# STATE OF NEW YORK

4840--A

2017-2018 Regular Sessions

# IN SENATE

March 3, 2017

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Introduced by Sens. RIVERA, ADDABBO, ALCANTARA, AVELLA, BAILEY, BENJAMIN, BRESLIN, BROOKS, CARLUCCI, COMRIE, DILAN, GIANARIS, HAMILTON, HOYLMAN, KAMINSKY, KENNEDY, KLEIN, KRUEGER, MONTGOMERY, PARKER, PERALTA, PERSAUD, SANDERS, SAVINO, SERRANO, STAVISKY, STEWART-COUSINS, VALESKY -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- recommitted to the Committee on Health in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law and the state finance law, in relation to enacting the "New York health act" and to 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. New Yorkers - as individuals, employers, and
13 taxpayers - have experienced a rise in the cost of health care and
14 coverage in recent years, including rising premiums, deductibles and
15 co-pays, restricted provider networks and high out-of-network charges.
16 Many New Yorkers go without health care because they cannot afford it or
17 suffer financial hardship to get it. Businesses have also experienced

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

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1 increases in the costs of health care benefits for their employees, and
2 many employers are shifting a larger share of the cost of coverage to
3 their employees or dropping coverage entirely. Health care providers
4 are also affected by inadequate health coverage in New York state. A
5 large portion of hospitals, health centers and other providers now expe-
6 rience substantial losses due to the provision of care that is uncompen-
7 sated. Individuals often find that they are deprived of affordable care
8 and choice because of decisions by health plans guided by the plan's
9 economic interests rather than the individual's health care needs. To
10 address the fiscal crisis facing the health care system and the state
11 and to assure New Yorkers can exercise their right to health care,
12 affordable and comprehensive health coverage must be provided. Pursuant
13 to the state constitution's charge to the legislature to provide for the
14 health of New Yorkers, this legislation is an enactment of state concern
15 for the purpose of establishing a comprehensive universal guaranteed
16 health care coverage program and a health care cost control system for
17 the benefit of all residents of the state of New York.
18 2. (a) It is the intent of the Legislature to create the New York
19 Health program to provide a universal single payer health plan for every
20 New Yorker, funded by broad-based revenue based on ability to pay. The
21 state shall work to obtain waivers and other approvals relating to Medi-
22 caid, Child Health Plus, Medicare, the Affordable Care Act, and any
23 other appropriate federal programs, under which federal funds and other
24 subsidies that would otherwise be paid to New York State, New Yorkers,
25 and health care providers for health coverage that will be equaled or
26 exceeded by New York Health will be paid by the federal government to
27 New York State and deposited in the New York Health trust fund, or paid
28 to health care providers and individuals in combination with New York
29 Health trust fund payments, and for other program modifications (includ-
30 ing elimination of cost sharing and insurance premiums). Under such
31 waivers and approvals, health coverage under those programs will, to the
32 maximum extent possible, be replaced and merged into New York Health,
33 which will operate as a true single-payer program.
34 (b) If any necessary waiver or approval is not obtained, the state
35 shall use state plan amendments and seek waivers and approvals to maxi-
36 mize, and make as seamless as possible, the use of federally-matched
37 health programs and federal health programs in New York Health. Thus,
38 even where other programs such as Medicaid or Medicare may contribute to
39 paying for care, it is the goal of this legislation that the coverage
40 will be delivered by New York Health and, as much as possible, the
41 multiple sources of funding will be pooled with other New York Health
42 funds and not be apparent to New York Health members or participating
43 providers.
44 (c) This program will promote movement away from fee-for-service
45 payment, which tends to reward quantity and requires excessive adminis-
46 trative expense, and towards alternate payment methodologies, such as
47 global or capitated payments to providers or health care organizations,
48 that promote quality, efficiency, investment in primary and preventive
49 care, and innovation and integration in the organizing of health care.
50 (d) The program shall promote the use of clinical data to improve the
51 quality of health care and public health, consistent with protection of
52 patient confidentiality. The program shall maximize patient autonomy in
53 choice of health care providers and health care decision making.
54 3. This act does not create any employment benefit, nor does it
55 require, prohibit, or limit the providing of any employment benefit.

