

# STATE OF NEW YORK

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5474

2021-2022 Regular Sessions

## IN SENATE

March 8, 2021

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Introduced by Sens. RIVERA, RAMOS, ADDABBO, BAILEY, BENJAMIN, BIAGGI, BRESLIN, BRISPORT, BROUK, COMRIE, COONEY, GIANARIS, GOUNARDES, HARCKHAM, HINCHEY, HOYLMAN, JACKSON, KAVANAGH, KENNEDY, KRUEGER, LIU, MAY, MAYER, MYRIE, PARKER, PERSAUD, REICHLIN-MELNICK, SALAZAR, SANDERS, SEPULVEDA, SERRANO, STAVISKY, THOMAS -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the state finance law, in relation to enacting the "New York health act" and 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  
18 premiums, deductibles and co-pays, restricted provider networks and high  
19 out-of-network charges. Many New Yorkers go without health care because  
20 they cannot afford it or suffer financial hardship to get it. Busi-

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

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nesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely. Including long-term services and supports (LTSS) in New York Health is a major step forward for older adults, people with disabilities, and their families. Older adults and people with disabilities often cannot receive the services necessary to stay in the community or other LTSS. Even when older adults and people with disabilities receive LTSS, especially services in the community, it is often at the cost of unreasonable demands on unpaid family caregivers, depleting their own or family resources, or impoverishing themselves to qualify for public coverage. Health care providers are also affected by inadequate health coverage in New York state. A large portion of hospitals, health centers and other providers now experience substantial losses due to the provision of care that is uncompensated. Medicaid and Medicare often do not pay rates that are reasonably related to the cost of efficiently providing health care services and sufficient to assure an adequate and accessible supply of health care services, as guaranteed under the New York Health Act. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic interests rather than the individual's health care needs. To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided. Pursuant to the state constitution's charge to the legislature to provide for the health of New Yorkers, this legislation is an enactment of state concern for the purpose of establishing a comprehensive universal guaranteed health care coverage program and a health care cost control system for the benefit of all residents of the state of New York.

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

(b) If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus, even where other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the

multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers.

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

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

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

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

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

5. There have been numerous professional economic analyses of state and national single-payer health proposals, including the New York Health Act, by noted consulting firms and academic economists. They have almost all come to similar conclusions of net savings in the cost of health coverage and health care. These savings are driven by (a) eliminating the administrative bureaucracy costs, marketing, and profit of multiple health plans and replacing that with the dramatically lower costs of running a single-payer system; (b) substantially reducing the administrative costs borne by health care providers dealing with those health plans; and (c) using the negotiating power of 20 million consumers to achieve lower drug prices. These savings will more than offset costs primarily from (a) relieving patients of deductibles, co-pays, and out-of-network charges; (b) covering the uninsured; (c) increasing provider payment rates above Medicare and Medicaid rates; and (d) replacing uncompensated home health care with paid care. Unlike premiums and out-of-pocket spending, the New York Health Act tax will be progressively graduated based on ability to pay. The vast majority of New Yorkers today spend dramatically more in premiums, deductibles and other out-of-pocket costs than they will in New York Health Act taxes. They will have broader coverage (including long-term care), no restricted provider networks or out-of-network charges, and no deductibles or co-pays.

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

ARTICLE 51

NEW YORK HEALTH

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

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

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

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

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

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

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

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

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

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

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

2. The commissioner shall, to the maximum extent possible, organize, administer and market the program and services as a single program under the name "New York Health" or such other name as the commissioner shall determine, regardless of under which law or source the definition of a benefit is found including (on a voluntary basis) retiree health benefits. In implementing this article, the commissioner shall avoid jeop-

1 ardizing federal financial participation in these programs and shall  
2 take care to promote public understanding and awareness of available  
3 benefits and programs.

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

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

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

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

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

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

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

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

53 (iii) Where an external appeal is denied, the external appeal agent  
54 shall notify the member or the member's designee and, where appropriate,  
55 the member's health care provider, within two business days of the  
56 determination. The notice shall include a statement that the member,



1 member's designee or health care provider has the right to appeal the  
2 determination to a fair hearing under this subdivision and seek judicial  
3 review.

