STATE OF NEW YORK

4545

2025-2026 Regular Sessions

IN ASSEMBLY

February 4, 2025

Introduced by M. of A. JENSEN -- read once and referred to the Committee on Health

AN ACT to amend the tax law and the public health law, in relation to providing expanded enrollment through New York state of health through tax returns (Part A); to amend the public health law, in relation to allowing for enrollment through the New York state of health at any time for first-time enrollees (Part B); to amend the insurance law and the legislative law, in relation to creating the New York health benefit and cost commission; and to repeal section 213 of the insurance law relating thereto (Part C); and to amend the public health law and the tax law, in relation to establishing New York health care savings accounts to expand and incentivize purchasing private health insurance (Part D)

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

Section 1. Short title. This act shall be known and may be cited as the "real choice health act".

§ 2. Legislative intent. The Legislature recognizes the importance of ensuring a robust and responsive healthcare system that meets the needs and preferences of its residents. Although significant improvements have been made to reduce the number of uninsured New Yorkers and control costs, there is still substantial work to be done. However, despite the need to ensure that more New Yorkers are insured and can afford their healthcare costs, preserving individual choices in healthcare is paramount. Although some argue that a single-payer system in the State of New York would improve access and reduce costs, doing so would eliminate important healthcare choices for many New Yorkers by creating blanket State coverage, require significant tax increases on individuals and businesses in New York, which would further perpetuate our outmigration problem, create potential domestic migration of individuals with costly adverse health issues, eliminate jobs by dismantling the health insur-

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

LBD08297-01-5

ance industry and lead to voluntary unemployment without the need for employer-based coverage and require continued and expanded reliance on the Federal government for funding and waivers. The single-payer system would place the responsibility of healthcare for all New Yorkers solely in the hands of the State, exposing healthcare needs to even more political pressures. New York State government has proven that it has difficulty administrating large programs effectively and without mismanagement, with both the existing Medicaid program and the roll-out of legal recreational cannabis serving as important examples.

Moving forward, New York should continue to improve on the positive changes in the current system that have been made thus far. Doing so would continue to enable a competitive healthcare system that encourages innovation and drives continuous improvements in care, ensuring access to cutting-edge treatments and technologies for all residents. This system would ensure that the opinions and preferences of the population would continue to shape the healthcare system.

Therefore, this proposal focuses on preserving individual choices by improving access to health insurance enrollment through expanded enrollment period and enhanced outreach, creating a State process for analyzing costs before significant health insurance changes are made, and incentivizing individuals to purchase health insurance and reduce out-of-pocket costs by creating a New York health care savings account.

§ 3. This act enacts into law major components of legislation providing expanded enrollment through New York state of health through tax returns, allowing for enrollment through the New York state of health at any time for first-time enrollees, expanding New York state of health navigator program, creating the New York health benefit and cost commission, and establishing New York health care savings accounts to expand and incentivize purchasing private health insurance. Each component is wholly contained within a Part identified as Parts A through D. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes reference to a section "of this act," when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found.

PART A

Section 1. The tax law is amended by adding a new section 664 to read as follows:

§ 664. Health marketplace eligibility. The commissioner shall require that all income tax returns allow the taxpayer to request, by checking a box, to be included on the return, that the department of health review relevant and necessary taxpayer data in order to provide the taxpayer with information related to their eligibility for health marketplace programs, plans, and available incentives. Adjacent to such box, there shall be a statement in prominent type, "IF YOU CHECK THIS BOX, YOU AFFIRM THAT YOU ARE UNINSURED, DO NOT HAVE EMPLOYER-SPONSORED COVERAGE AVAILABLE, AND ARE (1) REQUESTING THAT THE STATE DEPARTMENT OF HEALTH REVIEW NECESSARY PORTIONS OF YOUR TAX FILING, (2) USE SUCH DATA AS NECESSARY TO MAKE DETERMINATIONS AS TO YOUR ELIGIBILITY FOR MEDICAL ASSISTANCE (MEDICAID), THE BASIC HEALTH PLAN (ESSENTIAL PLAN), OR PLANS THROUGH THE NY STATE OF HEALTH AND AVAILABLE INCENTIVES, AND (3) CONTACT YOU TO PROVIDE SUCH ELIGIBILITY INFORMATION."