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1 4. In order to promote improved quality of, and access to, health care
2 services and promote improved clinical outcomes, it is the policy of the
3 state to encourage cooperative, collaborative and integrative arrange-
4 ments among health care providers who might otherwise be competitors,
5 under the active supervision of the commissioner of health. It is the
6 intent of the state to supplant competition with such arrangements and
7 regulation only to the extent necessary to accomplish the purposes of
8 this act, and to provide state action immunity under the state and
9 federal antitrust laws to health care providers, particularly with
10 respect to their relations with the single-payer New York Health plan
11 created by this act.
12 § 3. Article 50 and sections 5000, 5001, 5002 and 5003 of the public
13 health law are renumbered article 80 and sections 8000, 8001, 8002 and
14 8003, respectively, and a new article 51 is added to read as follows:
15 ARTICLE 51
16 NEW YORK HEALTH
17 Section 5100. Definitions.
18 5101. Program created.
19 5102. Board of trustees.
20 5103. Eligibility and enrollment.
21 5104. Benefits.
22 5105. Health care providers; care coordination; payment method-
23 ologies.
24 5106. Health care organizations.
25 5107. Program standards.
26 5108. Regulations.
27 5109. Provisions relating to federal health programs.
28 5110. Additional provisions.
29 5111. Regional advisory councils.
30 § 5100. Definitions. As used in this article, the following terms
31 shall have the following meanings, unless the context clearly requires
32 otherwise:
33 1. "Board" means the board of trustees of the New York Health program
34 created by section fifty-one hundred two of this article, and "trustee"
35 means a trustee of the board.
36 2. "Care coordination" means, but is not limited to, managing, refer-
37 ring to, locating, coordinating, and monitoring health care services for
38 the member to assure that all medically necessary health care services
39 are made available to and are effectively used by the member in a timely
40 manner, consistent with patient autonomy. Care coordination does not
41 include a requirement for prior authorization for health care services
42 or for referral for a member to receive a health care service.
43 3. "Care coordinator" means an individual or entity approved to
44 provide care coordination under subdivision two of section fifty-one
45 hundred five of this article.
46 4. "Federally-matched public health program" means the medical assist-
47 ance program under title eleven of article five of the social services
48 law, the basic health program under section three hundred sixty-nine-gg
49 of the social services law, and the child health plus program under
50 title one-A of article twenty-five of this chapter.
51 5. "Health care organization" means an entity that is approved by the
52 commissioner under section fifty-one hundred six of this article to
53 provide health care services to members under the program.
54 6. "Health care provider" means any individual or entity legally
55 authorized to provide a health care service under Medicaid or Medicare
56 or this article. "Health care professional" means a health care provider

1 that is an individual licensed, certified, registered or otherwise
2 authorized to practice under title eight of the education law to provide
3 such health care service, acting within his or her lawful scope of prac-
4 tice.
5 7. "Health care service" means any health care service, including care
6 coordination, included as a benefit under the program.
7 8. "Implementation period" means the period under subdivision three of
8 section fifty-one hundred one of this article during which the program
9 will be subject to special eligibility and financing provisions until it
10 is fully implemented under that section.
11 9. "Long term care" means long term care, treatment, maintenance,
12 services and supports, with the exception of short term rehabilitation
13 and short term home care, as defined by the commissioner.
14 10. "Medicaid" or "medical assistance" means title eleven of article
15 five of the social services law and the program thereunder. "Child
16 health plus" means title one-A of article twenty-five of this chapter
17 and the program thereunder. "Medicare" means title XVIII of the federal
18 social security act and the programs thereunder. "Affordable care act"
19 means the federal patient protection and affordable care act, public law
20 111-148, as amended by the health care and education reconciliation act
21 of 2010, public law 111-152, and as otherwise amended and any regu-
22 lations or guidance issued thereunder. "Basic health program" means
23 section three hundred sixty-nine-gg of the social services law and the
24 program thereunder.
25 11. "Member" means an individual who is enrolled in the program.
26 12. "New York Health", "New York Health program", and "program" mean
27 the New York Health program created by section fifty-one hundred one of
28 this article.
29 13. "New York Health trust fund" means the New York Health trust fund
30 established under section eighty-nine-i of the state finance law.
31 14. "Out-of-state health care service" means a health care service
32 provided to a member while the member is temporarily out of the state
33 and (a) it is medically necessary that the health care service be
34 provided while the member is out of the state, or (b) it is clinically
35 appropriate that the health care service be provided by a particular
36 health care provider located out of the state rather than in the state.
37 However, any health care service provided to a New York Health enrollee
38 by a health care provider qualified under paragraph (a) of subdivision
39 three of section fifty-one hundred five of this article that is located
40 outside the state shall not be considered an out-of-state service and
41 shall be covered as otherwise provided in this article.
42 15. "Participating provider" means any individual or entity that is a
43 health care provider qualified under subdivision three of section
44 fifty-one hundred five of this article that provides health care
45 services to members under the program, or a health care organization.
46 16. "Person" means any individual or natural person, trust, partner-
47 ship, association, unincorporated association, corporation, company,
48 limited liability company, proprietorship, joint venture, firm, joint
49 stock association, department, agency, authority, or other legal entity,
50 whether for-profit, not-for-profit or governmental.
51 17. "Prescription and non-prescription drugs" means prescription drugs
52 as defined in section two hundred seventy of this chapter, and non-pres-
53 cription smoking cessation products or devices.
54 18. "Resident" means an individual whose primary place of abode is in
55 the state, without regard to the individual's immigration status, as
56 determined according to regulations of the commissioner.