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

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

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

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

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

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

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

44 9. The program shall include provisions for an appropriate reserve  
45 fund.

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

54 (b) This paragraph applies to the retiree while he or she is a resi-  
55 dent of New York state. The retiree shall enroll in the program. If, by  
56 the implementation date, the retiree has not enrolled in the program,

1 the appropriate public employee retiree health benefit program and the  
2 commissioner shall enroll the retiree in the New York Health program. If  
3 the retiree's public employee retiree health benefit includes any  
4 service for which coverage is not offered under the New York Health  
5 program, the retiree shall continue to receive that benefit from the  
6 appropriate public employee retiree health benefit program.

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

11 § 5102. Board of trustees. 1. The New York Health board of trustees is  
12 hereby created in the department. The board of trustees shall, at the  
13 request of the commissioner, consider any matter to effectuate the  
14 provisions and purposes of this article, and may advise the commissioner  
15 thereon; and it may, from time to time, submit to the commissioner any  
16 recommendations to effectuate the provisions and purposes of this arti-  
17 cle. The commissioner may propose regulations under this article and  
18 amendments thereto for consideration by the board. The board of trustees  
19 shall have no executive, administrative or appointive duties except as  
20 otherwise provided by law. The board of trustees shall have power to  
21 establish, and from time to time, amend regulations to effectuate the  
22 provisions and purposes of this article, subject to approval by the  
23 commissioner.

24 2. The board shall be composed of:

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

27 (b) thirty-one trustees appointed by the governor;

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

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

35 (iii) five of whom shall be representatives of professional organiza-  
36 tions representing licensed or registered health care professionals  
37 other than physicians;

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

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

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

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

45 (viii) two of whom shall be representatives of health care organiza-  
46 tions;

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

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

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

53 (c) fourteen trustees appointed by the governor; five of whom to be  
54 appointed on the recommendation of the speaker of the assembly; five of  
55 whom to be appointed on the recommendation of the temporary president of  
56 the senate; two of whom to be appointed on the recommendation of the



1 minority leader of the assembly; and two of whom to be appointed on the  
2 recommendation of the minority leader of the senate.

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

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

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

21 5. Trustees shall serve without compensation but shall be reimbursed  
22 for their necessary and actual expenses incurred while engaged in the  
23 business of the board. However, the board may provide for compensation  
24 in cases where a lack of compensation would limit the ability of a trus-  
25 tee or represented organization to participate in board business.

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

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

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

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

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

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

52 (d) The board shall develop a proposal for integration of federal  
53 veterans health administration programs with New York Health coverage of  
54 health care services; provided however that enrollment in or eligibility  
55 for federal veterans health administration programs shall not affect a  
56 resident's eligibility for New York Health coverage.

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

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

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

8     § 5104. Benefits. 1. The program shall provide comprehensive health  
9 coverage to every member, which shall include all health care services  
10 required to be covered under any of the following, without regard to  
11 whether the member would otherwise be eligible for or covered by the  
12 program or source referred to:

13     (a) child health plus;

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

19     (c) Medicare;

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

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

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

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

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

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

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

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

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

44     § 5105. Health care providers; care coordination; payment methodol-  
45 ogies. 1. Choice of health care provider. (a) Any health care provider  
46 qualified to participate under this section may provide health care  
47 services under the program, provided that the health care provider is  
48 otherwise legally authorized to perform the health care service for the  
49 individual and under the circumstances involved.

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

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

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

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

15     (iii) a health care organization;

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

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

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

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

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

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

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

48     (e) The commissioner shall develop and implement procedures and stand-  
49 ards for an individual or entity to be approved to be a care coordinator  
50 in the program, including but not limited to procedures and standards  
51 relating to the revocation, suspension, limitation, or annulment of  
52 approval on a determination that the individual or entity is not quali-  
53 fied or competent to be a care coordinator or has exhibited a course of  
54 conduct which is either inconsistent with program standards and regu-  
55 lations or which exhibits an unwillingness to meet such standards and  
56 regulations, or is a potential threat to the public health or safety.

