STATE OF NEW YORK

9508

IN SENATE

July 22, 2022

Introduced by Sen. COONEY -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the social services law, in relation to the basic health program (Part A); to amend the financial services law, in relation to cost containment and consumer protection; to amend the civil practice law and rules, in relation to income execution; and to repeal certain provisions of the financial services law relating thereto (Part B); to amend the public health law and the insurance law, in relation to the chronic disease demonstration program (Part C); to amend the public health law, in relation to addressing health equity through safety net hospital support (Part D); and to amend the public health law, in relation to providing that the commissioner of health may require any health care provider or third-party payer to report additional claim or price information not already reported pursuant to section 2816 of such law to analyze all health care expenditures in the state from public and private sources (Part E)

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

Section 1. Short title. This act shall be known and may be cited as the "health equity, affordability, and reform act".

§ 2. This act enacts into law components of legislation relating to the health equity, affordability, and reform act. Each component is wholly contained within a Part identified as Parts A through E. The effective date for each particular provision contained within such part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

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

LBD15220-03-2

Section 1. Section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, paragraph (c) of subdivision 1 as separately amended by sections 4 of part BBB of chapter 56 and part P of chapter 57 of the laws of 2022, paragraph (e) of subdivision 1, and subdivisions 5 and 7 as amended by section 2 of part H of chapter 57 of the laws of 2021, subdivision 2 as amended and subdivision 9 as added by section 28-a, subdivision 6 as added by section 28 and subdivision 8 as amended by section 46 of part B of chapter 57 of the laws of 2015, paragraph (d) of subdivision 3 as amended by section 2 and paragraph (b) of subdivision 5 as amended by section 7-a of part BBB of chapter 56 of the laws of 2022, is amended to read as follows:

§ 369-gg. Basic health program. 1. Definitions. For purposes of this section:

(a) "Eligible organization" means an insurer licensed pursuant to article thirty-two or forty-two of the insurance law, a corporation or an organization under article forty-three of the insurance law, or an organization certified under article forty-four of the public health law, including providers certified under section forty-four hundred three-e of the public health law;

(b) "Approved organization" means an eligible organization approved by the commissioner to underwrite a basic health insurance plan pursuant to this title;

(c) "Health care services" means (i) the services and supplies as defined by the commissioner in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner for the purposes of defining such benefits, and shall include coverage of and access to the services of any national cancer institute-designated cancer center licensed by the department of health within the service area of the approved organization that is willing to agree to provide cancer-related inpatient, outpatient and medical services to all enrollees in approved organizations' plans in such cancer center's service area under the prevailing terms and conditions that the approved organization requires of other similar providers to be included in the approved organization's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services; (ii) dental and vision services as defined by the commissioner, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting;

(d) "Qualified health plan" means a health plan that meets the criteria for certification described in § 1311(c) of the Patient Protection and Affordable Care Act (P.L. 111-148), and is offered to individuals through the health insurance exchange marketplace; [~~and~~]

(e) "Basic health insurance plan" means a standard health plan providing health care services, separate and apart from qualified health

plans, that is issued by an approved organization and certified in accordance with this section[~~.~~]**;**

(f) "Eligible small group" means any employer, or trustee or trustees of a fund established by an employer, members of a trade association, labor union, fund established or participated in by two or more employers or by one or more labor unions, association, or a trustee or trustees of a fund established, created or maintained for the benefit of members of one or more associations, church, or any entity that may be eligible to purchase group coverage under the insurance law, provided that any of the foregoing groups identified employ, represent, or cover one hundred or less individuals;

(g) "Qualified dependents" mean the spouse, and any dependent children of an individual seeking coverage through the basic health program buy-in; and

(h) "Family coverage" means the cost to buy-in to the basic health program for an individual and any eligible partner or qualified dependents based on the per member, per month cost applicable.

2. Authorization. If it is in the financial interest of the state to do so, the commissioner of health is authorized, with the approval of the director of the budget, to establish a basic health program. The commissioner's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services to offer a basic health program in accordance with 42 U.S.C. 18051. The commissioner may take any and all actions necessary to obtain such approvals. Notwithstanding the foregoing, within ninety days of the effective date of [~~the~~] **part B of** chapter **fifty-seven** of the laws of two thousand fifteen [~~which amended this subdivision~~] the commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly detailing a contingency plan in the event eligibility rules or regulations are modified or repealed; or in the event federal payment is reduced from ninety five percent of the premium tax credits and cost-sharing reductions pursuant to the patient protection and affordable care act (P.L. 111-148). The contingency plan shall be implemented within ninety days of the above stated events or the time period specified in federal law.

3. Eligibility. A person is eligible to receive coverage for health care services pursuant to this title if he or she:

(a) resides in New York state and is under sixty-five years of age;

(b) is not eligible for medical assistance under title eleven of this article or for the child health insurance plan described in title one-A of article twenty-five of the public health law;

(c) is not eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Service Code of 1986, or is eligible for an employer-sponsored plan that is not affordable, in accordance with section 5000A of such code; **provided, however, that the commissioner of health may seek authority from the secretary of health and human services to permit individuals who are eligible for an employer-sponsored plan to purchase coverage through the basic health program buy-in;** and

(d) (i) except as provided by subparagraph (ii) of this paragraph, has household income at or below two hundred **fifty** percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size**, unless the individual or eligible small group purchases coverage through a basic health plan under the basic health program buy-in set forth under subdivision eleven or twelve of this section**; and has

household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to their immigration status; provided however, that subject to approval from the secretary of health and human services, a person shall also be eligible to receive coverage for health care services under this title, without regard to federal financial participation, if he or she is a resident of New York state, has household income below two hundred fifty percent of the federal poverty line as defined and annually revised by the United States department of health and human services for a household of the same size, and is ineligible for federal financial participation in the basic health program under 42 U.S.C. section 18051 on the basis of immigration status, but otherwise meets the eligibility requirements in paragraphs (a), (b), and (c) of this subdivision;

