

# STATE OF NEW YORK

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3577--A

2019-2020 Regular Sessions

## IN SENATE

February 11, 2019

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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:

1 Section 1. Short title. This act shall be known and may be cited as  
2 the "New York health act".  
3 § 2. Legislative findings and intent. 1. The state constitution  
4 states: "The protection and promotion of the health of the inhabitants  
5 of the state are matters of public concern and provision therefor shall  
6 be made by the state and by such of its subdivisions and in such manner,  
7 and by such means as the legislature shall from time to time determine."  
8 (Article XVII, §3.) The legislature finds and declares that all resi-  
9 dents of the state have the right to health care. While the federal  
10 Affordable Care Act brought many improvements in health care and health  
11 coverage, it still leaves many New Yorkers without coverage or with  
12 inadequate coverage. Millions of New Yorkers do not get the health care  
13 they need or face financial obstacles and hardships to get it. That is  
14 not acceptable. There is no plan other than the New York health act  
15 that will enable New York state to meet that need. New Yorkers - as  
16 individuals, employers, and taxpayers - have experienced a rise in the  
17 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.

LBD09777-07-0

1 premiums, deductibles and co-pays, restricted provider networks and high  
2 out-of-network charges. Many New Yorkers go without health care because  
3 they cannot afford it or suffer financial hardship to get it. Busi-  
4 nesses have also experienced increases in the costs of health care bene-  
5 fits for their employees, and many employers are shifting a larger share  
6 of the cost of coverage to their employees or dropping coverage entire-  
7 ly. Including long-term services and supports (LTSS) in New York Health  
8 is a major step forward for older adults, people with disabilities, and  
9 their families. Older adults and people with disabilities often cannot  
10 receive the services necessary to stay in the community or other LTSS.  
11 Even when older adults and people with disabilities receive LTSS, espe-  
12 cially services in the community, it is often at the cost of unreason-  
13 able demands on unpaid family caregivers, depleting their own or family  
14 resources, or impoverishing themselves to qualify for public coverage.  
15 Health care providers are also affected by inadequate health coverage in  
16 New York state. A large portion of hospitals, health centers and other  
17 providers now experience substantial losses due to the provision of care  
18 that is uncompensated. Medicaid and Medicare often do not pay rates  
19 that are reasonably related to the cost of efficiently providing health  
20 care services and sufficient to assure an adequate and accessible supply  
21 of health care services, as guaranteed under the New York Health Act.  
22 Individuals often find that they are deprived of affordable care and  
23 choice because of decisions by health plans guided by the plan's econom-  
24 ic interests rather than the individual's health care needs. To address  
25 the fiscal crisis facing the health care system and the state and to  
26 assure New Yorkers can exercise their right to health care, affordable  
27 and comprehensive health coverage must be provided. Pursuant to the  
28 state constitution's charge to the legislature to provide for the health  
29 of New Yorkers, this legislation is an enactment of state concern for  
30 the purpose of establishing a comprehensive universal guaranteed health  
31 care coverage program and a health care cost control system for the  
32 benefit of all residents of the state of New York.

33 2. (a) It is the intent of the Legislature to create the New York  
34 Health program to provide a universal single payer health plan for every  
35 New Yorker, funded by broad-based revenue based on ability to pay. The  
36 legislature intends that federal waivers and approvals be sought where  
37 they will improve the administration of the New York Health program, but  
38 the legislature intends that the program be implemented even in the  
39 absence of such waivers or approvals. The state shall work to obtain  
40 waivers and other approvals relating to Medicaid, Child Health Plus,  
41 Medicare, the Affordable Care Act, and any other appropriate federal  
42 programs, under which federal funds and other subsidies that would  
43 otherwise be paid to New York State, New Yorkers, and health care  
44 providers for health coverage that will be equaled or exceeded by New  
45 York Health will be paid by the federal government to New York State and  
46 deposited in the New York Health trust fund, or paid to health care  
47 providers and individuals in combination with New York Health trust fund  
48 payments, and for other program modifications (including elimination of  
49 cost sharing and insurance premiums). Under such waivers and approvals,  
50 health coverage under those programs will, to the maximum extent possi-  
51 ble, be replaced and merged into New York Health, which will operate as  
52 a true single-payer program.