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1 § 5101. Program created. 1. The New York Health program is hereby
2 created in the department. The commissioner shall establish and imple-
3 ment the program under this article. The program shall provide compre-
4 hensive health coverage to every resident who enrolls in the program.
5 2. The commissioner shall, to the maximum extent possible, organize,
6 administer and market the program and services as a single program under
7 the name "New York Health" or such other name as the commissioner shall
8 determine, regardless of under which law or source the definition of a
9 benefit is found including (on a voluntary basis) retiree health bene-
10 fits. In implementing this article, the commissioner shall avoid jeop-
11 ardizing federal financial participation in these programs and shall
12 take care to promote public understanding and awareness of available
13 benefits and programs.
14 3. The commissioner shall determine when individuals may begin enroll-
15 ing in the program. There shall be an implementation period, which shall
16 begin on the date that individuals may begin enrolling in the program
17 and shall end as determined by the commissioner.
18 4. An insurer authorized to provide coverage pursuant to the insurance
19 law or a health maintenance organization certified under this chapter
20 may, if otherwise authorized, offer benefits that do not cover any
21 service for which coverage is offered to individuals under the program,
22 but may not offer benefits that cover any service for which coverage is
23 offered to individuals under the program. Provided, however, that this
24 subdivision shall not prohibit (a) the offering of any benefits to or
25 for individuals, including their families, who are employed or self-em-
26 ployed in the state but who are not residents of the state, or (b) the
27 offering of benefits during the implementation period to individuals who
28 enrolled or may enroll as members of the program, or (c) the offering of
29 retiree health benefits.
30 5. A college, university or other institution of higher education in
31 the state may purchase coverage under the program for any student, or
32 student's dependent, who is not a resident of the state.
33 6. To the extent any provision of this chapter, the social services
34 law, the insurance law or the elder law:
35 (a) is inconsistent with any provision of this article or the legisla-
36 tive intent of the New York Health Act, this article shall apply and
37 prevail, except where explicitly provided otherwise by this article; and
38 (b) is consistent with the provisions of this article and the legisla-
39 tive intent of the New York Health Act, the provision of that law shall
40 apply.
41 7. The program shall be deemed to be a health care plan for purposes
42 of utilization review and external appeal under article forty-nine of
43 this chapter.
44 8. No member shall be required to receive any health care service
45 through any entity organized, certified or operating under guidelines
46 under article forty-four of this chapter, or specified under section
47 three hundred sixty-four-j of the social services law, the insurance law
48 or the elder law. No such entity shall receive payment for health care
49 services (other than care coordination) from the program. However, this
50 subdivision shall not preclude the use of a Medicare managed care
51 ("Medicare advantage") entity under the program and otherwise consistent
52 with this article.
53 9. The program shall include provision for an appropriate reserve
54 fund.
55 § 5102. Board of trustees. 1. The New York Health board of trustees is
56 hereby created in the department. The board of trustees shall, at the