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; however, MAGI eligible aliens lawfully present in the United States with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this title if such alien would be ineligible for medical assistance under title eleven of this article due to their immigration status;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible for and receiving coverage for health care services pursuant to this title is eligible to continue to receive health care services pursuant to this title during the pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this title;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs [~~(2)~~] two or [~~(4)~~] four of paragraph (b) of subdivision [~~1~~] one of section three hundred [~~and~~] sixty-six of [~~the social services law~~] this article shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

An applicant who fails to make an applicable premium payment, if any, shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

3-a. Basic health program buy-in eligibility. A person or eligible small group shall be permitted to purchase coverage from a basic health plan on behalf of an individual, spouse, and any qualified dependents through the basic health program buy-in described under paragraph eleven or twelve of this section, as long as the individual, spouse, and any qualified dependents otherwise meet the eligibility requirements in paragraphs (a), (b), and (c) of subdivision three of this section. An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

4. Enrollment. (a) Subject to federal approval, the commissioner is authorized to establish an application and enrollment procedure for prospective enrollees. Such procedure shall include a verification system for applicants, which shall be consistent with 42 USC § 1320b-7.

(b) Such procedure shall allow for continuous enrollment for enrollees to the basic health program where an individual may apply and enroll for coverage at any point.

(c) Upon an applicant's enrollment in a basic health insurance plan, coverage for health care services pursuant to the provisions of this title shall be prospective. Coverage shall begin in a manner consistent with the requirements for qualified health plans offered through the health insurance exchange marketplace, as delineated in federal regulation at 42 CFR 155.420(b)(1) or any successor regulation thereof.

(d) A person who has enrolled for coverage pursuant to this title, and who loses eligibility to enroll in the basic health program for a reason other than citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage pursuant to this title, or failure to make an applicable premium payment, before the end of a twelve month period beginning on the effective date of the person's initial eligibility for coverage, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility, shall have his or her eligibility for coverage continued until the end of such twelve month period, provided that the state receives federal approval for using funds from the basic health program trust fund, established under section 97-oooo of the state finance law, for the costs associated with such assistance.

5. Premiums and cost sharing. (a) Subject to federal approval, the commissioner shall establish premium payments enrollees shall pay to approved organizations for coverage of health care services pursuant to this title. No payment is required for individuals with a household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size.

(a-1) For an individual with a household income above two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size, an individual who purchases individual, couple, or family coverage through the basic health program buy-in under subdivision eleven of this section, or an eligible small group who purchases or contributes to the cost of such coverage under subdivision twelve of this section for such individual and any qualified dependents, shall make an applicable premium payment equaling the per member-per month payment received by a basic health plan for providing basic health program services in the region where the individual resides, provided that the commissioner shall pursue any federal waivers and be permitted

to take any other actions necessary to offset the premium payment to the maximum extent possible for individuals with household incomes less than five hundred percent of the federal poverty line, as defined and annually revised by the United States department of health and human services for a household of the same size, including seeking authority to use federal premium tax credits and cost sharing reductions, in an effort to keep the applicable premium payment as low as possible for individuals at these household income levels. The commissioner shall be authorized to assign variable premium amounts based on income such that individuals with lower household incomes are required to pay less premium.

(a-2) Eligible small groups that purchase coverage for an individual under subdivision eleven of this section for which the individual or the state receives federal premium tax credits and cost sharing reductions for individuals to subsidize that coverage, shall be required to pay to the basic health plan, or pay directly to the state, the amount of premium tax credits and cost sharing reductions received by the basic health program trust fund for the individual, in addition to any premium supplement that may apply based on the household income of the individual, as set forth under paragraph (ii) of subdivision (a-3) of this section. Basic health plans shall remit these amounts to the basic health program trust fund or a separate state fund, as may be determined by the commissioner. Such fund shall be used to help ensure deficit neutrality and program viability, and for other purposes that may be allowed by the secretary of health and human services, including but not limited to, rate adequacy for approved organizations and network providers, as may be determined by the commissioner.

(a-3) (i) The commissioner shall contract with an independent actuary to study and make recommendations around premiums and cost sharing for approved organizations operating a basic health plan, and for all individuals participating in the basic health program buy-in. The analysis for developing premiums for approved organizations shall include an analysis of rates of payment in relation to the expected population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the projected utilization of such services, the network of providers required to meet state standards, and subject to approval from the secretary of health and human services and the division of the budget, existing rates of payment in effect under the basic health program, and subject to approval by the secretary of health and human services and the division of the budget, and once enrollment in the basic health program buy-in has reached more than one hundred thousand enrollees, rates of payment in effect under Medicare Part A, B, and C.

(ii) Premium supplement payments. The analysis conducted by the independent actuary shall include recommended premium supplement amounts that shall be required for certain individuals and may be required for eligible small groups to increase available funds for the basic health program. Premium supplement payments shall be paid by individuals that enroll in the basic health program buy-in, who have household income above eight hundred percent of the federal poverty line, as defined and annually revised by the United States department of health and human services for a household of the same size, and in the discretion of the commissioner, may be required to be paid by eligible small groups that contribute to coverage for any individuals qualified under subdivision twelve of this section.

(a-4) For coverage purchased through subdivision eleven of this section, for individuals and qualified dependents with household incomes

above eight hundred percent of the federal poverty line, as defined and annually revised by the United States department of health and human services for a household of the same size, a premium supplement payment shall be paid to increase state share funds for the program. The premium supplement shall be determined by the commissioner in accordance with principles of equity and fairness, increasing commensurate with household income, and may consider assumed savings for the individual compared to traditional insurance coverage, provided the premium supplement amount shall be structured in a way to maximize affordability at lower applicable household income levels, and shall not result in coverage being more expensive under the basic health program buy-in than under a silver level metallic plan offered by a qualified health plan under the New York health benefits exchanges for comparable coverage until household income of an individual meets or exceeds fifteen hundred percent of the federal poverty line, defined and annually revised by the United States department of health and human services for a household of the same size.

