

STATE OF NEW YORK

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

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
16 need. New Yorkers - as individuals, employers, and taxpayers - have
17 experienced a rise in the cost of health care and coverage in recent
18 years, including rising premiums, deductibles and co-pays, restricted
19 provider networks and high out-of-network charges. Many New Yorkers go

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 51

NEW YORK HEALTH

Section 5100. Definitions.

5101. Program created.

5102. Board of trustees.

5103. Eligibility and enrollment.

5104. Benefits.

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

5106. Health care organizations.

5107. Program standards.

5108. Regulations.

5109. Provisions relating to federal health programs.

5110. Additional provisions.

5111. Regional advisory councils.

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

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

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

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

4. "Federally-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.

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

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

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

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

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

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

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

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

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

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

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

47 17. "Resident" means an individual (a) whose primary place of abode is
48 in the state; or (b) in the case of an individual whose primary place of
49 abode is not in the state, who is employed or self-employed full-time in
50 the state. Resident status shall be determined without regard to the
51 individual's immigration status, and according to regulations of the
52 commissioner. Such regulations shall include a process for appealing
53 denials of residency.

54 § 5101. Program created. 1. The New York Health program is hereby
55 created in the department. The commissioner shall establish and imple-

1 ment the program under this article. The program shall provide compre-
2 hensive health coverage to every resident who enrolls in the program.

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

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

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

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

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

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

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

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

47 (ii) An external appeal shall not require utilization review or an
48 adverse determination under title one of article forty-nine of this
49 chapter. Any reference in article forty-nine to utilization review or a
50 universal review agent shall mean the program. Where the program makes
51 an adverse determination, an external appeal shall be automatic unless
52 specifically waived or withdrawn by the member or the member's designee.
53 Services, including services provided for a chronic condition, will
54 continue unchanged until the outcome of the external appeal decision is
55 issued. Where an external appeal is initiated or pursued by the
56 patient's health care provider, the provider shall notify the member or

1 the member's designee, and it shall be subject to the member's or
2 member's designee's right to waive or withdraw the external appeal. No
3 fee shall be required to be paid by any party in connection with an
4 external appeal, including the member's health care provider.

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

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

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

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

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

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

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

42 (b) However, this subdivision shall not preclude the use of any
43 program or entity where reasonably necessary to maximize federal finan-
44 cial participation or other federal financial support under any federal-
45 ly-subsidized public health program, including but not limited to Medi-
46 caid, Medicare, or the Affordable Care Act, provided that such program
47 or entity shall not deprive any member or health care provider of any
48 right or benefit under the program under this article and otherwise
49 consistent with this article (including but not limited to the scope of
50 benefits; choice of health care provider; prohibition of deductibles,
51 copayments or other co-insurance, or out-of-network charges; and payment
52 for services) and shall, to the maximum extent feasible, operate in the
53 background, without burden on or interference with the member and health
54 care provider.

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

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

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

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

24 § 5102. Board of trustees. 1. The New York Health board of trustees is
25 hereby created in the department. The board of trustees shall, at the
26 request of the commissioner, consider any matter to effectuate the
27 provisions and purposes of this article, and may advise the commissioner
28 thereon; and it may, from time to time, submit to the commissioner any
29 recommendations to effectuate the provisions and purposes of this arti-
30 cle. The commissioner may propose regulations under this article and
31 amendments thereto for consideration by the board. The board of trustees
32 shall have no executive, administrative or appointive duties except as
33 otherwise provided by law. The board of trustees shall have power to
34 establish, and from time to time, amend regulations to effectuate the
35 provisions and purposes of this article, subject to approval by the
36 commissioner.

37 2. The board shall be composed of:

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

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

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

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

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

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

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

54 (vi) two of whom shall be representatives of rehabilitation or home
55 care providers;

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

3 (viii) two of whom shall be representatives of health care organiza-
4 tions;

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

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

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

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

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

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

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

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

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

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

47 8. No later than eighteen months after the effective date of this
48 article:

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

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

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

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

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

18 § 5103. Eligibility and enrollment. 1. Every resident of the state
19 shall be eligible and entitled to enroll as a member under the program.

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

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

25 § 5104. Benefits. 1. The program shall provide comprehensive health
26 coverage to every member, which shall include all health care services
27 required to be covered under any of the following, without regard to
28 whether the member would otherwise be eligible for or covered by the
29 program or source referred to:

30 (a) child health plus;

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

36 (c) Medicare;

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

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

43 (f) the basic health plan;

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

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

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

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

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

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

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

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

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

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

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

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

(iii) a health care organization;

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

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

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

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

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

1 individual changing their primary care provider or managed care provid-
2 er.

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

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

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

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

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

44 3. Health care providers. (a) The commissioner shall establish and
45 maintain procedures and standards for health care providers to be quali-
46 fied to participate in the program, including but not limited to proce-
47 dures and standards relating to the revocation, suspension, limitation,
48 or annulment of qualification to participate on a determination that the
49 health care provider is not qualified or competent to be a provider of
50 specific health care services or has exhibited a course of conduct which
51 is 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 health care provider participation in the
55 program for criteria other than those under this section and shall be
56 consistent with good professional practice. Such procedures and stand-

ards may be different for different types of health care providers and health care professionals. The commissioner may require that health care providers and health care professionals participate in Medicaid, child health plus, or Medicare to qualify to participate in the program. Any health care provider that is qualified to participate under Medicaid, child health plus or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified under this sentence shall follow the procedures to become qualified under the program by the end of the implementation period.

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

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

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

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

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

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

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

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

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

11 (e) The program may provide in payment methodologies for payment for
12 capital related expenses for specifically identified capital expendi-
13 tures.