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

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

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

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

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

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

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

38 5. There have been numerous professional economic analyses of state  
39 and national single-payer health proposals, including the New York  
40 Health Act, by noted consulting firms and academic economists. They have  
41 almost all come to similar conclusions of net savings in the cost of  
42 health coverage and health care. These savings are driven by (a) elimi-  
43 nating the administrative bureaucracy costs, marketing, and profit of  
44 multiple health plans and replacing that with the dramatically lower  
45 costs of running a single-payer system; (b) substantially reducing the  
46 administrative costs borne by health care providers dealing with those  
47 health plans; and (c) using the negotiating power of 20 million consum-  
48 ers to achieve lower drug prices. These savings will more than offset  
49 costs primarily from (a) relieving patients of deductibles, co-pays, and  
50 out-of-network charges; (b) covering the uninsured; (c) increasing  
51 provider payment rates above Medicare and Medicaid rates; and (d)  
52 replacing uncompensated home health care with paid care. Unlike premiums  
53 and out-of-pocket spending, the New York Health Act tax will be progres-  
54 sively graduated based on ability to pay. The vast majority of New  
55 Yorkers today spend dramatically more in premiums, deductibles and other  
56 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

#### Section 5100. Definitions.

5101. Program created.

5102. Board of trustees.

5103. Eligibility and enrollment.

5104. Benefits.

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

5106. Health care organizations.

5107. Program standards.

5108. Regulations.

5109. Provisions relating to federal health programs.

5110. Additional provisions.

5111. Regional advisory councils.

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

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

2. "Care coordination" means, 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

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

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

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

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

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

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

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

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

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

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

49 § 5101. Program created. 1. The New York Health program is hereby  
50 created in the department. The commissioner shall establish and imple-  
51 ment the program under this article. The program shall provide compre-  
52 hensive health coverage to every resident who enrolls in the program.

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

1 benefit is found including (on a voluntary basis) retiree health bene-  
2 fits. In implementing this article, the commissioner shall avoid jeop-  
3 ardizing federal financial participation in these programs and shall  
4 take care to promote public understanding and awareness of available  
5 benefits and programs.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

46 9. The program shall include provisions for an appropriate reserve  
47 fund.

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

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

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

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

27 2. The board shall be composed of:

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

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

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

36 (ii) three of whom shall be representatives of professional organiza-  
37 tions representing physicians;

38 (iii) three of whom shall be representatives of professional organiza-  
39 tions representing licensed or registered health care professionals  
40 other than physicians;

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

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

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

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

48 (viii) two of whom shall be representatives of health care organiza-  
49 tions;

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

3 § 5103. Eligibility and enrollment. 1. Every resident of the state  
4 shall be eligible and entitled to enroll as a member under the program.

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

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

10 § 5104. Benefits. 1. The program shall provide comprehensive health  
11 coverage to every member, which shall include all health care services  
12 required to be covered under any of the following, without regard to  
13 whether the member would otherwise be eligible for or covered by the  
14 program or source referred to:

15 (a) child health plus;

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

21 (c) Medicare;

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

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

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

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

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

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

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

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

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

46 § 5105. Health care providers; care coordination; payment methodol-  
47 ogies. 1. Choice of health care provider. (a) Any health care provider  
48 qualified to participate under this section may provide health care  
49 services under the program, provided that the health care provider is  
50 otherwise legally authorized to perform the health care service for the  
51 individual and under the circumstances involved.

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

1 provisions of this article relating to discrimination), and the appro-  
2 priate clinically-relevant circumstances.

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

5 (i) a health care practitioner who is: (A) the member's primary care  
6 practitioner; (B) at the option of a female member, the member's provid-  
7 er of primary gynecological care; or (C) at the option of a member who  
8 has a chronic condition that requires specialty care, a specialist  
9 health care practitioner who regularly and continually provides treat-  
10 ment for that condition to the member;

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

17 (iii) a health care organization;

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

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

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

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

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

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

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

50 (e) The commissioner shall develop and implement procedures and stand-  
51 ards for an individual or entity to be approved to be a care coordinator  
52 in the program, including but not limited to procedures and standards  
53 relating to the revocation, suspension, limitation, or annulment of  
54 approval on a determination that the individual or entity is not quali-  
55 fied or competent to be a care coordinator or has exhibited a course of  
56 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

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

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

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

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

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

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

37 (ii) Where the member is enrolled in a managed care provider and a  
38 prescription for the member is made under section 340B of the federal  
39 Public Health Service Act (the "340B program") and under a memorandum of  
40 understanding relating to the 340B program between the New York Health  
41 program and the relevant 340B program covered entity, the managed care  
42 provider shall purchase, pay for and provide for the drugs under the  
43 340B program. However, the prescription shall be subject to section two  
44 hundred seventy-three (preferred drug program prior authorization) and  
45 section two hundred seventy-four (clinical drug review program) of this  
46 chapter.