(a-5) Once enrollment in the basic health program buy-in has reached one hundred thousand individuals, the commissioner shall have discretion to determine whether eligible small groups shall be required to pay premium supplement payments for any individual and qualified dependents who they contribute coverage costs for under subdivision twelve of this section, if it becomes necessary to increase state share funds for the program a premium subsidy amount can be applied without undermining viability and affordability of the program. The premium supplement that would be owed by an eligible small group shall be determined by the commissioner, but shall comprise a per person amount that is developed to ensure maximum fairness for eligible small groups, and take into consideration the size, age, and revenue of the eligible small group, the household income of the covered individual, and the cost savings for the eligible small group under the basic health program buy-in compared to traditional small group insurance coverage, as applicable.

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval. There shall be no cost-sharing obligations for enrollees for dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision one of this section; services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision one of this section; and health care services authorized under subparagraphs (iii) and (iv) of paragraph (d) of subdivision three of this section. Such cost sharing shall: (i) not include deductibles for individuals at any household income level; (ii) subject to available funds, not require any cost sharing for household incomes not exceeding five hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size, but if this is not possible, then such cost sharing shall be set as low as possible for the lowest household incomes; and (iii) not be established as a percentage of the cost of the service and comprise a fixed cost intended to be as affordable as possible and not act as a barrier to care, that in no event shall be more than two hundred dollars for any covered health care service. Cost sharing owed for services above five hundred percent of the federal poverty line shall vary based on income to promote equity and fairness.

6. Rates of payment. (a) The commissioner shall select the contract with an independent actuary to study and recommend appropriate reimbursement methodologies for the cost of health care service coverage

pursuant to this title. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to; the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards**, existing rates of payment in effect under the basic health program, and subject to approval by the secretary of health and human services and the division of the budget, and once enrollment in the basic health program buy-in has reached more than one hundred thousand enrollees, rates of payment in effect under Medicare Part A, B, and C**.

(b) Upon consultation with the independent actuary and entities representing approved organizations, the commissioner shall develop reimbursement methodologies and fee schedules for determining rates of payment, which rate shall be approved by the director of the division of the budget, to be made by the department to approved organizations for the cost of health care services coverage pursuant to this title. Such reimbursement methodologies and fee schedules may include provisions for capitation arrangements. **Providers and approved organizations shall be permitted to negotiate rates of payment, provided, however, that the commissioner shall be authorized to establish mandatory rates of payment to ensure affordability and viability of the program.**

(c) The commissioner shall have the authority to promulgate regulations, including emergency regulations, necessary to effectuate the provisions of this subdivision.

(d) The department shall require the independent actuary selected pursuant to paragraph (a) of this subdivision to provide a complete actuarial report, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates for the basic health plan authorized under this section. Such report shall be provided annually to the temporary president of the senate and the speaker of the assembly.

7. Any funds transferred by the secretary of health and human services to the state pursuant to 42 U.S.C. 18051(d) shall be deposited in trust. Funds from the trust shall be used for providing health benefits through [~~an approved organization~~] **a basic health plan**, which, at a minimum, shall include essential health benefits as defined in 42 U.S.C. 18022(b); to reduce the premiums, if any, and cost sharing of participants in the basic health program; or for such other purposes as may be allowed by the secretary of health and human services. Health benefits available through the basic health program shall be provided by one or more approved organizations pursuant to an agreement with the department of health and shall meet the requirements of applicable federal and state laws and regulations.

8. An individual who is lawfully admitted for permanent residence, permanently residing in the United States under color of law, or who is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15), and who would be ineligible for medical assistance under title eleven of this article due to his or her immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall be considered to be ineligible for medical assistance for purposes of paragraphs (b) and (c) of subdivision three of this section.

9. Reporting. The commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall include, at a minimum, an analy-

sis of the basic health program and its impact on the financial interest of the state; its impact on the health benefit exchange including enrollment and premiums; its impact on the number of uninsured individuals in the state; its impact on the Medicaid global cap; its impact on health care affordability for middle class New Yorkers; its impact on small business and economic activity; its impact on population trends in the state; the impact of basic health program payment rates on hospital finances and financial sustainability, and recommendations to address any potential concerns based on migration from the commercial insurance market to the basic health program; and the demographics of basic health program enrollees including age and immigration status.

10. Network participation. Any provider licensed or certified under article thirty-one or thirty-two of the mental hygiene law, and any hospital licensed under article twenty-eight of the public health law, including any clinic, physician or specialist group, outpatient facility or practice, ambulatory care setting or other office-based setting, or other health care setting owned in whole or in part by a hospital licensed under article twenty-eight of the public health law, as well as any single or multi-specialty free-standing ambulatory surgery centers licensed under article twenty-eight of the public health law, shall make health care services available to any individual in the basic health program. Approved organizations operating basic health plans and providers shall use good faith efforts to negotiate network participation arrangements for individuals enrolled in the basic health program.

11. Basic health program buy-in for individuals. Any individual who meets the eligibility requirements of paragraphs (a) and (b) of subdivision three of this section shall be permitted to purchase basic health program coverage for themselves and any qualified dependents who otherwise meet the eligibility requirements of paragraphs (a) and (b) of subdivision three of this section, through the basic health program buy-in. Subject to approval from the United States secretary of health and human services, the basic health program buy-in shall allow eligible individuals to pay the regional per member, per month premium that is paid to a basic health plan for eligible individuals in the region, or any subsidized premium based on the availability of federal or state subsidies as basic health program funds permit, for themselves and any qualified dependents, and gain coverage through the basic health program.

12. Basic health program buy-in for eligible small groups. Any eligible small group may pay to a basic health plan the full or partial amount of the premium costs for an individual and their qualified dependents to buy-in to the basic health program as a benefit to members of the eligible small group. The commissioner shall establish procedures through which eligible small groups can pay voluntary premium contributions, and if contributions are made, any applicable required subsidy equivalency payments and premium supplements for covered individuals and their qualified dependents, directly to a basic health plan on an aggregate, monthly basis.

