STATE OF NEW YORK

3577--A

2019-2020 Regular Sessions

IN SENATE

February 11, 2019

Introduced by Sens. RIVERA, RAMOS, ADDABBO, BAILEY, BENJAMIN, BIAGGI, BRESLIN, CARLUCCI, COMRIE, GIANARIS, GOUNARDES, HARCKHAM, HOYLMAN, JACKSON, KAVANAGH, KENNEDY, KRUEGER, LIU, MAY, MAYER, METZGER, MONTGOMERY, MYRIE, PARKER, PERSAUD, SALAZAR, SANDERS, SEPULVEDA, SERRANO, STAVISKY, THOMAS -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- recommitted to the Committee on Health in accordance with Senate Rule 6, sec. 8 -- 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:

Section 1. Short title. This act shall be known and may be cited as the "New York health act".

§ 2. Legislative findings and intent. 1. The state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." (Article XVII, §3.) The legislature finds and declares that all residents of the state have the right to health care. While the federal Affordable Care Act brought many improvements in health care and health 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

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

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

(b) If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus,

even where other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers.

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

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

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

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

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

5. There have been numerous professional economic analyses of state and national single-payer health proposals, including the New York Health Act, by noted consulting firms and academic economists. They have almost all come to similar conclusions of net savings in the cost of health coverage and health care. These savings are driven by (a) eliminating the administrative bureaucracy costs, marketing, and profit of multiple health plans and replacing that with the dramatically lower costs of running a single-payer system; (b) substantially reducing the administrative costs borne by health care providers dealing with those health plans; and (c) using the negotiating power of 20 million consumers to achieve lower drug prices. These savings will more than offset costs primarily from (a) relieving patients of deductibles, co-pays, and out-of-network charges; (b) covering the uninsured; (c) increasing provider payment rates above Medicare and Medicaid rates; and (d) replacing uncompensated home health care with paid care. Unlike premiums and out-of-pocket spending, the New York Health Act tax will be progressively graduated based on ability to pay. The vast majority of New Yorkers today spend dramatically more in premiums, deductibles and other out-of-pocket costs than they will in New York Health Act taxes. They

will have broader coverage (including long-term care), no restricted provider networks or out-of-network charges, and no deductibles or co-pays.

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

ARTICLE 51

NEW YORK HEALTH

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

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

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

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

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

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

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

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

8. "Implementation period" means the period under subdivision three of section fifty-one hundred one of this article during which the program

will be subject to special eligibility and financing provisions until it is fully implemented under that section.

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

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

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

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

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

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

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

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

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

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

2. The commissioner shall, to the maximum extent possible, organize, administer and market the program and services as a single program under the name "New York Health" or such other name as the commissioner shall determine, regardless of under which law or source the definition of a

benefit is found including (on a voluntary basis) retiree health benefits. In implementing this article, the commissioner shall avoid jeopardizing federal financial participation in these programs and shall take care to promote public understanding and awareness of available benefits and programs.

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

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

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

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

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

(b) is consistent with the provisions of this article and the legislative intent of the New York Health Act, the provision of that law shall apply.

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

(ii) An external appeal shall not require utilization review or an adverse determination under title one of article forty-nine of this chapter. Any reference in article forty-nine to utilization review or a universal review agent shall mean the program. Where the program makes an adverse determination, an external appeal shall be automatic unless specifically waived or withdrawn by the member or the member's designee. Services, including services provided for a chronic condition, will continue unchanged until the outcome of the external appeal decision is issued. Where an external appeal is initiated or pursued by the patient's health care provider, the provider shall notify the member or the member's designee, and it shall be subject to the member's or member's designee's right to waive or withdraw the external appeal. No fee shall be required to be paid by any party to an external appeal, including the member's health care provider.

(iii) Where an external appeal is denied, the external appeal agent shall notify the member or the member's designee and, where appropriate,

the member's health care provider, within two business days of the determination. The notice shall include a statement that the member, member's designee or health care provider has the right to appeal the determination to a fair hearing under this subdivision and seek judicial review.

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

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

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

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

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

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

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

9. The program shall include provisions for an appropriate reserve 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;

(viii) two of whom shall be representatives of health care organizations;

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

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

(xi) two of whom shall be employers or representatives of employers who pay the payroll tax under this article, or, prior to the tax becoming effective, will pay the tax; and

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

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

(b) Each trustee shall serve at the pleasure of the appointing officer, except the ex officio trustees.