1 request of the commissioner, consider any matter to effectuate the
2 provisions and purposes of this article, and may advise the commissioner
3 thereon; and it may, from time to time, submit to the commissioner any
4 recommendations to effectuate the provisions and purposes of this arti-
5 cle. The commissioner may propose regulations under this article and
6 amendments thereto for consideration by the board. The board of trustees
7 shall have no executive, administrative or appointive duties except as
8 otherwise provided by law. The board of trustees shall have power to
9 establish, and from time to time, amend regulations to effectuate the
10 provisions and purposes of this article, subject to approval by the
11 commissioner.
12 2. The board shall be composed of:
13 (a) the commissioner, the superintendent of financial services, and
14 the director of the budget, or their designees, as ex officio members;
15 (b) twenty-six trustees appointed by the governor;
16 (i) six of whom shall be representatives of health care consumer advo-
17 cacy organizations which have a statewide or regional constituency, who
18 have been involved in activities related to health care consumer advoca-
19 cy, including issues of interest to low- and moderate-income individ-
20 uals;
21 (ii) two of whom shall be representatives of professional organiza-
22 tions representing physicians;
23 (iii) two of whom shall be representatives of professional organiza-
24 tions representing licensed or registered health care professionals
25 other than physicians;
26 (iv) three of whom shall be representatives of general hospitals, one
27 of whom shall be a representative of public general hospitals;
28 (v) one of whom shall be a representative of community health centers;
29 (vi) two of whom shall be representatives of rehabilitation or home
30 care providers;
31 (vii) two of whom shall be representatives of behavioral or mental
32 health or disability service providers;
33 (viii) two of whom shall be representatives of health care organiza-
34 tions;
35 (ix) two of whom shall be representatives of organized labor;
36 (x) two of whom shall have demonstrated expertise in health care
37 finance; and
38 (xi) two of whom shall be employers or representatives of employers
39 who pay the payroll tax under this article, or, prior to the tax becom-
40 ing effective, will pay the tax;
41 (c) fourteen trustees appointed by the governor; five of whom to be
42 appointed on the recommendation of the speaker of the assembly; five of
43 whom to be appointed on the recommendation of the temporary president of
44 the senate; two of whom to be appointed on the recommendation of the
45 minority leader of the assembly; and two of whom to be appointed on the
46 recommendation of the minority leader of the senate.
47 3. After the end of the implementation period, no person shall be a
48 trustee unless he or she is a member of the program, except the ex offi-
49 cio trustees. Each trustee shall serve at the pleasure of the appointing
50 officer, except the ex officio trustees.
51 4. The chair of the board shall be appointed, and may be removed as
52 chair, by the governor from among the trustees. The board shall meet at
53 least four times each calendar year. Meetings shall be held upon the
54 call of the chair and as provided by the board. A majority of the
55 appointed trustees shall be a quorum of the board, and the affirmative
56 vote of a majority of the trustees voting, but not less than ten, shall

1 be necessary for any action to be taken by the board. The board may
2 establish an executive committee to exercise any powers or duties of the
3 board as it may provide, and other committees to assist the board or the
4 executive committee. The chair of the board shall chair the executive
5 committee and shall appoint the chair and members of all other commit-
6 tees. The board of trustees may appoint one or more advisory committees.
7 Members of advisory committees need not be members of the board of trus-
8 tees.
9 5. Trustees shall serve without compensation but shall be reimbursed
10 for their necessary and actual expenses incurred while engaged in the
11 business of the board.
12 6. Notwithstanding any provision of law to the contrary, no officer or
13 employee of the state or any local government shall forfeit or be deemed
14 to have forfeited his or her office or employment by reason of being a
15 trustee.
16 7. The board and its committees and advisory committees may request
17 and receive the assistance of the department and any other state or
18 local governmental entity in exercising its powers and duties.
19 8. No later than two years after the effective date of this article:
20 (a) The board shall develop a proposal, consistent with the principles
21 of this article, for provision by the program of long-term care cover-
22 age, including the development of a proposal, consistent with the prin-
23 ciples of this article, for its funding. In developing the proposal,
24 the board shall consult with an advisory committee, appointed by the
25 chair of the board, including representatives of consumers and potential
26 consumers of long-term care, providers of long-term care, labor, and
27 other interested parties. The board shall present its proposal to the
28 governor and the legislature.
29 (b) The board shall develop proposals for: (i) incorporating retiree
30 health benefits into New York Health; (ii) accommodating employer reti-
31 ree health benefits for people who have been members of New York Health
32 but live as retirees out of the state; and (iii) accommodating employer
33 retiree health benefits for people who earned or accrued such benefits
34 while residing in the state prior to the implementation of New York
35 Health and live as retirees out of the state. The board shall present
36 its proposals to the governor and the legislature.
37 (c) The board shall develop a proposal for New York Health coverage of
38 health care services covered under the workers' compensation law,
39 including whether and how to continue funding for those services under
40 that law and whether and how to incorporate an element of experience
41 rating.
42 § 5103. Eligibility and enrollment. 1. Every resident of the state
43 shall be eligible and entitled to enroll as a member under the program.
44 2. No individual shall be required to pay any premium or other charge
45 for enrolling in or being a member under the program.
46 3. A newborn child shall be enrolled as of the date of the child's
47 birth if enrollment is done prior to the child's birth or within sixty
48 days after the child's birth.
49 § 5104. Benefits. 1. The program shall provide comprehensive health
50 coverage to every member, which shall include all health care services
51 required to be covered under any of the following, without regard to
52 whether the member would otherwise be eligible for or covered by the
53 program or source referred to:
54 (a) child health plus;
55 (b) Medicaid;
56 (c) Medicare;

