

# STATE OF NEW YORK

7897

2023-2024 Regular Sessions

## IN ASSEMBLY

July 19, 2023

Introduced by M. of A. PAULIN, DINOWITZ, L. ROSENTHAL, STECK, BICHOTTE HERMELYN, SAYEGH, REYES, GONZALEZ-ROJAS, RAJKUMAR, FORREST, KELLES, ANDERSON, ARDILA, BARRETT, BENEDETTO, BRONSON, BURDICK, BURGOS, BURKE, CARROLL, CLARK, COLTON, COOK, CRUZ, DARLING, DE LOS SANTOS, DICKENS, DILAN, EPSTEIN, FALL, GALLAGHER, HUNTER, HYNDMAN, JACKSON, JEAN-PIERRE, JOYNER, KIM, LAVINE, LEE, LUNSFORD, LUPARDO, MAMDANI, MEEKS, MITAYNES, OTIS, PEOPLES-STOKES, RAGA, SEAWRIGHT, SEPTIMO, SHRESTHA, SILLITTI, SIMON, SIMONE, STIRPE, TAYLOR, THIELE, VANEL, WALKER, WALLACE, WEPRIN, WILLIAMS, ZINERMAN -- Multi-Sponsored by -- M. of A. AUBRY, DAVILA, FAHY, GLICK, GUNTHER, MAGNARELLI, PRETLOW, ROZIC -- read once and referred 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 that has been put forward other than  
15 the New York health act that will enable New York state to meet that

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

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

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

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

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

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

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

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

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

42 5. There have been numerous professional economic analyses of state  
43 and national single-payer health proposals, including the New York  
44 Health Act, by noted consulting firms and academic economists. They have  
45 almost all come to similar conclusions of net savings in the cost of  
46 health coverage and health care. These savings are driven by (a) elimi-  
47 nating the administrative bureaucracy costs, marketing, and profit of  
48 multiple health plans and replacing that with the dramatically lower  
49 costs of running a single-payer system; (b) substantially reducing the  
50 administrative costs borne by health care providers dealing with those  
51 health plans; and (c) using the negotiating power of 20 million consum-  
52 ers to achieve lower drug prices. These savings will more than offset  
53 costs primarily from (a) relieving patients of deductibles, co-pays, and  
54 out-of-network charges; (b) covering the uninsured; (c) increasing  
55 provider payment rates above Medicare and Medicaid rates; and (d)  
56 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-subsidized 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 or under this chapter to provide such health care service, acting within their lawful scope of practice.

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

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

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

18 10. "Member" or "enrollee" means an individual who is enrolled in the  
19 program.

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

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

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

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

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

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

51 17. "Resident" means an individual (a) whose primary place of abode is  
52 in the state; or (b) in the case of an individual whose primary place of  
53 abode is not in the state, who is employed or self-employed full-time in  
54 the state. Resident status shall be determined without regard to the  
55 individual's immigration status, and according to regulations of the

1 commissioner. Such regulations shall include a process for appealing  
2 denials of residency.

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

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

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

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

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

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

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

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

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

51 (ii) An external appeal shall not require utilization review or an  
52 adverse determination under title one of article forty-nine of this  
53 chapter. Any reference in article forty-nine to utilization review or a  
54 universal review agent shall mean the program. Where the program makes  
55 an adverse determination, an external appeal shall be automatic unless  
56 specifically waived or withdrawn by the member or the member's designee.



1 Services, including services provided for a chronic condition, will  
2 continue unchanged until the outcome of the external appeal decision is  
3 issued. Where an external appeal is initiated or pursued by the  
4 patient's health care provider, the provider shall notify the member or  
5 the member's designee, and it shall be subject to the member's or  
6 member's designee's right to waive or withdraw the external appeal. No  
7 fee shall be required to be paid by any party in connection with an  
8 external appeal, including the member's health care provider.

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

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

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

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

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

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

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

46 (b) However, this subdivision shall not preclude the use of any  
47 program or entity where reasonably necessary to maximize federal finan-  
48 cial participation or other federal financial support under any federal-  
49 ly-subsidized public health program, including but not limited to Medi-  
50 caid, Medicare, or the Affordable Care Act, provided that such program  
51 or entity shall not deprive any member or health care provider of any  
52 right or benefit under the program under this article and otherwise  
53 consistent with this article (including but not limited to the scope of  
54 benefits; choice of health care provider; prohibition of deductibles,  
55 copayments or other co-insurance, or out-of-network charges; and payment  
56 for services) and shall, to the maximum extent feasible, operate in the

1 background, without burden on or interference with the member and health  
2 care provider.