§ 2. Section 206 of the public health law is amended by adding a new subdivision 32 to read as follows:

32. The commissioner shall create a program within the department to assist uninsured individuals without employer-sponsored coverage with enrolling in health insurance coverage through state income tax filings. This program shall:

(a) review relevant and necessary taxpayer data authorized under the tax law within thirty days of receiving such authorization;

(b) contact individuals who opt to have their tax filings reviewed within thirty days of such review;

(c) determine whether an individual is eligible for medical assistance, child health insurance plan, or basic health plan coverage;

(d) upon determining an individual is eligible for medical assistance, child health insurance plan, or basic health plan coverage, offer such individuals an invitation to select a plan, provided that the individual does not have employer-sponsored coverage available; and

(e) in the case of individuals ineligible for medical assistance, child health insurance plan, or basic health plan coverage, provide a referral to a navigator certified under subdivision fifteen of section two hundred sixty-eight-c of this chapter.

§ 3. This act shall take effect on the first of January next succeeding the date on which it shall have become a law.

PART B

Section 1. Subdivisions 5 and 15 of section 268-c of the public health law, as added by section 2 of part T of chapter 57 of the laws of 2019, are amended to read as follows:

5. Maintain enrollment periods in the best interest of qualified individuals consistent with federal and state law. **Such periods shall include, but may not be limited to:**

(a) allowing special enrollment at any time for currently uninsured individuals enrolling in the Marketplace for the first time who do not have employer-sponsored coverage available; and

(b) allowing special enrollment for uninsured individuals who do not have employer-sponsored coverage available enrolling through the established income tax return process.

15. Operate a program under which the Marketplace awards grants to entities to serve as navigators in accordance with applicable federal law and regulations adopted thereunder, and/or a program under which the Marketplace awards grants to entities to provide community based enrollment assistance in accordance with requirements developed by the Marketplace; and/or a program under which the Marketplace certifies New York state licensed producers to provide assistance to eligible individuals and/or small employers pursuant to federal or state law. **Subject to appropriation, additional grants shall be awarded on an annual basis to providers in the city of New York and counties where the rate of uninsured individuals below four hundred percent of the federal poverty level is above the statewide average.**

§ 2. This act shall take effect on the first of January next succeeding the date on which it shall have become a law.

PART C

Section 1. The insurance law is amended by adding a new section 3221-a to read as follows:

§ 3221-a. Health benefit and cost commission. (a) For the purposes of this section, "mandated health benefit" shall mean any requirement that individual, group or blanket accident and health insurance policies or contracts issued by hospital or health service corporations include:

(1) coverage for specific health services, treatment, tests, drugs, supplies, or equipment to diagnose or treat a particular disease or condition; and

(2) coverage for services of specific providers of health care services.

(b) There is hereby created a commission within the department, to be known as the "New York health benefit and cost commission" consisting of thirteen members to be appointed as follows: three to be appointed by the governor, three to be appointed by the temporary president of the senate, three to be appointed by the speaker of the assembly, and one each to be appointed by the minority leader of the senate and the assembly. The superintendent and the commissioner of health, or their designated representatives, shall also serve as members of the commission. The members shall elect a person to serve as chair.

(c) Each member shall serve for a term of four years. Vacancies shall be appointed in the same manner as original appointments. The members of the commission shall receive no compensation for their services but shall be allowed actual and necessary expenses incurred in the performance of their duties. The commission may request and shall receive from any department, board, bureau, commission, office, agency, or other instrumentality of the state such facilities, assistance, and data as it deems necessary or desirable for the proper execution of its powers and duties. The commission may seek the assistance and advice of any person, organization, or entity as may be relevant or necessary and may hire or contract with any such person, organization, or entity. The commission shall have the power to hold public hearings and solicit testimony on any matter it deems relevant to carrying out its mission.