1 (d) article forty-four of this chapter or article thirty-two or
2 forty-three of the insurance law;
3 (e) article eleven of the civil service law, as of the date one year
4 before the beginning of the implementation period;
5 (f) any cost incurred defined in paragraph one of subsection (a) of
6 section fifty-one hundred two of the insurance law, provided that this
7 coverage shall not replace coverage under article fifty-one of the
8 insurance law; and
9 (g) any additional health care service authorized to be added to the
10 program's benefits by the program;
11 (h) provided that none of the above shall include long term care,
12 until a proposal under paragraph (a) of subdivision eight of section
13 fifty-one hundred two of this article is enacted into law.
14 2. No member shall be required to pay any premium, deductible, co-pay-
15 ment or co-insurance under the program.
16 3. The program shall provide for payment under the program for:
17 (a) emergency and temporary health care services provided to a member
18 or individual entitled to become a member who has not had a reasonable
19 opportunity to become a member or to enroll with a care coordinator; and
20 (b) health care services provided in an emergency to an individual who
21 is entitled to become a member or enrolled with a care coordinator,
22 regardless of having had an opportunity to do so.
23 § 5105. Health care providers; care coordination; payment methodol-
24 ogies. 1. Choice of health care provider. (a) Any health care provider
25 qualified to participate under this section may provide health care
26 services under the program, provided that the health care provider is
27 otherwise legally authorized to perform the health care service for the
28 individual and under the circumstances involved.
29 (b) A member may choose to receive health care services under the
30 program from any participating provider, consistent with provisions of
31 this article relating to care coordination and health care organiza-
32 tions, the willingness or availability of the provider (subject to
33 provisions of this article relating to discrimination), and the appro-
34 priate clinically-relevant circumstances.
35 2. Care coordination. (a) A care coordinator may be an individual or
36 entity that is approved by the program that is:
37 (i) a health care practitioner who is: (A) the member's primary care
38 practitioner; (B) at the option of a female member, the member's provid-
39 er of primary gynecological care; or (C) at the option of a member who
40 has a chronic condition that requires specialty care, a specialist
41 health care practitioner who regularly and continually provides treat-
42 ment for that condition to the member;
43 (ii) an entity licensed under article twenty-eight of this chapter or
44 certified under article thirty-six of this chapter, or, with respect to
45 a member who receives chronic mental health care services, an entity
46 licensed under article thirty-one of the mental hygiene law or other
47 entity approved by the commissioner in consultation with the commission-
48 er of mental health;
49 (iii) a health care organization;
50 (iv) a Taft-Hartley fund, with respect to its members and their family
51 members; provided that this provision shall not preclude a Taft-Hartley
52 fund from becoming a care coordinator under subparagraph (v) of this
53 paragraph or a health care organization under section fifty-one hundred
54 six of this article; or
55 (v) any not-for-profit or governmental entity approved by the program.