1 Such procedures and standards shall not limit approval to be a care  
2 coordinator in the program for criteria other than those under this  
3 section and shall be consistent with good professional practice. In  
4 developing the procedures and standards, the commissioner shall: (i)  
5 consider existing standards developed by national accrediting and  
6 professional organizations; and (ii) consult with national and local  
7 organizations working on care coordination or similar models, including  
8 health care practitioners, hospitals, clinics, birth centers, long-term  
9 supports and service providers, consumers and their representatives, and  
10 labor organizations representing health care workers. When developing  
11 and implementing standards of approval of care coordinators for individ-  
12 uals receiving chronic mental health care services, the commissioner  
13 shall consult with the commissioner of mental health. An individual or  
14 entity may not be a care coordinator unless the services included in  
15 care coordination are within the individual's professional scope of  
16 practice or the entity's legal authority.

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

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

24 3. Health care providers. (a) The commissioner shall establish and  
25 maintain procedures and standards for health care providers to be quali-  
26 fied to participate in the program, including but not limited to proce-  
27 dures and standards relating to the revocation, suspension, limitation,  
28 or annulment of qualification to participate on a determination that the  
29 health care provider is not qualified or competent to be a provider of  
30 specific health care services or has exhibited a course of conduct which  
31 is either inconsistent with program standards and regulations or which  
32 exhibits an unwillingness to meet such standards and regulations, or is  
33 a potential threat to the public health or safety. Such procedures and  
34 standards shall not limit health care provider participation in the  
35 program for criteria other than those under this section and shall be  
36 consistent with good professional practice. Such procedures and stand-  
37 ards may be different for different types of health care providers and  
38 health care professionals. The commissioner may require that health  
39 care providers and health care professionals participate in Medicaid,  
40 child health plus, or Medicare to qualify to participate in the program.  
41 Any health care provider that is qualified to participate under Medi-  
42 caid, child health plus or Medicare shall be deemed to be qualified to  
43 participate in the program, and any health care provider's revocation,  
44 suspension, limitation, or annulment of qualification to participate in  
45 any of those programs shall apply to the health care provider's quali-  
46 fication to participate in the program; provided that a health care  
47 provider qualified under this sentence shall follow the procedures to  
48 become qualified under the program by the end of the implementation  
49 period.

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

54 (c) Procedures and standards under this subdivision shall include  
55 provisions for expedited temporary qualification to participate in the  
56 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, birth centers, long-term supports and service  
4 providers, consumers and their representatives and labor organizations  
5 representing health care workers. When developing and implementing stan-  
6 dards of approval of health care organizations, the commissioner shall  
7 consult with the commissioner of mental health, the commissioner of  
8 developmental disabilities, the director of the state office for the  
9 aging, the commissioner of the office of addiction services and  
10 supports, and the commissioner of the division of human rights.

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

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

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

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

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

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

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

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

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

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

44 (c) elimination of health care disparities;

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

51 (e) accessibility of care coordination, health care organization  
52 services and health care services, including accessibility for people  
53 with disabilities and people with limited ability to speak or understand  
54 English, and the providing of care coordination, health care organiza-  
55 tion services and health care services in a culturally competent manner;  
56 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 the commissioner of mental health, the commissioner of developmental  
23 disabilities, the director of the state office for the aging, the  
24 commissioner of the office of addiction services and supports, the  
25 commissioner of the division of human rights, representatives of  
26 members, health care providers, care coordinators, health care organiza-  
27 tions employers, organized labor including representatives of health  
28 care workers, and other interested parties.

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

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

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

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

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

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

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

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

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

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

1 of the program; and (iv) does not require or has received any necessary  
2 federal waivers or approvals to ensure federal financial participation.

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

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

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

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

41 (i) The program shall make a reasonable effort to notify members of  
42 their obligations under this subdivision. After a reasonable effort has  
43 been made to contact the member, the member shall be notified in writing  
44 that he or she has sixty days to provide such required information. If  
45 such information is not provided within the sixty day period, the  
46 member's coverage under the program may be terminated. Upon the  
47 member's satisfactory provision of the information, the member's cover-  
48 age under the program shall be reinstated retroactive to the date upon  
49 which the coverage was terminated.