§ 2. The legislative law is amended by adding a new section 52-a to read as follows:

§ 52-a. Requirements with respect to bills affecting mandated health benefits. 1. For purposes of this section, the terms "mandated health benefits" shall have the same meanings that they have in section three thousand two hundred twenty-one-a of the insurance law.

2. In addition to any other fiscal note required, a bill that enacts or amends any law in relation to mandating health benefits shall be accompanied by an impact statement consisting of a fiscal note separately stating the estimated cost of the health benefits mandate in the bill for the first year it is to be in effect and for the next succeeding year, as well as a statement of the public purpose to be served by such mandate.

3. The commission shall conduct a review and public comment period and issue a report relating to legislation that would enact a mandated health benefit. Such issuance shall:

(a) consider and summarize all public comment and all scientific, medical, and actuarial data and information provided or obtained relating to the proposed mandated health benefit;

(b) report on public and patient health issues, including:

(i) the extent to which the proposed mandated health benefit is available and utilized by the state's population and the level of public demand for the benefit;

(ii) the extent to which the proposed mandated health benefit is already a covered health benefit;

(iii) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care and results in financial hardship for those needing such care;

(iv) projected utilization rates and access to service that would result from the proposed mandated health benefit;

(v) whether the proposed mandated health benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and managed health care; and

(vi) the extent to which the proposed mandated health benefit is generally recognized by the medical community as being effective and efficacious, including appropriate review by scientific and medical peer review literature; and

(c) report on access to coverage and economic issues, including:

(i) the impact on premiums, rates, and costs of health coverage in all affected markets;

(ii) the impact that the proposed mandated health benefit may have on the availability of other benefits;

(iii) the impact that the proposed mandated health benefit may have on the availability of health coverage in each affected market and the impact on the number of persons covered through self-insured plans; and

(iv) report on any other matter, question, or concern relating to a mandated health benefit as may be determined relevant by the commission or by the person having issued the request.

4. The commission shall allow a thirty-day public comment period and issue a report to the governor and the legislature within ninety days after receipt of a written request. The commission may extend its review period and reporting time upon the consent of the person having issued the request.

5. The commission shall review and report on utilization rates, public and patient health effects, and impact on premiums and access to health care and health coverage of all mandated health benefits existing on the effective date of this section.

§ 3. Section 213 of the insurance law is REPEALED.

§ 4. This act shall take effect immediately.

PART D

Section 1. Short title. This act shall be known and may be cited as the "New York health care savings act".

§ 2. The public health law is amended by adding a new article 48-A to read as follows:

ARTICLE 48-A

NEW YORK STATE HEALTH CARE SAVINGS PROGRAM

Section 4850. Program established.

4851. Purposes.

4852. Definitions.

4853. Functions of the comptroller and the corporation.

4854. Powers of the comptroller.

4855. Program requirements; New York state health care savings account.

4856. Program limitations; New York state health care savings account.

§ 4850. Program established. There is hereby established the New York state health care savings program and such program shall be known and may be cited as the "New York state health care savings program".

§ 4851. Purposes. The purposes of the New York state health care savings program shall be to authorize the establishment of New York state health care savings accounts and to provide guidelines for the maintenance of such accounts.

§ 4852. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "Account" or "New York health care savings account" shall mean an individual or family savings account established in accordance with the provisions of this article.

2. "Account owner" shall mean a person who enters into a health care savings agreement pursuant to the provisions of this article, including a person who enters into such an agreement as a fiduciary or agent on behalf of a trust, estate, partnership, association, company or corporation. The account owner may also be the designated beneficiary of the account.