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

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

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

26 § 5106. Health care organizations. 1. A member may choose to enroll
27 with and receive health care services under the program from a health
28 care organization.

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

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

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

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

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

1 field of health care organizations, including health care practitioners,
2 hospitals, clinics, birth centers, long-term supports and service
3 providers, consumers and their representatives and labor organizations
4 representing health care workers. When developing and implementing stan-
5 dards of approval of health care organizations, the commissioner shall
6 consult with the commissioner of mental health, the commissioner of
7 developmental disabilities, the director of the state office for the
8 aging, the commissioner of the office of addiction services and
9 supports, and the commissioner of the division of human rights.

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

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

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

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

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

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

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

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

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

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

43 (c) elimination of health care disparities;

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

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

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

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

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

20 5. In developing requirements and standards and making other policy
21 determinations under this article, the commissioner shall consult with
22 the commissioner of mental health, the commissioner of developmental
23 disabilities, the director of the state office for the aging, the
24 commissioner of the office of addiction services and supports, the
25 commissioner of the division of human rights, representatives of
26 members, health care providers, care coordinators, health care organiza-
27 tions employers, organized labor including representatives of health
28 care workers, and other interested parties.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52 (ii) Impacted employees shall be eligible for:

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

55 (B) up to two years of unemployment benefits, provided that the
56 impacted employee is enrolled in a department of labor approved training

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

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

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

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

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

36 § 5111. Regional advisory councils. 1. The New York Health regional
37 advisory councils (each referred to in this article as a "regional advi-
38 sory council") are hereby created in the department.

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

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

42 (b) New York City;

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

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

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

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

54 3. Each regional advisory council shall be composed of not fewer than
55 twenty-seven members, as determined by the commissioner and the board,
56 as necessary to appropriately represent the diverse needs and concerns

1 of the region. Members of a regional advisory council shall be residents
2 of or have their principal place of business in the region served by the
3 regional advisory council.

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

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

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

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

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

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

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

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

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

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

25 (ii) representatives of professional organizations representing physi-
26 cians;

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

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

30 (v) representatives of community health centers;

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

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

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

38 (ix) representatives of health care organizations;

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

41 (xi) representatives of employers; and

42 (xii) representatives of municipal and county government.

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

50 6. Members of the regional advisory councils shall serve without
51 compensation but shall be reimbursed for their necessary and actual
52 expenses incurred while engaged in the business of the advisory coun-
53 cils. The program shall provide financial support for such expenses and
54 other expenses of the regional advisory councils. However, the board may
55 provide for compensation in cases where a lack of compensation would

1 limit the ability of a trustee or represented organization to partic-
2 ipate in council business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Cross-border employees. (i) State residents employed out-of-state. If an individual is employed out-of-state by an employer that is subject to New York state law, the employer and employee shall be required to

1 pay the payroll tax as to that employee as if the employment were in the
2 state. If an individual is employed out-of-state by an employer that is
3 not subject to New York state law, either (A) the employer and employee
4 shall voluntarily comply with the tax or (B) the employee shall pay the
5 tax as if he or she were self-employed.

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

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

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

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

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

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

46 TITLE III

47 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH
48 NEW YORK HEALTH

49 Section 4920. Definitions.

50 4921. Collective negotiation authorized.

51 4922. Collective negotiation requirements.

52 4923. Requirements for health care providers' representative.

53 4924. Mediation.

54 4925. Certain collective action prohibited.

55 4926. Fees.

56 4927. Confidentiality.

1 4928. Severability and construction.

2 § 4920. Definitions. For purposes of this title:

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

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

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

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

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

16 § 4921. Collective negotiation authorized. 1. Health care providers
17 may meet and communicate for the purpose of collectively negotiating
18 with New York Health on any matter relating to New York Health, includ-
19 ing but not limited to rates of payment and payment methodologies.

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

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

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

30 § 4922. Collective negotiation requirements. 1. Collective negotiation
31 rights granted by this title must conform to the following requirements:

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

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

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

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

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

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

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

52 § 4923. Requirements for health care providers' representative. Before
53 engaging in collective negotiations with New York Health on behalf of
54 health care providers, a health care providers' representative shall
55 file with the commissioner, in the manner prescribed by the commission-
56 er, information identifying the representative, the representative's

1 plan of operation, and the representative's procedures to ensure compli-
2 ance with this title.

3 § 4924. Mediation. 1. In the event the commissioner, or a health care
4 providers' representative that is party to the negotiation, determines
5 that an impasse exists in the negotiations, the commissioner shall
6 render assistance as follows:

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

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

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

29 § 4925. Certain collective action prohibited. 1. This title is not
30 intended to authorize competing health care providers to act in concert
31 in response to a health care providers' representative's discussions or
32 negotiations with New York Health except as authorized by other law.

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

39 § 4926. Fees. Each person who acts as the representative of negotiat-
40 ing parties under this title shall pay to the department a fee to act as
41 a representative. The commissioner, by regulation, shall set fees in
42 amounts deemed reasonable and necessary to cover the costs incurred by
43 the department in administering this title.

44 § 4927. Confidentiality. All reports and other information required to
45 be reported to the department under this title shall not be subject to
46 disclosure under article six of the public officers law.

47 § 4928. Severability and construction. If any provision or application
48 of this title shall be held to be invalid, or to violate or be incon-
49 sistent with any applicable federal law or regulation, that shall not
50 affect other provisions or applications of this title which can be given
51 effect without that provision or application; and to that end, the
52 provisions and applications of this title are severable. The provisions
53 of this title shall be liberally construed to give effect to the
54 purposes thereof.

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

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

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

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

2. The fund shall consist of:

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

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

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

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

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

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

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

1 their designees shall serve as non-voting ex officio members of the
2 commission.

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

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

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

31 § 10. This act shall take effect immediately.