13. The commissioner shall seek any federal waivers, approvals, and take any and all actions necessary to implement this section, including but not limited to federal waivers and approvals, and pursue any state statutory or regulatory changes necessary to implement this act, including establishing penalties, fines, and oversight authority, in conjunction with the department of taxation and finance, to capture accurate information from individuals and eligible small groups, and ensure

eligible small groups are complying with the requirements of this section.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date; provided, further, that the amendments to paragraphs (c) and (e) of subdivision 1, paragraph (d) of subdivision 3, and subdivisions 5 and 7 of section 369-gg of the social services law made by section one of this act shall not affect the expiration of such paragraphs and subdivisions and shall be deemed to expire therewith.

PART B

Section 1. Legislative intent. The legislature finds and declares all of the following:

Medical care should never result in financial hardship or bankruptcy; that out-of-network service reimbursement should be fair to providers but put consumers first; and that hospitals should not be able to place liens on their patients' homes to secure payment of out-of-pocket costs.

For too many New Yorkers, an unexpected medical emergency or diagnosis carries both life-altering health and financial consequences. An individual should not need to substantially modify theirs and their family's future by liquidating college or retirement savings or need to start an online fundraiser to afford the bills from a medical emergency. For those who have experienced a medical travesty and cannot work, ongoing costs they cannot afford compound the trauma.

As a result of the Affordable Care Act, health insurance plans today are required to establish out-of-pocket payment maximums that attempt to limit one's out-of-pocket cost liability for health care. While these are certainly preferred over no coverage, they offer little protection against debt and bankruptcy because they exclude out-of-network care as well as premium contributions paid by an individual. This means that the sum of premium payments a person makes for their health care does not count towards the out-of-pocket cap, meaning the cap is not account for what could be a substantial amount of available resources that have already been devoted to pay for one's health care. In addition, the out-of-pocket maximum does not account for an individual's household income, exacerbating equity issues by failing to consider one's ability to actually afford their out-of-pocket maximum, or if it is an amount that would inevitably lead to debt and bankruptcy.

While there are many contributing factors to health care cost increases, one of the drivers continues to be out-of-network charges. While New York has led the way in protecting consumers from surprise bills, studies have shown New York's Independent Dispute Resolution process and its reliance on health care charges to resolve disputes incentivizes out-of-network providers to continually increase their "charges", as charges are part of the criteria used to determine payment of a disputed out-of-network charge. Higher charges result in higher awards and more costs being built into premiums in subsequent years. As long as the state maintains a health care system that permits and incentivizes this behavior, the system will continue to incentivize such cost increases while encouraging those who do not participate in networks to continue to do so, with consumers caught in between. It is essential to address out-of-network charges in a way that is fair to providers but

takes patients completely out of the middle of health plan and provider disputes.

§ 2. Article 6 of the financial services law is REPEALED and a new article 6 is added to read as follows:

ARTICLE 6

COST CONTAINMENT AND CONSUMER PROTECTIONS

§ 601. Applicability. This article shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including the workers' compensation law and article fifty-one of the insurance law, and shall not preempt any such law.

§ 602. Definitions. For purposes of this article:

(a) "Emergency health care services" means health care services rendered to an insured experiencing an "emergency condition".

(b) "Emergency condition" means medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; (4) serious disfigurement of such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the social security act 42 U.S.C. 1395dd.

(c) "Health care plan" means an insurer licensed to write accident and health insurance pursuant to article thirty-two of the insurance law; a corporation organized pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of the public health law; or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law.

(d) "Insured" means a patient covered under a health care plan's policy or contract.

(e) "Nonemergency health care services" means health care services rendered to an insured experiencing a medical condition other than an emergency condition.

(f) "In-network contracted rate" means the rate contracted between an insured's health care plan and a participating health care provider for the reimbursement of health care services delivered by that health care provider to the insured.

(g) "Median, in-network contracted rate" means the median allowed amount paid to in-network providers for a specific service by a specific health plan.

(h) "Non-participating commercial rate for emergency services" means the amount set pursuant to this section, and used to determine the rate of payment to a health care provider for the provision of emergency

health care services to an insured when the health care provider is not in the insurer's network.

(i) "Noncontracted commercial rate for nonemergency services" means the amount set pursuant to this section, and used to determine the rate of payment to a health care provider for the provision of nonemergency health care services to an insured when the health care provider is not in the insurer's network.

(j) "Relative price" means the negotiated allowed amount paid for a medical service by a health care plan, including amounts paid from both the health care plan and the insured, compared against the Medicare reimbursement rate for the same procedure and facility.

(k) "Core CPI" means the Consumer Price Index for All Urban Consumers, All Items Less Food & Energy, developed by the United States Bureau of Labor Statistics.

§ 603. Rates of payment for non-participating services. All health care plans shall pay non-participating providers of emergency and non-emergency health care services provided to an insured at the insurers median, in-network rate for the service provided. Providers shall be prohibited from balance billing an insured for any amount above the median, in-network rate paid for the health care service. The superintendent may promulgate regulations necessary to implement this section.

§ 604. Annual limit on consumer health care expenditures. (a) Notwithstanding any out-of-pocket maximums that may exist today, the superintendent shall establish annual limits on the overall financial amount an insured shall be responsible for in the state regulated commercial health insurance market, for payment of health care costs under a contract with a New York state regulated health plan, which shall be inclusive of all premium contributions made directly by the individual for individual or family coverage, as well as any amounts paid towards copays, coinsurance, and deductibles, for all medically necessary health care services, irrespective of whether the service is provided by an in-network or out-of-network provider, such that when the total amount of health care costs paid by an individual reaches the applicable limit, the consumer is no longer financially responsible to the insurer for payment of out-of-pocket costs. For purposes of this section, any financial contributions toward the premium made by an employer for health insurance coverage shall not count towards the annual out-of-pocket maximum.