3. "Designated beneficiary" shall mean, with respect to an account or accounts, the individual designated as the individual whose health care expenses are expected to be paid from the account or accounts.

4. "Financial organization" shall mean an organization authorized to do business in the state of New York and:

(a) which is an authorized fiduciary to act as a trustee pursuant to the provisions of an act of congress entitled "Employee Retirement Income Security Act of 1974" as such provisions may be amended from time to time, or an insurance company;

(b) (i) is licensed or chartered by the department of financial services;

(ii) is chartered by an agency of the federal government;

(iii) is subject to the jurisdiction and regulation of the securities and exchange commission of the federal government; or

(iv) is any other entity otherwise authorized to act in this state as a trustee pursuant to the provisions of an act of congress entitled "Employee Retirement Income Security Act of 1974" as such provisions may be amended from time to time.

5. "Member of the family" shall mean a family member as defined in section five hundred twenty-nine of the Internal Revenue Code of 1986, as amended.

6. "Program" shall mean the New York state health care savings program established pursuant to this article.

7. "Qualified health care expenses" shall mean any health care-related expense including but not limited to: premiums, deductibles, copays, long-term care, and any out-of-pocket expense incurred by the designated beneficiary or their member of the family eligible for such expense.

8. "Qualified withdrawal" shall mean a withdrawal from an account to pay the qualified health care expenses of the designated beneficiary of the account.

9. "Nonqualified withdrawal" shall mean a withdrawal from an account, but shall not mean:

(a) a qualified withdrawal; or

(b) a withdrawal made as the result of the death or disability of the designated beneficiary of an account.

10. "Department" shall mean the department of health of the state of New York.

11. "Comptroller" shall mean the comptroller of the state of New York.

12. "Management contract" shall mean the contract executed by the comptroller and a financial organization selected to act as a depository and manager of the program.

13. "Health care savings agreement" shall mean an agreement between the comptroller or a financial organization and the account owner.

14. "Program manager" shall mean a financial organization selected by the comptroller to act as a depository and manager of the program.

§ 4853. Functions of the comptroller and the corporation. 1. The comptroller and the department shall implement the program under the terms and conditions established by this article and a memorandum of understanding relating to any terms or conditions not otherwise expressly provided for in this article.

2. In furtherance of such implementation the memorandum of understanding shall address the authority and responsibility of the comptroller and the department to:

(a) develop and implement the program in a manner consistent with the provisions of this article through rules and regulations established in accordance with the state administrative procedure act;

(b) engage the services of consultants on a contract basis for rendering professional and technical assistance and advice;

(c) seek rulings and other guidance from the United States department of treasury and the internal revenue service relating to the program;

(d) seek federal waivers in order for the participants in the program to obtain the federal income tax benefits or treatment provided by section two hundred twenty-three of the Internal Revenue Code of 1986, as amended, or any similar successor legislation;

(e) charge, impose, and collect administrative fees and service charges in connection with any agreement, contract or transaction relating to the program;

(f) develop marketing plans and promotion material;

(g) establish the methods by which the funds held in such accounts be dispersed;

(h) establish the method by which funds shall be allocated to pay for administrative costs; and

(i) do all things necessary and proper to carry out the purposes of this article.

§ 4854. Powers of the comptroller. 1. The comptroller may implement the program through use of financial organizations as account depositories and managers. Under the program, individuals may establish accounts directly with an account depository.

2. The comptroller may solicit proposals from financial organizations to act as depositories and managers of the program. Financial organizations submitting proposals shall describe the investment instrument which will be held in accounts. The comptroller shall select as program depositories and managers the financial organization, from among the bidding financial organizations that demonstrates the most advantageous combination, both to potential program participants and this state, of the following factors:

(a) financial stability and integrity of the financial organization;

(b) the safety of the investment instrument being offered;

(c) the ability of the investment instrument to track increasing costs of health care;

(d) the ability of the financial organization to satisfy recordkeeping and reporting requirements;

(e) the financial organization's plan for promoting the program and the investment it is willing to make to promote the program;

(f) the fees, if any, proposed to be charged to persons for opening accounts;

(g) the minimum initial deposit and minimum contributions that the financial organization will require;

(h) the ability of financial organizations to accept electronic withdrawals, including payroll deduction plans; and

(i) other benefits to the state or its residents included in the proposal, including fees payable to the state to cover expenses of operation of the program.