50 § 5110. Additional provisions. 1. The commissioner shall contract  
51 with not-for-profit organizations to provide:

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

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

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

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

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

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

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

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

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

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

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

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

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

48 (ii) Impacted employees shall be eligible for:

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

51 (B) up to two years of unemployment benefits, provided that the  
52 impacted employee is enrolled in a department of labor approved training  
53 program, is actively seeking employment, and is not currently employed  
54 full time; provided, however, that such impacted employee may maintain  
55 unemployment benefits for up to two years even if he or she does not



1 meet the criteria set forth in this clause but is sixty-three years of  
2 age or older at the time of loss of employment as an impacted employee.

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

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

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

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

33 § 5111. Regional advisory councils. 1. The New York Health regional  
34 advisory councils (each referred to in this article as a "regional advi-  
35 sory council") are hereby created in the department.

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

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

39 (b) New York City;

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

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

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

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

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



4. Appointment of members of the regional advisory councils.

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

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

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

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

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

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

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

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

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

(ii) representatives of professional organizations representing physicians;

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

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

(v) representatives of community health centers;

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

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

(viii) representatives of health service providers serving lesbian, gay, bisexual, transgender, gender non-conforming, and nonbinary patients;

(ix) representatives of health care organizations;

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

(xi) representatives of employers; and

(xii) representatives of municipal and county government.

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

6. Members of the regional advisory councils shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the advisory councils. The program shall provide financial support for such expenses and other expenses of the regional advisory councils. However, the board may provide for compensation in cases where a lack of compensation would limit the ability of a trustee or represented organization to participate in council business.

7. Each regional advisory council shall meet at least quarterly. Each regional advisory council may form committees to assist it in its work.

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

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

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

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

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

(c) identifying gaps in regional health care services;

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

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

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

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

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

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

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

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

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

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

(b) The governor shall submit to the legislature a revenue proposal. The revenue proposal shall be submitted to the legislature as part of the executive budget under article VII of the state constitution, for the fiscal year commencing on the first day of April in the calendar

1 year after this act shall become a law. In developing the revenue proposal, the governor shall consult with appropriate officials of the executive branch; the temporary president of the senate; the speaker of the assembly; the chairs of the fiscal and health committees of the senate and assembly; and representatives of business, labor, consumers and local government.

2. (a) Basic structure. The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two taxes. First, there shall be a progressively graduated tax on all payroll and self-employed income, paid by employers, employees and self-employed individuals. Second, there shall be a progressively graduated tax on taxable income (such as interest, dividends, and capital gains) not subject to the payroll tax. Income in the bracket below twenty-five thousand dollars per year shall be exempt from the taxes; provided that for individuals enrolled in Medicare as defined in the program, income in the bracket below fifty thousand dollars per year shall be exempt from the taxes. Higher brackets of income subject to the taxes shall be assessed at a higher marginal rate than lower brackets. The taxes shall be set at levels anticipated to produce sufficient revenue to finance the program, to be scaled up as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provision shall be made for state residents who are employed out-of-state, and non-residents who are employed in the state (including those employed less than full-time).

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

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

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

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

(ii) Out-of-state residents employed in the state. The payroll tax shall apply to any out-of-state resident who is employed or self-employed in the state. Such individual and individual's employer shall be able to take a credit against the payroll taxes each would otherwise pay as to that individual for amounts they spend respectively on health benefits (A) for the individual, if the individual is not eligible to be

1 a member of the program, and (B) for any member of the individual's  
2 immediate family. For the employer, the credit shall be available  
3 regardless of the form of the health benefit (e.g., health insurance, a  
4 self-insured plan, direct services, or reimbursement for services), to  
5 make sure that the revenue proposal does not relate to employment bene-  
6 fits in violation of any federal law. For non-employment-based spending  
7 by the individual, the credit shall be available for and limited to  
8 spending for health coverage (not out-of-pocket health spending). The  
9 credit shall be available without regard to how little is spent or how  
10 sparse the benefit. The credit may only be taken against the payroll  
11 tax. Any excess amount may not be applied to other tax liability. The  
12 credit shall be distributed between the employer and employee in the  
13 same proportion as the spending by each for the benefit and may be  
14 applied to their respective portion of the tax. If any provision of this  
15 subparagraph or any application of it shall be ruled to violate federal  
16 law, the provision or the application of it shall be null and void and  
17 the ruling shall not affect any other provision or application of this  
18 section or the act that enacted it.