3 9. The program shall include provisions for appropriate reserves with-  
4 in the New York health trust fund account established under section  
5 eighty-nine-k of the state finance law.

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

14 (b) This paragraph applies to the retiree while he or she is a resi-  
15 dent of New York state. The retiree shall enroll in the program. If, by  
16 the end of the implementation period, the retiree has not enrolled in  
17 the program, the commissioner shall enroll the retiree in the New York  
18 Health program. If the retiree's public employee retiree health benefit  
19 includes any service for which coverage is not offered under the New  
20 York Health program, the retiree shall continue to receive that benefit  
21 from the appropriate public employee retiree health benefit program.

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

26 § 5102. Board of trustees. 1. The New York Health board of trustees is  
27 hereby created in the department. The board of trustees shall, at the  
28 request of the commissioner, consider any matter to effectuate the  
29 provisions and purposes of this article, and may advise the commissioner  
30 thereon; and it may, from time to time, submit to the commissioner any  
31 recommendations to effectuate the provisions and purposes of this arti-  
32 cle. The commissioner may propose regulations under this article and  
33 amendments thereto for consideration by the board. The board of trustees  
34 shall have no executive, administrative or appointive duties except as  
35 otherwise provided by law. The board of trustees shall have power to  
36 establish, and from time to time, amend regulations to effectuate the  
37 provisions and purposes of this article, subject to approval by the  
38 commissioner.

39 2. The board shall be composed of:

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

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

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

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

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

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

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



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

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

5 (viii) two of whom shall be representatives of health care organiza-  
6 tions;

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

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

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

13 (c) fourteen trustees appointed by the governor; five of whom to be  
14 appointed on the recommendation of the speaker of the assembly; five of  
15 whom to be appointed on the recommendation of the temporary president of  
16 the senate; two of whom to be appointed on the recommendation of the  
17 minority leader of the assembly; and two of whom to be appointed on the  
18 recommendation of the minority leader of the senate.

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

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

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

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

42 6. Notwithstanding any provision of law to the contrary, no officer or  
43 employee of the state or any local government shall forfeit or be deemed  
44 to have forfeited their office or employment by reason of being a trus-  
45 tee.

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

49 8. No later than eighteen months after the effective date of this  
50 article:

51 (a) The board shall develop proposals for: (i) incorporating retiree  
52 health benefits into New York Health; (ii) accommodating employer reti-  
53 ree health benefits for people who have been members of New York Health  
54 but live as retirees out of the state; and (iii) accommodating employer  
55 retiree health benefits for people who earned or accrued such benefits

1 while residing in the state prior to the implementation of New York  
2 Health and live as retirees out of the state.

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

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

13 (d) The board shall develop a proposal for integration of federal  
14 veterans health administration programs with New York Health coverage of  
15 health care services; provided however that enrollment in or eligibility  
16 for federal veterans health administration programs shall not affect a  
17 resident's eligibility for New York Health coverage.

18 (e) The board shall present all proposals developed under this  
19 subdivision to the governor and the legislature.

20 § 5103. Eligibility and enrollment. 1. Every resident of the state  
21 shall be eligible and entitled to enroll as a member under the program.

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

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

27 § 5104. Benefits. 1. The program shall provide comprehensive health  
28 coverage to every member, which shall include all health care services  
29 required to be covered under any of the following, without regard to  
30 whether the member would otherwise be eligible for or covered by the  
31 program or source referred to:

32 (a) child health plus;

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

38 (c) Medicare;

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

41 (e) article eleven of the civil service law, and any employee or reti-  
42 ree health benefit plan of any public employer as defined in section two  
43 hundred one of the civil service law, as of the date one year before the  
44 beginning of the implementation period;

45 (f) the basic health plan;

46 (g) reimbursement for any costs or expenses incurred as defined in  
47 paragraph one of subsection (a) of section fifty-one hundred two of the  
48 insurance law, provided that this coverage shall not replace coverage  
49 under article fifty-one of the insurance law;

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

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

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

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

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

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

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

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

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

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

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

(iii) a health care organization;

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

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

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

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

(iii) The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coor-

1 dinator on terms at least as permissive as the provisions of section  
2 three hundred sixty-four-j of the social services law relating to an  
3 individual changing their primary care provider or managed care provid-  
4 er.