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1 (b)(i) Every member shall enroll with a care coordinator that agrees
2 to provide care coordination to the member prior to receiving health
3 care services to be paid for under the program. Health care services
4 provided to a member shall not be subject to payment under the program
5 unless the member is enrolled with a care coordinator at the time the
6 health care service is provided.
7 (ii) This paragraph shall not apply to health care services provided
8 under subdivision three of section fifty-one hundred four of this arti-
9 cle.
10 (iii) The member shall remain enrolled with that care coordinator
11 until the member becomes enrolled with a different care coordinator or
12 ceases to be a member. Members have the right to change their care coor-
13 dinator on terms at least as permissive as the provisions of section
14 three hundred sixty-four-j of the social services law relating to an
15 individual changing his or her primary care provider or managed care
16 provider.
17 (c) Care coordination shall be provided to the member by the member's
18 care coordinator. A care coordinator may employ or utilize the services
19 of other individuals or entities to assist in providing care coordi-
20 nation for the member, consistent with regulations of the commissioner.
21 (d) A health care organization may establish rules relating to care
22 coordination for members in the health care organization, different from
23 this subdivision but otherwise consistent with this article and other
24 applicable laws.
25 (e) The commissioner shall develop and implement procedures and stand-
26 ards for an individual or entity to be approved to be a care coordinator
27 in the program, including but not limited to procedures and standards
28 relating to the revocation, suspension, limitation, or annulment of
29 approval on a determination that the individual or entity is not compe-
30 tent to be a care coordinator or has exhibited a course of conduct which
31 is either inconsistent with program standards and regulations or which
32 exhibits an unwillingness to meet such standards and regulations, or is
33 a potential threat to the public health or safety. Such procedures and
34 standards shall not limit approval to be a care coordinator in the
35 program for economic purposes and shall be consistent with good profes-
36 sional practice. In developing the procedures and standards, the commis-
37 sioner shall: (i) consider existing standards developed by national
38 accrediting and professional organizations; and (ii) consult with
39 national and local organizations working on care coordination or similar
40 models, including health care practitioners, hospitals, clinics, and
41 consumers and their representatives. When developing and implementing
42 standards of approval of care coordinators for individuals receiving
43 chronic mental health care services, the commissioner shall consult with
44 the commissioner of mental health. An individual or entity may not be a
45 care coordinator unless the services included in care coordination are
46 within the individual's professional scope of practice or the entity's
47 legal authority.
48 (f) To maintain approval under the program, a care coordinator must:
49 (i) renew its status at a frequency determined by the commissioner; and
50 (ii) provide data to the department as required by the commissioner to
51 enable the commissioner to evaluate the impact of care coordinators on
52 quality, outcomes and cost.
53 (g) Nothing in this subdivision shall authorize any individual to
54 engage in any act in violation of title eight of the education law.
55 3. Health care providers. (a) The commissioner shall establish and
56 maintain procedures and standards for health care providers to be quali-

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1 fied to participate in the program, including but not limited to proce-
2 dures and standards relating to the revocation, suspension, limitation,
3 or annulment of qualification to participate on a determination that the
4 health care provider is not competent to be a provider of specific
5 health care services or has exhibited a course of conduct which is
6 either inconsistent with program standards and regulations or which
7 exhibits an unwillingness to meet such standards and regulations, or is
8 a potential threat to the public health or safety. Such procedures and
9 standards shall not limit health care provider participation in the
10 program for economic purposes and shall be consistent with good profes-
11 sional practice. Such procedures and standards may be different for
12 different types of health care providers and health care professionals.
13 Any health care provider who is qualified to participate under Medicaid,
14 child health plus or Medicare shall be deemed to be qualified to partic-
15 ipate in the program, and any health care provider's revocation, suspen-
16 sion, limitation, or annulment of qualification to participate in any of
17 those programs shall apply to the health care provider's qualification
18 to participate in the program; provided that a health care provider
19 qualified under this sentence shall follow the procedures to become
20 qualified under the program by the end of the implementation period.
21 (b) The commissioner shall establish and maintain procedures and stan-
22 dards for recognizing health care providers located out of the state for
23 purposes of providing coverage under the program for out-of-state health
24 care services.
25 (c) Procedures and standards under this subdivision shall include
26 provisions for expedited temporary qualification to participate in the
27 program for health care professionals who are (i) temporarily authorized
28 to practice in the state or (ii) are recently arrived in the state or
29 recently authorized to practice in the state.
30 4. Payment for health care services. (a) The commissioner may estab-
31 lish by regulation payment methodologies for health care services and
32 care coordination provided to members under the program by participating
33 providers, care coordinators, and health care organizations. There may
34 be a variety of different payment methodologies, including those estab-
35 lished on a demonstration basis. All payment rates under the program
36 shall be reasonable and reasonably related to the cost of efficiently
37 providing the health care service and assuring an adequate and accessi-
38 ble supply of the health care service. Until and unless another payment
39 methodology is established, health care services provided to members
40 under the program shall be paid for on a fee-for-service basis, except
41 for care coordination.
42 (b) The program shall engage in good faith negotiations with health
43 care providers' representatives under title III of article forty-nine of
44 this chapter, including, but not limited to, in relation to rates of
45 payment and payment methodologies.
46 (c) Notwithstanding any provision of law to the contrary, payment for
47 drugs provided by pharmacies under the program shall be made pursuant to
48 title one of article two-A of this chapter. However, the program shall
49 provide for payment for prescription drugs under section 340B of the
50 federal public service act where applicable. Payment for prescription
51 drugs provided by health care providers other than pharmacies shall be
52 pursuant to other provisions of this article.
53 (d) Payment for health care services established under this article
54 shall be considered payment in full. A participating provider shall not
55 charge any rate in excess of the payment established under this article
56 for any health care service provided under the program and shall not