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

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

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



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

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

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

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

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

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

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

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

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

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

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



1 and (ii) consult with national and local organizations working in the  
2 field of health care organizations, including health care practitioners,  
3 hospitals, clinics, long-term supports and service providers, consumers  
4 and their representatives and labor organizations representing health  
5 care workers. When developing and implementing standards of approval of  
6 health care organizations, the commissioner shall consult with the  
7 commissioner of mental health, the commissioner of developmental disa-  
8 bilities, the director of the state office for the aging and the commis-  
9 sioner of the office of alcoholism and substance abuse services.

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

16 5. The commissioner shall make regulations relating to health care  
17 organizations consistent with and to ensure compliance with this arti-  
18 cle.

19 6. The provision of health care services directly or indirectly by a  
20 health care organization through health care providers shall not be  
21 considered the practice of a profession under title eight of the educa-  
22 tion law by the health care organization.

23 § 5107. Program standards. 1. The commissioner shall establish  
24 requirements and standards for the program and for health care organiza-  
25 tions, care coordinators, and health care providers, consistent with  
26 this article, including requirements and standards for, as applicable:

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

28 (b) relations between health care organizations or health care provid-  
29 ers and members; and

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

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

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

39 (b) primary and preventive care, care coordination, efficient and  
40 effective health care services, quality assurance, coordination and  
41 integration of health care services, including use of appropriate tech-  
42 nology, and promotion of public, environmental and occupational health;

43 (c) elimination of health care disparities;

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

50 (e) accessibility of care coordination, health care organization  
51 services and health care services, including accessibility for people  
52 with disabilities and people with limited ability to speak or understand  
53 English, and the providing of care coordination, health care organiza-  
54 tion services and health care services in a culturally competent manner;  
55 and

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

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

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

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

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

31 § 5108. Regulations. The commissioner shall make regulations under  
32 this article by approving regulations and amendments thereto, under  
33 subdivision one of section fifty-one hundred two of this article. The  
34 commissioner may make regulations or amendments thereto under this arti-  
35 cle on an emergency basis under section two hundred two of the state  
36 administrative procedure act, provided that such regulations or amend-  
37 ments shall not become permanent unless adopted under subdivision one of  
38 section fifty-one hundred two of this article.

39 § 5109. Provisions relating to federal health programs. 1. The commis-  
40 sioner shall seek all federal waivers and other federal approvals and  
41 arrangements and submit state plan amendments necessary to operate the  
42 program consistent with this article to the maximum extent possible. No  
43 provision of this article and no action under the program shall diminish  
44 any right or benefit the member would otherwise have under any federal-  
45 ly-matched program or Medicare.

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

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

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

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

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

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

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

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

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

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

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

25 (h) If the commissioner has reasonable grounds to believe that a  
26 member could be eligible for an income-related subsidy under section  
27 1860D-14 of Title XVIII of the federal social security act, the member  
28 shall provide, and authorize the program to obtain, any information or  
29 documentation required to establish the member's eligibility for such  
30 subsidy, provided that the commissioner shall attempt to obtain as much  
31 of the information and documentation as possible from records that are  
32 available to him or her.

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

39 § 5110. Additional provisions. 1. The commissioner shall contract  
40 with not-for-profit organizations to provide:

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

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

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

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

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

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

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

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

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

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

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

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

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

37     (ii) Impacted employees shall be eligible for:

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

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

47     (d) The commissioner shall provide funds from the New York Health  
48 trust fund or otherwise appropriated for this purpose to the commission-  
49 er of labor for retraining and re-employment programs for impacted  
50 employees under this subdivision.

51     (e) The commissioner of labor shall make regulations and take other  
52 actions reasonably necessary to implement this subdivision. This subdivi-  
53 vision shall be implemented consistent with applicable law and regu-  
54 lations.

55     4. The commissioner shall, directly and through grants to not-for-pro-  
56 fit entities, conduct programs using data collected through the New York



1 Health program, to promote and protect the quality of health care  
2 services, patient outcomes, and public, environmental and occupational  
3 health, including cooperation with other data collection and research  
4 programs of the department, consistent with this article, the protection  
5 of the security and confidentiality of individually identifiable patient  
6 information, and otherwise applicable law.

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

21 § 5111. Regional advisory councils. 1. The New York Health regional  
22 advisory councils (each referred to in this article as a "regional advi-  
23 sory council") are hereby created in the department.

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

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

27 (b) New York City;

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

30 (d) Northern, consisting of Albany, Clinton, Columbia, Essex, Frank-  
31 lin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Montgomery,  
32 Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence,  
33 Warren, Washington counties;

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

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

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

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

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

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

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

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

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

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



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

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

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

11 (ii) representatives of professional organizations representing physi-  
12 cians;

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

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

16 (v) representatives of community health centers;

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

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

21 (viii) representatives of health care organizations;

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

24 (x) representatives of employers; and

25 (xi) representatives of municipal and county government.