(b) In implementing subsection (a) of this section, the superintendent may use the IRS Employer Health Plan Affordability Threshold as a baseline, but shall establish cap amounts at various household income levels, such that individuals with less household income shall be subject to a lower annual payment cap, and individuals with higher household income shall be subject to a higher annual cap, but in no event shall the annual out-of-pocket maximum cap more than double the IRS Employer Health Plan Affordability Threshold for individuals at any income level. The superintendent shall be permitted to apply for any federal waivers and pursue any reinsurance options for insurers or the state and take other actions consistent with this section to implement its intent.

(c) Insurers shall be prohibited from increasing health insurance premiums to account for the out-of-pocket limits, and the actuarial value of the insurance product shall be regarded as if the underlying insurance product did not include any revised out-of-pocket limit.

(d) The commissioner of health shall work with the commissioner of taxation and finance to establish appropriate penalties and safeguards to ensure proper implementation of this article.

§ 605. Service level caps on high health care costs. (a) No health care plan shall be permitted to reimburse any inpatient or outpatient hospital licensed under article twenty-eight of the public health law, and any single or multi-specialty free-standing ambulatory surgery centers licensed under article twenty-eight of the public health law, more than two hundred forty percent of the Medicare benchmark rate for the service.

(b) Any provider subject to this paragraph shall be prohibited from balance billing an insured for costs above the benchmark rate or cost up to the benchmark rate if the provider has negotiated a lower charge for the service from the health care plan.

(c) Any rate filings that may be required shall be subject to presumptive disapproval if it includes any payment to providers that is more than two hundred forty percent of the Medicare benchmark rate.

(d) The superintendent shall assess the impact of this provision on health care costs in consultation with the commissioner of health, and may recommend modifications to the service level caps, including, but not limited to, revising the methodology to establish new caps, establishing regional caps, or lowering or raising caps as may be necessary based on health care utilization, price, and trend analysis conducted by the commissioner of health.

§ 606. Cost growth caps. Any rate filings submitted to the superintendent may not include aggregate unit price growth for nonprofessional services that exceed the following:

(a) One year after the analysis on health care cost growth and trends is completed by the commissioner of health under section twenty hundred sixteen of the public health law, the commissioner of health shall establish three tiers of hospitals based on health care prices paid by health care plans to inpatient and outpatient hospitals and hospital systems, and all ambulatory surgery centers licensed or certified under article twenty-eight of the public health law, such that:

(1) The first tier shall consist of those facilities in the state that fall below the median of all facilities in terms of relative reimbursement received by health care plans for services; hospitals in this tier shall be permitted to negotiate increases to their reimbursement and health care plans are permitted to pay increases without limitation;

(2) The second tier shall consist of those facilities between the median and ninety-fifth percentile of all facilities in terms of relative reimbursement received by health care plans for services; beginning for policies that take effect January first, two thousand twenty-four, the superintendent shall permit health care plans to submit rate filings that allow unit price growth for these facilities that does not exceed the greater of 2.5 percent or Core CPI plus 1 percent; and,

(3) The third tier shall consist of those facilities above the ninety-fifth percentile of all facilities in terms of relative reimbursement received by health care plans for services; beginning for policies that take effect January first, two thousand twenty-four, the superintendent shall not permit any rate filings that allow unit price growth for these facilities.

(b) Any rate filings submitted by a health care plan that violates these requirements shall be subject to presumptive disapproval by the superintendent.

(c) The superintendent is permitted to take other actions to enforce the requirements of this section, and shall implement regulations necessary to carry out its intent.

§ 3. Subdivision (b) of section 5201 of the civil practice law and rules is amended to read as follows:

(b) Property against which a money judgment may be enforced. A money judgment may be enforced against any property which could be assigned or transferred, whether it consists of a present or future right or interest and whether or not it is vested, unless it is exempt from application to the satisfaction of the judgment. A money judgment entered upon a joint liability of two or more persons may be enforced against individual property of those persons summoned and joint property of such persons with any other persons against whom the judgment is entered. **No property lien shall be entered against a debtor's primary residence in actions brought by a hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law.**

§ 4. Subdivision (b) of section 5231 of the civil practice law and rules, as amended by chapter 575 of the laws of 2008, is amended to read as follows:

(b) Issuance. Where a judgment debtor is receiving or will receive money from any source, an income execution for installments therefrom of not more than ten percent thereof may be issued and delivered to the sheriff of the county in which the judgment debtor resides or, where the judgment debtor is a non-resident, the county in which he is employed; provided, however, that (i) no amount shall be withheld from the judgment debtor's earnings pursuant to an income execution for any week unless the disposable earnings of the judgment debtor for that week exceed the greater of thirty times the federal minimum hourly wage prescribed in the Fair Labor Standards Act of 1938 or thirty times the state minimum hourly wage prescribed in section six hundred fifty-two of the labor law as in effect at the time the earnings are payable; (ii) the amount withheld from the judgment debtor's earnings pursuant to an income execution for any week shall not exceed twenty-five percent of the disposable earnings of the judgment debtor for that week, or, the amount by which the disposable earnings of the judgment debtor for that week exceed the greater of thirty times the federal minimum hourly wage prescribed by the Fair Labor Standards Act of 1938 or thirty times the state minimum hourly wage prescribed in section six hundred fifty-two of the labor law as in effect at the time the earnings are payable, whichever is less; (iii) if the earnings of the judgment debtor are also subject to deductions for alimony, support or maintenance for family members or former spouses pursuant to section five thousand two hundred forty-one or section five thousand two hundred forty-two of this article, the amount withheld from the judgment debtor's earnings pursuant to this section shall not exceed the amount by which twenty-five percent of the disposable earnings of the judgment debtor for that week exceeds the amount deducted from the judgment debtor's earnings in accordance with section five thousand two hundred forty-one or section five thousand two hundred forty-two of this article**; and (iv) no amount shall be imposed in judgments arising from a medical debt action brought by a hospital licensed under article twenty-eight of the public health law or a health care professional authorized under title eight of the education law**. Nothing in this section shall be construed to modify, abrogate, impair, or affect any exemption from the satisfaction of a money judgment otherwise granted by law.