1 solicit or accept payment from any member or third party for any such
2 service except as provided under section fifty-one hundred nine of this
3 article. However, this paragraph shall not preclude the program from
4 acting as a primary or secondary payer in conjunction with another
5 third-party payer where permitted under section fifty-one hundred nine
6 of this article.
7 (e) The program may provide in payment methodologies for payment for
8 capital related expenses for specifically identified capital expendi-
9 tures incurred by not-for-profit or governmental entities certified
10 under article twenty-eight of this chapter. Any capital related expense
11 generated by a capital expenditure that requires or required approval
12 under article twenty-eight of this chapter must have received that
13 approval for the capital related expense to be paid for under the
14 program.
15 (f) Payment methodologies and rates shall include a distinct component
16 of reimbursement for direct and indirect graduate medical education as
17 defined, calculated and implemented pursuant to section twenty-eight
18 hundred seven-c of this chapter.
19 (g) The commissioner shall provide by regulation for payment method-
20 ologies and procedures for paying for out-of-state health care services.
21 § 5106. Health care organizations. 1. A member may choose to enroll
22 with and receive health care services under the program from a health
23 care organization.
24 2. A health care organization shall be a not-for-profit or govern-
25 mental entity that is approved by the commissioner that is:
26 (a) an accountable care organization under article twenty-nine-E of
27 this chapter; or
28 (b) a Taft-Hartley fund (i) with respect to its members and their
29 family members, and (ii) if allowed by applicable law and approved by
30 the commissioner, for other members of the program.
31 3. A health care organization may be responsible for providing all or
32 part of the health care services to which its members are entitled under
33 the program, consistent with the terms of its approval by the commis-
34 sioner.
35 4. (a) The commissioner shall develop and implement procedures and
36 standards for an entity to be approved to be a health care organization
37 in the program, including but not limited to procedures and standards
38 relating to the revocation, suspension, limitation, or annulment of
39 approval on a determination that the entity is not competent to be a
40 health care organization or has exhibited a course of conduct which is
41 either inconsistent with program standards and regulations or which
42 exhibits an unwillingness to meet such standards and regulations, or is
43 a potential threat to the public health or safety. Such procedures and
44 standards shall not limit approval to be a health care organization in
45 the program for economic purposes and shall be consistent with good
46 professional practice. In developing the procedures and standards, the
47 commissioner shall: (i) consider existing standards developed by
48 national accrediting and professional organizations; and (ii) consult
49 with national and local organizations working in the field of health
50 care organizations, including health care practitioners, hospitals,
51 clinics, and consumers and their representatives. When developing and
52 implementing standards of approval of health care organizations, the
53 commissioner shall consult with the commissioner of mental health, the
54 commissioner of developmental disabilities and the commissioner of the
55 office of alcoholism and substance abuse services.

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1 (b) To maintain approval under the program, a health care organization
2 must: (i) renew its status at a frequency determined by the commission-
3 er; and (ii) provide data to the department as required by the commis-
4 sioner to enable the commissioner to evaluate the health care organiza-
5 tion in relation to quality of health care services, health care
6 outcomes, and cost.
7 5. The commissioner shall make regulations relating to health care
8 organizations consistent with and to ensure compliance with this arti-
9 cle.
10 6. The provision of health care services directly or indirectly by a
11 health care organization through health care providers shall not be
12 considered the practice of a profession under title eight of the educa-
13 tion law by the health care organization.
14 § 5107. Program standards. 1. The commissioner shall establish
15 requirements and standards for the program and for health care organiza-
16 tions, care coordinators, and health care providers, consistent with
17 this article, including requirements and standards for, as applicable:
18 (a) the scope, quality and accessibility of health care services;
19 (b) relations between health care organizations or health care provid-
20 ers and members; and
21 (c) relations between health care organizations and health care
22 providers, including (i) credentialing and participation in the health
23 care organization; and (ii) terms, methods and rates of payment.
24 2. Requirements and standards under the program shall include, but not
25 be limited to, provisions to promote the following:
26 (a) simplification, transparency, uniformity, and fairness in health
27 care provider credentialing and participation in health care organiza-
28 tion networks, referrals, payment procedures and rates, claims process-
29 ing, and approval of health care services, as applicable;
30 (b) primary and preventive care, care coordination, efficient and
31 effective health care services, quality assurance, coordination and
32 integration of health care services, including use of appropriate tech-
33 nology, and promotion of public, environmental and occupational health;
34 (c) elimination of health care disparities;
35 (d) non-discrimination with respect to members and health care provid-
36 ers on the basis of race, ethnicity, national origin, religion, disabil-
37 ity, age, sex, sexual orientation, gender identity or expression, or
38 economic circumstances; provided that health care services provided
39 under the program shall be appropriate to the patient's clinically-rele-
40 vant circumstances; and
41 (e) accessibility of care coordination, health care organization
42 services and health care services, including accessibility for people
43 with disabilities and people with limited ability to speak or understand
44 English, and the providing of care coordination, health care organiza-
45 tion services and health care services in a culturally competent manner.
46 3. Any participating provider or care coordinator that is organized as
47 a for-profit entity (other than a professional practice of one or more
48 health care professionals) shall be required to meet the same require-
49 ments and standards as entities organized as not-for-profit entities,
50 and payments under the program paid to such entities shall not be calcu-
51 lated to accommodate the generation of profit or revenue for dividends
52 or other return on investment or the payment of taxes that would not be
53 paid by a not-for-profit entity.
54 4. Every participating provider shall furnish to the program such
55 information to, and permit examination of its records by, the program,
56 as may be reasonably required for purposes of reviewing accessibility