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

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

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

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

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

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

56 (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

1 assessed at a higher marginal rate than lower brackets. The taxes shall  
2 be set at levels anticipated to produce sufficient revenue to finance  
3 the program, to be scaled up as enrollment grows, taking into consider-  
4 ation anticipated federal revenue available for the program. Provision  
5 shall be made for state residents who are employed out-of-state, and  
6 non-residents who are employed in the state (including those employed  
7 less than full-time).

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

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

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

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

34 (ii) Out-of-state residents employed in the state. The payroll tax  
35 shall apply to any out-of-state resident who is employed or self-em-  
36 ployed in the state. Such individual and individual's employer shall be  
37 able to take a credit against the payroll taxes each would otherwise pay  
38 as to that individual for amounts they spend respectively on health  
39 benefits (A) for the individual, if the individual is not eligible to be  
40 a member of the program, and (B) for any member of the individual's  
41 immediate family. For the employer, the credit shall be available  
42 regardless of the form of the health benefit (e.g., health insurance, a  
43 self-insured plan, direct services, or reimbursement for services), to  
44 make sure that the revenue proposal does not relate to employment bene-  
45 fits in violation of any federal law. For non-employment-based spending  
46 by the individual, the credit shall be available for and limited to  
47 spending for health coverage (not out-of-pocket health spending). The  
48 credit shall be available without regard to how little is spent or how  
49 sparse the benefit. The credit may only be taken against the payroll  
50 tax. Any excess amount may not be applied to other tax liability. The  
51 credit shall be distributed between the employer and employee in the  
52 same proportion as the spending by each for the benefit and may be  
53 applied to their respective portion of the tax. If any provision of this  
54 subparagraph or any application of it shall be ruled to violate federal  
55 law, the provision or the application of it shall be null and void and

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

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

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

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

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

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

19 TITLE III

20 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH

21 NEW YORK HEALTH

22 Section 4920. Definitions.

23 4921. Collective negotiation authorized.

24 4922. Collective negotiation requirements.

25 4923. Requirements for health care providers' representative.

26 4924. Mediation.

27 4925. Certain collective action prohibited.

28 4926. Fees.

29 4927. Confidentiality.

30 4928. Severability and construction.

31 § 4920. Definitions. For purposes of this title:

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

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

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

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

43 5. "Health care provider" means a health care provider under article  
44 fifty-one of this chapter. A health care professional as defined in  
45 article fifty-one of this chapter who practices as an employee or inde-  
46 pendent contractor of another health care provider shall not be deemed a  
47 health care provider for purposes of this title.

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

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

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

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

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

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

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

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

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

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

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

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

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

35 § 4924. Mediation. 1. In the event the commissioner determines that an  
36 impasse exists in the negotiations, the commissioner shall render  
37 assistance as follows:

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

44 (b) if an impasse continues, the commissioner shall appoint a fact-  
45 finding board of not more than three members, who are mutually accepta-  
46 ble to both the health care providers' representative and the represen-  
47 tative of New York Health. The fact-finding board shall have, in  
48 addition to the powers delegated to it by the board, the power to make  
49 recommendations for the resolution of the dispute;

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

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

4 § 4925. Certain collective action prohibited. 1. This title is not  
5 intended to authorize competing health care providers to act in concert  
6 in response to a health care providers' representative's discussions or  
7 negotiations with New York Health except as authorized by other law.

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

14 § 4926. Fees. Each person who acts as the representative of negotiat-  
15 ing parties under this title shall pay to the department a fee to act as  
16 a representative. The commissioner, by regulation, shall set fees in  
17 amounts deemed reasonable and necessary to cover the costs incurred by  
18 the department in administering this title.

19 § 4927. Confidentiality. All reports and other information required to  
20 be reported to the department under this title shall not be subject to  
21 disclosure under article six of the public officers law.

22 § 4928. Severability and construction. If any provision or application  
23 of this title shall be held to be invalid, or to violate or be incon-  
24 sistent with any applicable federal law or regulation, that shall not  
25 affect other provisions or applications of this title which can be given  
26 effect without that provision or application; and to that end, the  
27 provisions and applications of this title are severable. The provisions  
28 of this title shall be liberally construed to give effect to the  
29 purposes thereof.

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

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

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

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

50 2. The fund shall consist of:

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

53 (b) federal payments received as a result of any waiver or other  
54 arrangements agreed to by the United States secretary of health and  
55 human services or other appropriate federal officials for health care



1 programs established under Medicare, any federally-matched public health  
2 program, or the affordable care act;

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

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

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

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

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

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

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

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

1 or applications of this act which can be given effect without that  
2 provision or application; and to that end, the provisions and applica-  
3 tions of this act are severable.  
4 § 10. This act shall take effect immediately.