3. The comptroller may enter into a contract with a financial organization. Such financial organization management may provide one or more types of investment instrument.

4. The comptroller may select more than one financial organization for the program.

5. A management contract shall include, at a minimum, terms requiring the financial organization to:

(a) take any action required to keep the program in compliance with requirements of section four thousand eight hundred fifty-five of this article;

(b) keep adequate records of each account, keep each account segregated from each other account, and provide the comptroller with the information necessary to prepare the statements required by section four thousand eight hundred fifty-five of this article;

(c) compile and total information contained in statements required to be prepared under section four thousand eight hundred fifty-five of this article and provide such compilations to the comptroller;

(d) if there is more than one program manager, provide the comptroller with such information necessary to determine compliance with section four thousand eight hundred fifty-five of this article;

(e) provide the comptroller or their designee access to the books and records of the program manager to the extent needed to determine compliance with the contract;

(f) hold all accounts for the benefit of the account owner;

(g) be audited at least annually by a firm of certified public accountants selected by the program manager and that the results of such audit be provided to the comptroller;

(h) provide the comptroller with copies of all regulatory filings and reports made by it during the term of the management contract or while it is holding any accounts, other than confidential filings or reports that will not become part of the program. The program manager shall make available for review by the comptroller the results of any periodic examination of such manager by any state or federal banking, insurance, or securities commission, except to the extent that such report or reports may not be disclosed under applicable law or the rules of such commission; and

(i) ensure that any description of the program, whether in writing or through the use of any media, is consistent with the marketing plan developed in the memorandum of understanding pursuant to the provisions of section four thousand eight hundred fifty-three of this article.

6. The comptroller may provide that an audit shall be conducted of the operations and financial position of the program depository and manager at any time if the comptroller has any reason to be concerned about the financial position, the recordkeeping practices, or the status of accounts of such program depository and manager.

7. During the term of any contract with a program manager, the comptroller shall conduct an examination of such manager and its handling of accounts. Such examination shall be conducted at least biennially if such manager is not otherwise subject to periodic examination by the

superintendent of financial services, the federal deposit insurance corporation or other similar entity.

8. (a) If selection of a financial organization as a program manager or depository is not renewed, after the end of its term:

(i) accounts previously established and held in an investment instrument at such financial organization may be terminated;

(ii) additional contributions may be made to such accounts;

(iii) no new accounts may be placed with such financial organization; and

(iv) existing accounts held by such depository shall remain subject to all oversight and reporting requirements established by the comptroller.

(b) If the comptroller terminates a financial organization as a program manager or depository, they shall take custody of accounts held by such financial organization and shall seek to promptly transfer such accounts to another financial organization that is selected as a program manager or depository and into investment instruments as similar to the original instruments as possible.

9. The comptroller may enter into such contracts as necessary and proper for the implementation of the program.

§ 4855. Program requirements; New York state health care savings account. 1. New York health care savings accounts established pursuant to the provisions of this article shall be governed by the provisions of this section.

2. A New York health care savings account may be opened by any person who desires to save money for the payment of the qualified health care-related expenses of the designated beneficiary or their member of the family. An account owner may designate another person as successor owner of the account in the event of the death of the original account owner. Such person who opens an account or any successor owner shall be considered the account owner as defined in section four thousand eight hundred fifty-two of this article.