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

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

13 (e) The commissioner shall develop and implement procedures and stand-  
14 ards for an individual or entity to be approved to be a care coordinator  
15 in the program, including but not limited to procedures and standards  
16 relating to the revocation, suspension, limitation, or annulment of  
17 approval on a determination that the individual or entity is not quali-  
18 fied or competent to be a care coordinator or has exhibited a course of  
19 conduct which is either inconsistent with program standards and regu-  
20 lations or which exhibits an unwillingness to meet such standards and  
21 regulations, or is a potential threat to the public health or safety.  
22 Such procedures and standards shall not limit approval to be a care  
23 coordinator in the program for criteria other than those under this  
24 section and shall be consistent with good professional practice. In  
25 developing the procedures and standards, the commissioner shall: (i)  
26 consider existing standards developed by national accrediting and  
27 professional organizations; and (ii) consult with national and local  
28 organizations working on care coordination or similar models, including  
29 health care practitioners, hospitals, clinics, birth centers, long-term  
30 supports and service providers, consumers and their representatives, and  
31 labor organizations representing health care workers. When developing  
32 and implementing standards of approval of care coordinators for individ-  
33 uals receiving chronic mental health care services, the commissioner  
34 shall consult with the commissioner of mental health. An individual or  
35 entity may not be a care coordinator unless the services included in  
36 care coordination are within the individual's professional scope of  
37 practice or the entity's legal authority.

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

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

46 3. Health care providers. (a) The commissioner shall establish and  
47 maintain procedures and standards for health care providers to be quali-  
48 fied to participate in the program, including but not limited to proce-  
49 dures and standards relating to the revocation, suspension, limitation,  
50 or annulment of qualification to participate on a determination that the  
51 health care provider is not qualified or competent to be a provider of  
52 specific health care services or has exhibited a course of conduct which  
53 is either inconsistent with program standards and regulations or which  
54 exhibits an unwillingness to meet such standards and regulations, or is  
55 a potential threat to the public health or safety. Such procedures and  
56 standards shall not limit health care provider participation in the

1 program for criteria other than those under this section and shall be  
2 consistent with good professional practice. Such procedures and stand-  
3 ards may be different for different types of health care providers and  
4 health care professionals. The commissioner may require that health  
5 care providers and health care professionals participate in Medicaid,  
6 child health plus, or Medicare to qualify to participate in the program.  
7 Any health care provider that is qualified to participate under Medi-  
8 caid, child health plus or Medicare shall be deemed to be qualified to  
9 participate in the program, and any health care provider's revocation,  
10 suspension, limitation, or annulment of qualification to participate in  
11 any of those programs shall apply to the health care provider's quali-  
12 fication to participate in the program; provided that a health care  
13 provider qualified under this sentence shall follow the procedures to  
14 become qualified under the program by the end of the implementation  
15 period.

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

20 (c) Procedures and standards under this subdivision shall include  
21 provisions for expedited temporary qualification to participate in the  
22 program for health care professionals who are (i) temporarily authorized  
23 to practice in the state or (ii) are recently arrived in the state or  
24 recently authorized to practice in the state.

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

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

35 (iii) In determining such payment methodologies and rates, the commis-  
36 sioner shall consider factors including usual and customary rates imme-  
37 diately prior to the implementation of the program, reported in a bench-  
38 marking database maintained by a nonprofit organization specified by the  
39 superintendent of financial services, under section six hundred three of  
40 the financial services law; the level of training, education, and expe-  
41 rience of the health care provider or providers involved; and the scope  
42 of services, complexity, and circumstances of care including geographic  
43 factors. Until and unless other applicable payment methodologies are  
44 established, health care services provided to members under the program  
45 shall be paid for on a fee-for-service basis, except for care coordi-  
46 nation.

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

51 (c) (i) Prescription drugs eligible for reimbursement under this arti-  
52 cle and dispensed by a pharmacy shall be provided and paid for under the  
53 preferred drug program and the clinical drug review program under title  
54 one of article two-A of this chapter, except as otherwise provided in  
55 this paragraph.



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

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

14 (e) The program may provide in payment methodologies for payment for  
15 capital related expenses for specifically identified capital expendi-  
16 tures.

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

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

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

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

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

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

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

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

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



dures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working in the field of health care organizations, including health care practitioners, hospitals, clinics, birth centers, long-term supports and service providers, consumers and their representatives and labor organizations representing health care workers. When developing and implementing standards of approval of health care organizations, the commissioner shall consult with the commissioner of mental health, the commissioner of developmental disabilities, the director of the state office for the aging, the commissioner of the office of addiction services and supports, and the commissioner of the division of human rights.