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

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

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

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

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

### 35 TITLE III

#### 36 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH 37 NEW YORK HEALTH

#### 38 Section 4920. Definitions.

39 4921. Collective negotiation authorized.

40 4922. Collective negotiation requirements.

41 4923. Requirements for health care providers' representative.

42 4924. Mediation.

43 4925. Certain collective action prohibited.

44 4926. Fees.

45 4927. Confidentiality.

46 4928. Severability and construction.

47 § 4920. Definitions. For purposes of this title:

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

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

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

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

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

9 § 4921. Collective negotiation authorized. 1. Health care providers  
10 may meet and communicate for the purpose of collectively negotiating  
11 with New York Health on any matter relating to New York Health, includ-  
12 ing but not limited to rates of payment and payment methodologies.

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

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

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

23 § 4922. Collective negotiation requirements. 1. Collective negotiation  
24 rights granted by this title must conform to the following requirements:

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

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

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

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

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

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

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

45 § 4923. Requirements for health care providers' representative. Before  
46 engaging in collective negotiations with New York Health on behalf of  
47 health care providers, a health care providers' representative shall  
48 file with the commissioner, in the manner prescribed by the commission-  
49 er, information identifying the representative, the representative's  
50 plan of operation, and the representative's procedures to ensure compli-  
51 ance with this title.

52 § 4924. Mediation. 1. In the event the commissioner determines that an  
53 impasse exists in the negotiations, the commissioner shall render  
54 assistance as follows:

55 (a) to assist the parties to effect a voluntary resolution of the  
56 negotiations, the commissioner shall appoint a mediator who is mutually

1 acceptable to both the health care providers' representative and the  
2 representative of New York Health. If the mediator is successful in  
3 resolving the impasse, then the health care providers' representative  
4 shall proceed as set forth in this article;

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

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

21 § 4925. Certain collective action prohibited. 1. This title is not  
22 intended to authorize competing health care providers to act in concert  
23 in response to a health care providers' representative's discussions or  
24 negotiations with New York Health except as authorized by other law.

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

31 § 4926. Fees. Each person who acts as the representative of negotiat-  
32 ing parties under this title shall pay to the department a fee to act as  
33 a representative. The commissioner, by regulation, shall set fees in  
34 amounts deemed reasonable and necessary to cover the costs incurred by  
35 the department in administering this title.

36 § 4927. Confidentiality. All reports and other information required to  
37 be reported to the department under this title shall not be subject to  
38 disclosure under article six of the public officers law.

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

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

50 11. "State public health plan" means the medical assistance program  
51 established by title eleven of article five of the social services law  
52 (referred to in this article as "Medicaid"), the elderly pharmaceutical  
53 insurance coverage program established by title three of article two of  
54 the elder law (referred to in this article as "EPIC"), and the [family  
55 ~~health plus program established by section three hundred sixty-nine ee~~  
56 ~~of the social services law to the extent that section provides that the~~



~~program shall be subject to this article]~~ New York Health program established by article fifty-one of this chapter.

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

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

2. The fund shall consist of:

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

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

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

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

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

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

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

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

3. The commission shall examine the laws and regulations of the state and consult with health care providers, consumers, and other stakeholders and make such recommendations as are necessary to conform the laws

1 and regulations of the state and article 51 of the public health law  
2 establishing the New York Health program and other provisions of law  
3 relating to the New York Health program, and to improve and implement  
4 the program. The commission shall report its recommendations to the  
5 governor and the legislature. The commission shall immediately begin  
6 development of proposals consistent with the principles of article 51 of  
7 the public health law for provision of health care services covered  
8 under the workers' compensation law; and incorporation of retiree health  
9 benefits, as described in paragraphs (a), (b) and (c) of subdivision 8  
10 of section 5102 of the public health law. The commission shall provide  
11 its work product and assistance to the board established pursuant to  
12 section 5102 of the public health law upon completion of the appointment  
13 of the board.

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

20 § 10. This act shall take effect immediately.