(a) An application for such account shall be in the form prescribed by the program and contain the following:

(i) the name, address and social security number or employer identification number of the account owner;

(ii) the designation of a designated beneficiary;

(iii) the name, address, and social security number of the designated beneficiary; and

(iv) such other information as the program may require.

(b) The comptroller and the department may establish a nominal fee for such application.

3. Any person, including the account owner, may make contributions to the account after the account is opened.

4. Contributions to accounts may be made in cash or may be deposited by a taxpayer who has elected to contribute all or a portion of a refund of personal income tax to an account that has been established under this article.

(a) Taxpayer contributions shall be made by direct deposit to the designated account. The amount elected to be contributed by the taxpayer must be at least twenty-five dollars and may be applied as a contribution only for the tax year in which the refund is issued.

(b) The election shall be made on a form prescribed by the department of taxation and finance and filed with the taxpayer's tax return for the tax year or at such other time and in such other manner as the department may prescribe. The department shall prescribe the maximum number of

accounts to which a taxpayer may elect to contribute a portion of the refund.

(c) The election to contribute all or a portion of a refund shall not be revocable.

(d) All or a portion of a refund may not be contributed to an account that has been established under this article if the amount of the taxpayer's elected refund for such tax year is reduced by any other sections of the tax law to the amount less than the minimum amount of contribution authorized under this section.

5. An account owner may withdraw all or part of the balance from an account on sixty days notice or such shorter period as may be authorized under rules governing the program. Such rules shall include provisions that will generally enable the determination as to whether a withdrawal is a nonqualified withdrawal or a qualified withdrawal.

6. (a) An account owner may change the designated beneficiary of an account to an individual who is a member of the family of the prior designated beneficiary in accordance with procedures established by the memorandum of understanding pursuant to the provisions of section four thousand eight hundred fifty-three of this article.

(b) An account owner may transfer all or a portion of an account to another New York health care savings account, the subsequent designated beneficiary of which is a member of the family.

(c) Changes in designated beneficiaries and transfers under this subdivision shall not be permitted to the extent that they would cause all accounts for the same beneficiary to exceed the permitted aggregate maximum account balance.

7. The program shall provide separate accounting for each designated beneficiary.

8. No account owner or designated beneficiary of any account shall be permitted to direct the investment of any contributions to an account or the earnings thereon more than two times in any calendar year.

9. Neither an account owner nor a designated beneficiary may use an interest in an account as security for a loan. Any pledge of an interest in an account shall be of no force and effect.

10. The comptroller shall promulgate rules or regulations to prevent contributions on behalf of a designated beneficiary in excess of an amount that would cause the aggregate account balance for all accounts for a designated beneficiary to exceed a maximum account balance, as established from time to time by the comptroller and the department on the basis of health care costs in the state, with adequate safeguards to prevent more contributions than necessary to provide for qualified health care expenses of the beneficiary or their member of the family.

11. (a) If there is any distribution from an account to any individual or for the benefit of any individual during a calendar year, such distribution shall be reported to the internal revenue service and the account owner, the designated beneficiary, or the distributee to the extent required by federal law or regulation.

(b) Statements shall be provided to each account owner at least once each year within sixty days after the end of the twelve month period to which they relate. The statement shall identify the contributions made during a preceding twelve month period, the total contributions made to the account through the end of the period, the value of the account at the end of such period, distributions made during such period and any other information that the comptroller shall require to be reported to the account owner.

(c) Statements and information relating to accounts shall be prepared and filed to the extent required by federal and state tax law.

12. (a) A local government or organization described in section 501(c)(3) of the Internal Revenue Code of 1986, as amended, may open and become the account owner of an account to fund qualified health care expenses for persons whose identity will be determined upon disbursement.

(b) In the case of any account opened pursuant to paragraph (a) of this subdivision the requirement set forth in subdivision two of this section that a designated beneficiary be designated when an account is opened shall not apply and each individual who receives an interest in such account as a qualified health care expense shall be treated as a designated beneficiary with respect to such interest.