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

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

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

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

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

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

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

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

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

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

(c) elimination of health care disparities;

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

(e) accessibility of care coordination, health care organization services and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English, and the providing of care coordination, health care organiza-

tion services and health care services in a culturally competent manner;  
and

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

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

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

5. In developing requirements and standards and making other policy determinations under this article, the commissioner shall consult with the commissioner of mental health, the commissioner of developmental disabilities, the director of the state office for the aging, the commissioner of the office of addiction services and supports, the commissioner of the division of human rights, representatives of members, health care providers, care coordinators, health care organizations employers, organized labor including representatives of health care workers, and other interested parties.

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

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

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

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

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

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

19 3. (a) The commissioner may take actions consistent with this article  
20 to enable New York Health to administer Medicare in New York state,  
21 including but not limited to actions necessary to be a provider of drug  
22 coverage under Medicare part D for eligible members of New York Health.

23 (b) The commissioner may waive or modify the applicability of  
24 provisions of this section relating to any federally-subsidized public  
25 health program or Medicare as necessary to implement any waiver or  
26 arrangement under this section or to maximize the benefit to the New  
27 York Health program under this section, provided that the commissioner,  
28 in consultation with the director of the budget, shall determine that  
29 such waiver or modification is in the best interests of the members  
30 affected by the action and the state.

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

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

1 necessary federal waivers or approvals to ensure federal financial  
2 participation.

3 (e) To enable the commissioner to apply for coverage or financial  
4 support under any federally-subsidized public health program, the  
5 Affordable Care Act, or Medicare on behalf of any member and enroll the  
6 member in any such program, including an entity under paragraph (b) of  
7 subdivision eight of section fifty-one hundred one of this article if  
8 the 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 may  
30 exceed the low-income benchmark premium amount if determined to be cost  
31 effective to the program.

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

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

49 4. No action under this section shall deprive any member or health  
50 care provider of any right or benefit under the program and shall other-  
51 wise be consistent with this article (including, but not limited to,  
52 complying with provisions of this article relating to health care  
53 provider payment levels; barring premiums, deductibles, copayments,  
54 other coinsurance and restricted provider networks; and providing for  
55 choice of provider and prescription drug coverage).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

54 (ii) Impacted employees shall be eligible for:

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



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

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

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

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

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

38 § 5111. Regional advisory councils. 1. The New York Health regional  
39 advisory councils (each referred to in this article as a "regional advi-  
40 sory council") are hereby created in the department.

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

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

44 (b) New York City;

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

28 (ii) representatives of professional organizations representing physi-  
29 cians;

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

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

33 (v) representatives of community health centers;

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

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

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

41 (ix) representatives of health care organizations;

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

44 (xi) representatives of employers; and

45 (xii) representatives of municipal and county government.

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

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

1 other expenses of the regional advisory councils. However, the board may  
2 provide for compensation in cases where a lack of compensation would  
3 limit the ability of a trustee or represented organization to partic-  
4 ipate in council business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52 (iii) "Tax" means the payroll tax or non-payroll tax to be enacted  
53 under the revenue proposal. "Payroll tax" means the tax on payroll  
54 income and self-employed income subject to the Medicare Part A tax,  
55 provided for in subdivision two of this section. "Non-payroll tax" means  
56 the tax on taxable income (such as interest, dividends, and capital

1 gains) not subject to the payroll tax, provided for in subdivision two  
2 of this section.

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

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

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

39 (ii) Each public employer, as defined in section 201 of the civil  
40 service law, shall pay a percentage of the payroll tax for each of its  
41 employees that is equal to at least the greater of (A) the percentage of  
42 the cost of the employee's health benefit that is paid by the employer  
43 as of January 1 immediately preceding the date on which this section  
44 becomes a law, or (B) a greater percentage provided by collective  
45 bargaining, or (C) eighty percent.

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

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

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

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

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

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

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

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

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

### TITLE III

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

##### Section 4920. Definitions.

4921. Collective negotiation authorized.

4922. Collective negotiation requirements.

4923. Requirements for health care providers' representative.

4924. Mediation.

4925. Certain collective action prohibited.

4926. Fees.

4927. Confidentiality.

4928. Severability and construction.

§ 4920. Definitions. For purposes of this title:

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

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

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

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

5. "Health care provider" means a health care provider under article fifty-one of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

§ 4923. Requirements for health care providers' representative. Before engaging in collective negotiations with New York Health on behalf of

1 health care providers, a health care providers' representative shall  
2 file with the commissioner, in the manner prescribed by the commission-  
3 er, information identifying the representative, the representative's  
4 plan of operation, and the representative's procedures to ensure compli-  
5 ance with this title.