§ 5. This act shall take effect immediately, provided however, that it shall apply to all health care plan policies beginning on January 1, 2024. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART C

Section 1. Legislative intent. The legislature finds and declares all of the following:

The widening gap in health and life expectancy of New Yorkers based on income is a disturbing phenomenon. One of the many reasons why this is occurring is because those with lower incomes tend to be disproportionately impacted by multiple disparities, including higher rates of chronic illness and disease, and the ongoing costs of treatment create barriers to access and proper self-care. Countless studies have shown individuals are more likely to go without needed care when a deductible is involved, while lower income individuals are more likely to avoid care because of out-of-pocket costs. Thus, individuals with lower incomes do not manage chronic conditions as well as those with higher incomes, and tend to live shorter lives as a result. In addition to disproportionately impacting individuals from lower economic backgrounds, chronic diseases have also been found to disproportionately effect people of color, who face higher rates of diabetes, obesity, stroke, heart disease, and cancer, than caucasians. The impacts of poor health effect more than the individual, as studies have shown poor health can impact the well-being and future of the entire family when one member has a chronic condition. Economic advancement is typically more challenging for those with chronic illnesses, as not only does the disease impact work and productivity, but treatments and medications can account for a significant portion of available resources for those with lower incomes, making it difficult to survive on fixed incomes and forcing many to forgo needed care. Families with less income do not have the ability to outsource help and end up taking on more responsibility for family members impacted by disease, which impacts their own education and work opportunities. Thus, in many respects, chronic diseases exacerbate existing health and socioeconomic disparities, making it difficult for individuals and families from low-income backgrounds to overcome the burden.

It is imperative that life-saving services, treatments, and medications be made available to all New Yorkers without cost sharing, so cost is not a barrier for accessing preventive services and care. This is essential as a matter of public policy to address disparities in equity and access; however, there is also evidence that improved adherence and chronic disease management will reduce health care costs in the aggregate and could lead to improved health outcomes and other benefits for the individual and their family.

§ 2. The public health law is amended by adding a new section 2703 to read as follows:

§ 2703. Chronic disease demonstration program. 1. There shall be established a chronic disease demonstration program within the department. Such program shall recommend cost sharing eliminations for targeted high-value services, treatments and prescription drugs used to treat certain chronic conditions. In order to implement such program, the commissioner, in consultation with the superintendent of financial

services, shall identify one to three services, treatments, and prescription drugs in total used to treat each of the following chronic conditions: diabetes, asthma, chronic obstructive pulmonary disease, hypertension, coronary artery disease, congestive heart failure, opioid use disorder, bipolar disorder, and schizophrenia. The commissioner may, by regulation, include any other chronic conditions deemed necessary. In determining the targeted high-value services, treatments, and prescription drugs, the commissioner shall consider appropriate services, treatments and prescription drugs that are:

(a) out-patient or ambulatory services, including medications, lab tests, procedures, and office visits, generally offered in the primary care or medical home setting;

(b) of clear benefit, strongly supported by clinical evidence to be cost-effective;

(c) likely to reduce hospitalizations or emergency department visits, or reduce future exacerbations of illness progression, or improve quality of life;

(d) relatively low cost when compared to the cost of an acute illness or incident prevented or delayed by the use of the service, treatment or drug; and

(e) at low risk for overutilization, abuse, addiction, diversion or fraud.

The commissioner and the superintendent of financial services may further take into consideration other independent resources or models proven effective in reducing financial barriers to high-value care.

2. Every five years, the commissioner and the superintendent of financial services shall evaluate the effect of this section. Such evaluation shall include the impact on treatment adherence, incidence of related acute events, premiums and cost sharing, overall health, long-term health costs, and other issues that the superintendent and commissioner deem necessary. The superintendent of financial services may collaborate with an independent research organization to conduct such evaluation. The superintendent of financial services shall publish a public report on its findings, and shall make such report available on its website.

3. Such program shall be implemented no later than January first, two thousand twenty-three.

§ 3. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 37 to read as follows:

(37) Any policy, contract or certificate of insurance issued pursuant to this section shall provide coverage for the identified services, treatments and prescription drugs of the chronic disease demonstration program established under article twenty-seven of the public health law, at no cost sharing to the member, including co-payments, co-insurance, and such coverage shall not be subject to any deductible. The superintendent and the commissioner of health may adopt any written policies, procedures or regulations necessary to implement such program.

§ 4. Section 3221 of the insurance law is amended by adding a new subsection (u) to read as follows:

(u) Any policy, contract or certificate of insurance issued pursuant to this section shall provide coverage for the identified services, treatments and prescription drugs of the chronic disease demonstration program established under article twenty-seven of the public health law, at no cost sharing to the member, including co-payments, co-insurance, and such coverage shall not be subject to any deductible. The superintendent and the commissioner of health may adopt any written policies, procedures or regulations necessary to implement such program.

§ 5. Section 4303 of the insurance law is amended by adding a new subsection (tt) to read as follows:

(tt) Every contract which provides prescription drugs, or physician services, medical, major medical or similar comprehensive-type coverage, shall provide coverage for the identified services, treatments and prescription drugs of the chronic disease demonstration program established under article twenty-seven of the public health law, at no cost sharing to the member, including co-payments, co-insurance, and such coverage shall not be subject to any deductible. The superintendent and commissioner of health may adopt any written policies, procedures or regulations necessary to implement such program.