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

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

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

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

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

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

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

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

(d) The board shall develop a proposal for integration of federal veterans health administration programs with New York Health coverage of health care services; provided however that enrollment in or eligibility

for federal veterans health administration programs shall not affect a resident's eligibility for New York Health coverage.

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

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

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

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

(a) child health plus;

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

(c) Medicare;

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

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

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

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

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

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

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

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

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

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

(b) A member may choose to receive health care services under the program from any participating provider, consistent with provisions of this article relating to care coordination and health care organizations, the willingness or availability of the provider (subject to

provisions of this article relating to discrimination), and the appropriate clinically-relevant circumstances.

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

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

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

(iii) a health care organization;

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

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

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

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

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

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

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

lations 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.

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

(c) Procedures and standards under this subdivision shall include provisions for expedited temporary qualification to participate in the program for health care professionals who are (i) temporarily authorized

to practice in the state or (ii) are recently arrived in the state or recently authorized to practice in the state.

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

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

(iii) In determining such payment methodologies and rates, the commissioner shall consider factors including usual and customary rates immediately prior to the implementation of the program, reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of financial services, under section six hundred three of the financial services law; the level of training, education, and experience of the health care provider or providers involved; and the scope of services, complexity, and circumstances of care including geographic factors. Until and unless other applicable payment methodologies are established, health care services provided to members under the program shall be paid for on a fee-for-service basis, except for care coordination.

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

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

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

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

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

(d) Payment for health care services established under this article shall be considered payment in full. A participating provider shall not charge any rate in excess of the payment established under this article for any health care service provided under the program and shall not

solicit or accept payment from any member or third party for any such service except as provided under section fifty-one hundred nine of this article. However, this paragraph shall not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer where permitted under section fifty-one hundred nine of this article.

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

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

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

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

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

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

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

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

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

4. (a) The commissioner shall develop and implement procedures and standards for an entity to be approved to be a health care organization 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 entity is not competent to be a health care organization 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 health care organization 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 in the field of health care organizations, including health care practitioners, hospitals, clinics, long-term supports and service providers, consumers and their representatives and labor organizations representing health care workers. When developing and implementing standards of approval of health care organizations, the commissioner shall consult with the commissioner of mental health, the commissioner of developmental disabilities, the director of the state office for the aging and the commissioner of the office of alcoholism and substance abuse services.

(b) To maintain approval under the program, a health care organization 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 health care organization in relation to quality of health care services, health care outcomes, cost, and patient and provider satisfaction.

5. The commissioner shall make regulations relating to health care organizations consistent with and to ensure compliance with this article.

6. The provision of health care services directly or indirectly by a health care organization through health care providers shall not be considered the practice of a profession under title eight of the education law by the health care organization.

§ 5107. Program standards. 1. The commissioner shall establish requirements and standards for the program and for health care organizations, care coordinators, and health care providers, consistent with this article, including requirements and standards for, as applicable:

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

(b) relations between health care organizations or health care providers and members; and

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

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

(a) simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable;

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

(c) elimination of health care disparities;

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

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

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

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

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

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

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

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

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

2. (a) The commissioner shall apply to the secretary of health and human services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally-matched public health program, the affordable care act, and any other federal programs that provide federal funds for payment for health care services, that are necessary to enable all New York Health members to receive all benefits under the program through the program to enable the state to implement this article and to receive and deposit all federal payments under those programs (including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits) in the state treasury to the credit of the New York Health

trust fund and to use those funds for the New York Health program and other provisions under this article. To the extent possible, the commissioner shall negotiate arrangements with the federal government in which bulk or lump-sum federal payments are paid to New York Health in place of federal spending or tax benefits for federally-matched health programs or federal health programs. The commissioner shall take actions under paragraph (b) of subdivision eight of section fifty-one hundred one of this article as reasonably necessary.