13. An annual fee may be imposed upon the account owner for the maintenance of the account.

14. The program shall disclose the following information in writing to each account owner and prospective account owner of a New York health care savings account:

(a) the terms and conditions for purchasing a New York health care savings account;

(b) any restrictions on the substitution of beneficiaries;

(c) the person or entity entitled to terminate the New York health care savings account;

(d) the period of time during which a beneficiary may receive benefits under the health care savings agreement;

(e) the terms and conditions under which money may be wholly or partially withdrawn from the program, including, but not limited to, any reasonable charges and fees that may be imposed for withdrawal;

(f) the probable tax consequences associated with contributions to and distributions from accounts; and

(g) all other rights and obligations pursuant to health care savings agreements, and any other terms, conditions, and provisions deemed necessary and appropriate by the terms of the memorandum of understanding entered into pursuant to section four thousand eight hundred fifty-three of this article.

15. Health care savings agreements shall be subject to section fourteen-c of the banking law and the "truth-in-savings" regulations promulgated thereunder.

§ 4856. Program limitations; New York state health care savings account. 1. Nothing in this article shall be construed to:

(a) give any designated beneficiary any rights or legal interest with respect to an account unless the designated beneficiary is the account owner;

(b) create state residency for an individual merely because the individual is a designated beneficiary or their member of the family; or

(c) guarantee that amounts saved pursuant to the program will be sufficient to cover the qualified health care expenses of a designated beneficiary or their member of the family.

2. (a) Nothing in this article shall create or be construed to create any obligation of the comptroller, the state, or any agency or instrumentality of the state to guarantee for the benefit of any account owner or designated beneficiary with respect to:

(i) the rate of interest or other return on any account; and

(ii) the payment of interest or other return on any account.

(b) The comptroller and the department by rule or regulation shall provide that every contract, application, deposit slip, or other similar

document that may be used in connection with a contribution to an account clearly indicate that the account is not insured by the state and neither the principal deposited nor the investment return is guaranteed by the state.

§ 3. Subsection (b) of section 612 of the tax law is amended by adding a new paragraph 44 to read as follows:

(44) (A) Excess distributions received during the taxable year by a distributee of a New York health care savings account established under the New York health care savings program provided for under article forty-eight-A of the public health law, to the extent such excess distributions are deemed attributable to deductible contributions under paragraph forty-eight of subsection (c) of this section.

(B) (i) The term "excess distributions" means distributions which are not:

(I) qualified withdrawals within the meaning of subdivision eight of section four thousand eight hundred fifty-two of the public health law;

(II) withdrawals made as a result of the death or disability of the designated beneficiary within the meaning of subdivision nine of section four thousand eight hundred fifty-four of the public health law; or

(III) transfers described in paragraph b of subdivision six of section four thousand eight hundred fifty-five of the public health law.

(ii) Excess distributions shall be deemed attributable to deductible contributions to the extent the amount of any such excess distribution, when added to all previous excess distributions from the account, exceeds the aggregate of all nondeductible contributions to the account.

§ 4. Subsection (c) of section 612 of the tax law is amended by adding two new paragraphs 48 and 49 to read as follows:

(48) Contributions made during the taxable year by an account owner to one or more New York health care savings accounts established under the New York health savings program provided for under article forty-eight-A of the public health law, to the extent not deductible or eligible for credit for federal income tax purposes; provided, however, the exclusion provided for in this paragraph shall not exceed five thousand dollars for an individual or head of household, and for married couples who file joint tax returns, shall not exceed ten thousand dollars; provided, further, that such exclusion shall be available only to the account owner and not to any other person.

(49) Distributions from a New York health care savings account established under the New York state health care savings program provided for under article forty-eight-A of the public health law, to the extent includible in gross income for federal income tax purposes.

§ 5. This act shall take effect immediately and shall apply to taxable years beginning on or after the first of January next succeeding the date on which it shall have become a law.

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

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