§ 6. This act shall take effect immediately, provided however, that it shall apply to all health care plan policies beginning on January 1, 2024. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART D

Section 1. Legislative intent. The legislature finds and declares all of the following:

The COVID-19 pandemic magnified many longstanding health inequities and disparities that disproportionately impact many black and latinx communities. Examples of such racial and ethnic barriers include access to safe and secure housing, quality education, economic opportunity, and access to quality health care. Access to high quality health care has a positive effect not only on one's own health outcomes but significantly impacts how they approach decision-making about their own healthcare.

We have the finest medical institutions in the country right here in this state, but access to care and the quality of care received is unevenly experienced. Numerous studies have shown that when it comes to health, where you live has a greater impact on your life expectancy than your own genetic code. A baby born in one zip code may be expected to live an entire generation longer than a baby born in a neighboring zip code. In every major city of our state, there are well-known, vibrant institutions that attract patients who would accept medical care at no lesser institution. At the same time, there are hospitals that predominantly serve the poor and uninsured, whose patients have accepted this is where they go when they need care. If given the choice, most commercially insured in this state would not choose to receive their care at one of the financially distressed institutions.

Acute care hospitals that serve a higher proportion of Medicaid and Medicare patients tend to serve higher percentages of racial and ethnic minorities, people of color, and communities that are disproportionately impacted by the social determinants of health and other disparities. It is also well known that these hospitals receive lower reimbursement for the services they provide. While this is mostly because Medicaid and Medicare pay these hospitals less than commercial insurance would for the same procedure, it is also true that these hospitals receive substantially less in commercial insurance reimbursement, even when their patients do have commercial coverage. This is due to market position and negotiating leverage with insurers. While hospital price deregulation and consolidation has allowed some hospital systems to grow and establish dominant market positions with payers, safety net hospitals that serve poorer communities have no leverage to negotiate price with

insurers. As a result, the reimbursement they receive tends to be significantly lower than more affluent hospitals, which means an identical medical procedure can be reimbursed drastically different for hospitals located on the same city block. Right now in this state, we have world renown hospitals funding massive capital projects by issuing investment grade bonds on the capital markets, and at the same time, there are hospitals that are so financially destitute they rely on millions of dollars in taxpayer funds every year for capital funding and their very survival. In fiscal year 2019, 28 hospitals across the state received more than $700 million in government support funds from the commissioner of health just to maintain operations. The divide between successful and struggling hospitals is wide and growing. Yet despite this, every hospital in the state is a 501 (c)(3) charitable organization, required by law to operate exclusively for charitable purposes.

A hospital's financial wherewithal has a direct effect on its quality of care, and the quality of the patient experience. Prosperous hospitals attract top physicians, invest in their physical capacity, and continually raise funds to grow operations and improve services, which allows them to improve their reputational standing and continue to attract commercially insured and affluent patients, which helps them remain prosperous. Conversely, safety net hospitals cannot do any of these things. They rely on state and federal grants for operational improvements, and Medicaid cash assistance to prevent multimillion-dollar operating losses. They struggle to exist and do the best they can with the minimum reimbursement they receive, from patients beset by multiple disparities. With large hospital systems now located not far from many of these safety net hospitals, it is naive to think safety net institutions could ever compete with their more esteemed neighbors, even if improvements are made.

In order to meaningfully address health equity, we must do more than ensure our safety hospitals survive. We need to invest in these hospitals so they can provide care that is on par with other institutions throughout the state. As a first step, we need to ensure limited hospital support dollars are allocated to safety net hospitals that need the funds most, and are not allocated to those institutions who do not need the funds, and take other steps to make our health care delivery system more equitable, so safety net hospitals have the resources and ongoing support they need to improve care and operations.

§ 2. Section 2807-c of the public health law is amended by adding a new subdivision 36 to read as follows:

36. Addressing health equity through safety net hospital support. (a) (i) "Safety net hospital" means those hospitals that predominantly serve communities that experience significant racial, economic, and health disparities that have a Medicaid payer mix as of the most recent fiscal year at or above twenty-five percent, and twenty-five percent or less of discharged patients are commercially insured. The commissioner shall annually promulgate a list of those hospitals that qualify as safety net hospitals.

(ii) "Health equity pool" means a new trust to be administered by the commissioner to support safety net hospitals, promote health care access, and health equity for communities that experience significant health disparities.

(iii) "Commercial average relative price" means the average commercial reimbursement rate for each specific service, for each insurer, by region, for all hospital inpatient and outpatient procedures.

(iv) "Commercial health insurer" means entities authorized to provide health insurance pursuant to articles thirty-two and forty-three of the insurance law, a municipal cooperative health benefit plan established pursuant to article forty-seven of the insurance law, an entity certified pursuant to article forty-four of this chapter, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of the insurance law, the state insurance fund, and the New York state health insurance plan established under article eleven of the civil service law. However, the term commercial health insurer shall not include any of these entities acting as a managed care provider pursuant to title eleven of article five of the social services law and title one-A of article twenty-five of this chapter, or entities providing basic health plans pursuant to the basic health program under section three hundred sixty-nine-gg of the social services law.

(b) To promote health equity through commercial rate equity for safety net hospitals that predominantly serve communities that experience health disparities because of race, ethnicity, socioeconomic status or other status:

(i) all commercial health insurers shall reimburse safety net hospitals for every inpatient and outpatient service at no less than the eightieth percentile of the insurers commercial relative price for the service. Any rate filing that may be required to be submitted by a commercial health insurer that does not reimburse safety net hospitals in accordance with this section shall be subject to presumptive disapproval by the superintendent of financial services.

(ii) any hospital licensed under this article with more than three billion dollars in net patient revenue on its year end cost report shall contribute funds minimally equaling two percent of their annual revenue to the health equity pool to be used to support those safety net hospitals within the same geographic region. Hospitals subject to this paragraph shall be prohibited from negotiating for increases to rates of payment from commercial insurers and other health plans to offset payments to the health equity pool.

