be available for and limited to
2 spending for health coverage (not out-of-pocket health spending). The
3 credit shall be available without regard to how little is spent or how
4 sparse the benefit. The credit may only be taken against the payroll
5 tax. Any excess amount may not be applied to other tax liability. The
6 credit shall be distributed between the employer and employee in the
7 same proportion as the spending by each for the benefit and may be
8 applied to their respective portion of the tax. If any provision of this
9 subparagraph or any application of it shall be ruled to violate federal
10 law, the provision or the application of it shall be null and void and
11 the ruling shall not affect any other provision or application of this
12 section or the act that enacted it.

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

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

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

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

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

29 TITLE III

30 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH
31 NEW YORK HEALTH

32 Section 4920. Definitions.

33 4921. Collective negotiation authorized.

34 4922. Collective negotiation requirements.

35 4923. Requirements for health care providers' representative.

36 4924. Mediation.

37 4925. Certain collective action prohibited.

38 4926. Fees.

39 4927. Confidentiality.

40 4928. Severability and construction.

41 § 4920. Definitions. For purposes of this title:

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

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

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

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

53 5. "Health care provider" means a health care provider under article
54 fifty-one of this chapter. A health care professional as defined in
55 article fifty-one of this chapter who practices as an employee or inde-

pendent contractor of another 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;

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

(c) a health care providers' representative is the only party authorized to negotiate with New York Health on behalf of the health care providers as a group;

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

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

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

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

§ 4923. Requirements for health care providers' representative. Before engaging in collective negotiations with New York Health on behalf of health care providers, a health care providers' representative shall file with the commissioner, in the manner prescribed by the commissioner, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this title.

§ 4924. Mediation. 1. In the event the commissioner determines that an impasse exists in the negotiations, the commissioner shall render assistance as follows:

(a) to assist the parties to effect a voluntary resolution of the negotiations, the commissioner shall appoint a mediator who is mutually acceptable to both the health care providers' representative and the representative of New York Health. If the mediator is successful in resolving the impasse, then the health care providers' representative shall proceed as set forth in this article;

(b) if an impasse continues, the commissioner shall appoint a fact-finding board of not more than three members, who are mutually accepta-

1 ble to both the health care providers' representative and the represen-
2 tative of New York Health. The fact-finding board shall have, in
3 addition to the powers delegated to it by the board, the power to make
4 recommendations for the resolution of the dispute;

5 (c) the fact-finding board, acting by a majority of its members, shall
6 transmit its findings of fact and recommendations for resolution of the
7 dispute to the commissioner, and may thereafter assist the parties to
8 effect a voluntary resolution of the dispute. The fact-finding board
9 shall also share its findings of fact and recommendations with the
10 health care providers' representative and the representative of New York
11 Health. If within twenty days after the submission of the findings of
12 fact and recommendations, the impasse continues, the commissioner shall
13 order a resolution to the negotiations based upon the findings of fact
14 and recommendations submitted by the fact-finding board.

15 § 4925. Certain collective action prohibited. 1. This title is not
16 intended to authorize competing health care providers to act in concert
17 in response to a health care providers' representative's discussions or
18 negotiations with New York Health except as authorized by other law.

19 2. No health care providers' representative shall negotiate any agree-
20 ment that excludes, limits the participation or reimbursement of, or
21 otherwise limits the scope of services to be provided by any health care
22 provider or group of health care providers with respect to the perform-
23 ance of services that are within the health care provider's lawful scope
24 or terms of practice, license, registration, or certificate.

25 § 4926. Fees. Each person who acts as the representative of negotiat-
26 ing parties under this title shall pay to the department a fee to act as
27 a representative. The commissioner, by regulation, shall set fees in
28 amounts deemed reasonable and necessary to cover the costs incurred by
29 the department in administering this title.

30 § 4927. Confidentiality. All reports and other information required to
31 be reported to the department under this title shall not be subject to
32 disclosure under article six of the public officers law.

33 § 4928. Severability and construction. If any provision or application
34 of this title shall be held to be invalid, or to violate or be incon-
35 sistent with any applicable federal law or regulation, that shall not
36 affect other provisions or applications of this title which can be given
37 effect without that provision or application; and to that end, the
38 provisions and applications of this title are severable. The provisions
39 of this title shall be liberally construed to give effect to the
40 purposes thereof.

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

44 11. "State public health plan" means the medical assistance program
45 established by title eleven of article five of the social services law
46 (referred to in this article as "Medicaid"), the elderly pharmaceutical
47 insurance coverage program established by title three of article two of
48 the elder law (referred to in this article as "EPIC"), and the [~~family~~
49 ~~health plus program established by section three hundred sixty-nine-ee~~
50 ~~of the social services law to the extent that section provides that the~~
51 ~~program shall be subject to this article] New York Health program estab-~~
52 ~~lished by article fifty-one of this chapter.~~

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

55 § 89-j. New York Health trust fund. 1. There is hereby established in
56 the joint custody of the state comptroller and the commissioner of taxa-

tion and finance a special revenue fund to be known as the "New York Health trust fund", referred to in this section 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 taxes 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 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, referred to in this section 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 reasonable and necessary expenses incurred in the performance of their duties. The commission may employ staff as needed, prescribe their duties, and fix their compensation within amounts appropriated for the commission.

3. The commission shall examine the laws and regulations of the state and consult with health care providers, consumers, and other stakeholders and make such recommendations as are necessary to conform the laws and regulations of the state and article 51 of the public health law establishing the New York Health program and other provisions of law relating to the New York Health program, and to improve and implement the program. The commission shall report its recommendations to the governor and the legislature. The commission shall immediately begin development of proposals consistent with the principles of article 51 of

1 the public health law for provision of health care services covered
2 under the workers' compensation law; and incorporation of retiree health
3 benefits, as described in paragraphs (a), (b) and (c) of subdivision 8
4 of section 5102 of the public health law. The commission shall provide
5 its work product and assistance to the board established pursuant to
6 section 5102 of the public health law upon completion of the appointment
7 of the board.

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

14 § 10. This act shall take effect immediately.