6 § 4924. Mediation. 1. In the event the commissioner, or a health care  
7 providers' representative that is party to the negotiation, determines  
8 that an impasse exists in the negotiations, the commissioner shall  
9 render assistance as follows:

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

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

22 (c) the fact-finding board, acting by a majority of its members, shall  
23 transmit its findings of fact and recommendations for resolution of the  
24 dispute to the commissioner, and may thereafter assist the parties to  
25 effect a voluntary resolution of the dispute. The fact-finding board  
26 shall also share its findings of fact and recommendations with the  
27 health care providers' representative and the representative of New York  
28 Health. If within twenty days after the submission of the findings of  
29 fact and recommendations, the impasse continues, the commissioner shall  
30 order a resolution to the negotiations based upon the findings of fact  
31 and recommendations submitted by the fact-finding board.

32 § 4925. Certain collective action prohibited. 1. This title is not  
33 intended to authorize competing health care providers to act in concert  
34 in response to a health care providers' representative's discussions or  
35 negotiations with New York Health except as authorized by other law.

36 2. No health care providers' representative shall negotiate any agree-  
37 ment that excludes, limits the participation or reimbursement of, or  
38 otherwise limits the scope of services to be provided by any health care  
39 provider or group of health care providers with respect to the perform-  
40 ance of services that are within the health care provider's lawful scope  
41 or terms of practice, license, registration, or certificate.

42 § 4926. Fees. Each person who acts as the representative of negotiat-  
43 ing parties under this title shall pay to the department a fee to act as  
44 a representative. The commissioner, by regulation, shall set fees in  
45 amounts deemed reasonable and necessary to cover the costs incurred by  
46 the department in administering this title.

47 § 4927. Confidentiality. All reports and other information required to  
48 be reported to the department under this title shall not be subject to  
49 disclosure under article six of the public officers law.

50 § 4928. Severability and construction. If any provision or application  
51 of this title shall be held to be invalid, or to violate or be incon-  
52 sistent with any applicable federal law or regulation, that shall not  
53 affect other provisions or applications of this title which can be given  
54 effect without that provision or application; and to that end, the  
55 provisions and applications of this title are severable. The provisions



1 of this title shall be liberally construed to give effect to the  
2 purposes thereof.

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

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

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

17 § 89-k. New York Health trust fund. 1. There is hereby established in  
18 the joint custody of the state comptroller and the commissioner of taxa-  
19 tion and finance a special revenue fund to be known as the "New York  
20 Health trust fund", referred to in this section as "the fund". The defi-  
21 nitions in section fifty-one hundred of the public health law shall  
22 apply to this section.

23 2. The fund shall consist of:

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

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

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

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

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

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

49 § 8. Temporary commission on implementation. 1. There is hereby estab-  
50 lished a temporary commission on implementation of the New York Health  
51 program, referred to in this section as the commission, consisting of  
52 fifteen members: five members, including the chair, shall be appointed  
53 by the governor; four members shall be appointed by the temporary presi-  
54 dent of the senate, one member shall be appointed by the senate minority  
55 leader; four members shall be appointed by the speaker of the assembly,  
56 and one member shall be appointed by the assembly minority leader. The

1 commissioner of health, the superintendent of financial services, the  
2 commissioner of taxation and finance, and the director of the budget, or  
3 their designees shall serve as non-voting ex officio members of the  
4 commission.

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

11 3. The commission shall examine the laws and regulations of the state  
12 and consult with health care providers, consumers, and other stakehold-  
13 ers and make such recommendations as are necessary to conform the laws  
14 and regulations of the state and article 51 of the public health law  
15 establishing the New York Health program and other provisions of law  
16 relating to the New York Health program, and to improve and implement  
17 the program. The commission shall report its recommendations to the  
18 governor and the legislature. The commission shall immediately begin  
19 development of proposals consistent with the principles of article 51 of  
20 the public health law for provision of health care services covered  
21 under the workers' compensation law; and incorporation of retiree health  
22 benefits, as described in paragraphs (a), (b) and (c) of subdivision 8  
23 of section 5102 of the public health law. The commission shall provide  
24 its work product and assistance to the board established under section  
25 5102 of the public health law upon completion of the appointment of the  
26 board.

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

33 § 10. This act shall take effect immediately.