(iii) The commissioner shall revise the indigent care pool distribution formula established in regulations pursuant to section twenty-eight hundred seven-k of this article to prioritize annual distributions for safety net hospitals that ensures no less than seventy-five percent of available funds are distributed annually to those safety net hospitals with the greatest financial need. The revised methodology shall further ensure a more equitable distribution of disproportionate share hospital funds such that no funds are distributed to those hospitals that regardless of their reported payer mix or reported uncompensated care need, are in the discretion of the commissioner, financially stable hospitals that do not require disproportionate share hospital funds to maintain operations.

(c) The commissioner shall require that all private nonprofit hospitals licensed under this article provide charity care and make other investments benefitting the community equaling 5.9% of the hospital's overall expenditures. Any hospital payments to the health equity pool shall count towards the 5.9% threshold. Any hospital that does not contribute the required 5.9% shall be required to make payment up to the 5.9% amount to the health equity pool.

(d) The commissioner shall provide an annual analysis on the impact of this subdivision on safety net hospitals and health equity no later than January first, two thousand twenty-four.

§ 3. This act shall take effect on January 1, 2024, and shall apply to all health care plan policies beginning on January 1, 2024. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART E

Section 1. Legislative intent. The legislature finds and declares all of the following:

While there is a general awareness that the United States pays more for prescription drugs than any other nation, there is less awareness that we also pay substantially more for hospital and physician services. This is particularly true in New York, where we spend more on per-person health care costs than nearly any other state, with spending that exceeds the national average, year after year. Health care costs directly effect health insurance premiums, and the cost of health insurance has grown significantly faster in New York than inflation and wages--compounding at an annual rate of 6.5% per year between 1996 and 2019, turning a family premium of $5,300 in 1996 into $22,874 in 2019--without any end in sight.

Higher health care costs have also led to the growth in adoption of health benefit designs that not in the best interest of the health care consumer, like high deductible plans and plans with high out-of-pocket cost sharing. In 2019, the average New Yorker with employer-sponsored health coverage paid $5,149 in premiums and $2,899 in deductibles before their health insurance contributed at all to the cost of their care. These changes were designed to provide lower premium options and make consumers more responsible for their own costs, but too often they end up dissuading necessary health care utilization because of cost.

Yet, despite the overall cost growth this state has seen, numerous studies show that the growth in costs is not uniform across-the-board. Market power remains a key driver of price, resulting in significant variation in prices charged for the very same medical services, even in the same geographic region, as some entities are able to demand regular cost increases due to their name and status as an organization.

It is clear that health care costs, and the underlying factors that contribute to cost growth, is an issue that can no longer be ignored, must be better understood, and cannot simply be left to the private market to resolve. This has become much more than a health care issue, as critical services like education, childcare, social services, and economic growth will continue to see resources shifted as long as health care cost growth continues to outpace wages, inflation, or any measure of rational economic output.

§ 2. Section 2816 of the public health law is amended by adding a new subdivision 9-a to read as follows:

9-a. (a) The commissioner may require any health care provider or third-party payer to report additional claim or price information not already reported pursuant to this section to analyze all health care expenditures in the state from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers; (ii) all patient cost sharing amounts, such as, deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in regulations promulgated by the center.

(b) The commissioner shall publish an annual report based on the information submitted pursuant to this section concerning health care providers, third-party payer costs and cost trends. The commissioner shall compare the costs and cost trends by region, and shall detail:

(i) baseline information about health care cost, price, quality, utilization, and market power in the state's health care system; (ii) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (iii) factors that contribute to cost growth within the state's health care system, including provider consolidation, hospital acquisitions of physician practices, and to the relationship between provider costs and third-party payer premium rates; (iv) the impact of any assessments including, but not limited to, the HCRA surcharge on health insurance premiums; (v) trends in utilization of high-cost, unnecessary, or duplicative services, with particular emphasis on imaging and other high-cost services; (vi) the development and status of provider organizations, including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; (vii) the impact of health care payment and delivery reform on the quality of care delivered in the state; and (viii) any other information the commissioner deems necessary.

(c) As part of such report, the commissioner shall report on price variation of inpatient and outpatient medical services. The report shall include: (i) baseline information about price variation, identifying hospital inpatient and outpatient prices relative to Medicare; (ii) the annual change in price variation of hospital inpatient and outpatient prices; (iii) factors that contribute to price variation in the health care system; (iv) the impact of price variations on safety net hospitals and health insurance premiums; and (v) any recommendations to address cost growth to make health care as affordable and accessible as possible in this state.

(d) The commissioner may contract with an outside organization with expertise in reviewing data and preparing such reports to conduct the analysis and prepare the report required. The superintendent shall publish the report and provide the report to the legislature at least thirty days before the public hearing required under paragraph (e) of this section.

(e) Not later than October first of every year, the commissioner shall hold a public hearing which shall examine health care provider, provider organization and third-party payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the state. Public notice of any hearing shall be provided at least sixty days prior to such hearing date. The commissioner shall identify as witnesses for the public hearing a representative sample of health care providers, third-party payers and other relevant persons. Witnesses shall provide testimony under oath and be subject to questioning by a panel that shall consist of the commissioner, the superintendent of financial services or a designee, three appointees by the governor, three appointees by the temporary president of the senate, three

appointees by the speaker of the assembly, two appointees of the attorney general, and two appointees of the state comptroller. Witnesses shall be instructed on which topics they should be prepared to discuss, which may include: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system, efforts to reduce the inappropriate or duplicative use of technology and the impact of price transparency on prices; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to promote the standardization of administrative practices, the impact of price transparency, the extent of price variation between the payer's participating providers and efforts to reduce such price variation, and any other matters as determined by the commissioner.

§ 3. This act shall take effect immediately; provided, however, that the amendments to section 2816 of the public health law made by section two of this act shall not affect the expiration of such section and shall expire therewith.

§ 3. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by a court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provision had not been included herein.

§ 4. This act shall take effect immediately; provided, however, that the applicable effective date of Parts A through E of this act shall be as specifically set forth in the last section of such Parts.