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

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

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

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

(d) The commissioner shall by regulation increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally-matched public health program, and for any program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the affordable care act notwithstanding any law or regulation to the contrary. The commissioner may act under this paragraph upon a finding, approved by the director of the budget, that the action (i) will help to increase the number of members who are eligible for and enrolled in federally-matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the affordable care act; (ii) will not diminish any individual's access to any health care service, benefit or right the individual would otherwise have; (iii) is in the interest of the program; and (iv) does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(e) To enable the commissioner to apply for coverage or financial support under any federally-matched public health program, the Affordable Care Act, or Medicare on behalf of any member and enroll the member

in any such program, including an entity under paragraph (b) of subdivision eight of section fifty-one hundred one of this article if the member is eligible for it, the commissioner may require that every member or applicant to be a member shall provide information to enable the commissioner to determine whether the applicant is eligible for such program. The program shall make a reasonable effort to notify members of their obligations under this paragraph. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the member's coverage under the program may be terminated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) (i) Three or more impacted employees, a recognized union of workers including impacted employees, or an employer of impacted employees may file a petition with the commissioner of labor to certify such employees as being impacted employees.

(ii) Impacted employees shall be eligible for:

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

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

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

(ii) six members shall be appointed by the governor on the recommendation of the speaker of the assembly;

(iii) six members shall be appointed by the governor on the recommendation of the temporary president of the senate;

(iv) three members shall be appointed by the governor on the recommendation of the minority leader of the assembly; and

(v) three members shall be appointed by the governor on the recommendation of the minority leader of the senate.

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

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

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

(ii) representatives of professional organizations representing physicians;

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

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

(v) representatives of community health centers;

(vi) representatives of mental health, behavioral health (including substance use), physical disability, developmental disability, rehabilitation, home care and other service providers;

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

(viii) representatives of health care organizations;

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

(x) representatives of employers; and

(xi) representatives of municipal and county government.

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

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

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

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

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

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

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

(c) identifying gaps in regional health care services;

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

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

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

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

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

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

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

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

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

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

(b) The governor shall submit to the legislature a revenue proposal. The revenue proposal shall be submitted to the legislature as part of the executive budget under article VII of the state constitution, for the fiscal year commencing on the first day of April in the calendar year after this act shall become a law. In developing the revenue proposal, the governor shall consult with appropriate officials of the executive branch; the temporary president of the senate; the speaker of the assembly; the chairs of the fiscal and health committees of the senate and assembly; and representatives of business, labor, consumers and local government.

2. (a) Basic structure. The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two 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 by the individual, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll tax. Any excess amount may not be applied to other tax liability. The credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit and may be applied to their respective portion of the tax. If any provision of this subparagraph or any application of it shall be ruled to violate federal law, the provision or the application of it shall be null and void and

the ruling shall not affect any other provision or application of this section or the act that enacted it.

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

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

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

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

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

TITLE III

COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH NEW YORK HEALTH

§ 4920. Definitions. For purposes of this title:

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

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

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

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

5. "Health care provider" means a health care provider under article fifty-one of this chapter. A health care professional as defined in article fifty-one of this chapter who practices as an employee or independent 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 acceptable to both the health care providers' representative and the representative of New York Health. The fact-finding board shall have, in addition to the powers delegated to it by the board, the power to make recommendations for the resolution of the dispute;

(c) the fact-finding board, acting by a majority of its members, shall transmit its findings of fact and recommendations for resolution of the dispute to the commissioner, and may thereafter assist the parties to effect a voluntary resolution of the dispute. The fact-finding board shall also share its findings of fact and recommendations with the health care providers' representative and the representative of New York Health. If within twenty days after the submission of the findings of

fact and recommendations, the impasse continues, the commissioner shall order a resolution to the negotiations based upon the findings of fact and recommendations submitted by the fact-finding board.

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

2. No health care providers' representative shall negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's lawful scope or terms of practice, license, registration, or certificate.

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

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

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

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

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

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

§ 89-j. New York Health trust fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "New York Health trust fund", 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 the public health law for provision of health care services covered under the workers' compensation law; and incorporation of retiree health benefits, as described in paragraphs (a), (b) and (c) of subdivision 8 of section 5102 of the public health law. The commission shall provide its work product and assistance to the board established pursuant to section 5102 of the public health law upon completion of the appointment of the board.

§ 9. Severability. If any provision or application of this act shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions

or applications of this act which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 10. This act shall take effect immediately.