1 and utilization of health care services, quality assurance, promoting
2 improved patient outcomes and cost containment, the making of payments,
3 and statistical or other studies of the operation of the program or for
4 protection and promotion of public, environmental and occupational
5 health.
6 5. In developing requirements and standards and making other policy
7 determinations under this article, the commissioner shall consult with
8 representatives of members, health care providers, care coordinators,
9 health care organizations employers, organized labor, and other inter-
10 ested parties.
11 6. The program shall maintain the security and confidentiality of all
12 data and other information collected under the program when such data
13 would be normally considered confidential patient data. Aggregate data
14 of the program which is derived from confidential data but does not
15 violate patient confidentiality shall be public information including
16 for purposes of article six of the public officers law.
17 § 5108. Regulations. The commissioner may make regulations under this
18 article by approving regulations and amendments thereto, under subdivi-
19 sion one of section fifty-one hundred two of this article. The commis-
20 sioner may make regulations or amendments thereto under this article on
21 an emergency basis under section two hundred two of the state adminis-
22 trative procedure act, provided that such regulations or amendments
23 shall not become permanent unless adopted under subdivision one of
24 section fifty-one hundred two of this article.
25 § 5109. Provisions relating to federal health programs. 1. The commis-
26 sioner shall seek all federal waivers and other federal approvals and
27 arrangements and submit state plan amendments necessary to operate the
28 program consistent with this article to the maximum extent possible.
29 2. (a) The commissioner shall apply to the secretary of health and
30 human services or other appropriate federal official for all waivers of
31 requirements, and make other arrangements, under Medicare, any federal-
32 ly-matched public health program, the affordable care act, and any other
33 federal programs that provide federal funds for payment for health care
34 services, that are necessary to enable all New York Health members to
35 receive all benefits under the program through the program to enable the
36 state to implement this article and to receive and deposit all federal
37 payments under those programs (including funds that may be provided in
38 lieu of premium tax credits, cost-sharing subsidies, and small business
39 tax credits) in the state treasury to the credit of the New York Health
40 trust fund and to use those funds for the New York Health program and
41 other provisions under this article. To the extent possible, the commis-
42 sioner shall negotiate arrangements with the federal government in which
43 bulk or lump-sum federal payments are paid to New York Health in place
44 of federal spending or tax benefits for federally-matched health
45 programs or federal health programs.
46 (b) The commissioner may require members or applicants to be members
47 to provide information necessary for the program to comply with any
48 waiver or arrangement under this subdivision.
49 3. (a) The commissioner may take actions consistent with this article
50 to enable New York Health to administer Medicare in New York state, to
51 create a Medicare managed care plan ("Medicare Advantage") that would
52 operate consistent with this article, and to be a provider of drug
53 coverage under Medicare part D for eligible members of New York Health.
54 (b) The commissioner may waive or modify the applicability of
55 provisions of this section relating to any federally-matched public
56 health program or Medicare as necessary to implement any waiver or

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1 arrangement under this section or to maximize the benefit to the New
2 York Health program under this section, provided that the commissioner,
3 in consultation with the director of the budget, shall determine that
4 such waiver or modification is in the best interests of the members
5 affected by the action and the state.
6 (c) The commissioner may apply for coverage under any federally-
7 matched public health program on behalf of any member and enroll the
8 member in the federally-matched public health program or Medicare if the
9 member is eligible for it. Enrollment in a federally-matched public
10 health program or Medicare shall not cause any member to lose any health
11 care service provided by the program or diminish any right the member
12 would otherwise have.
13 (d) The commissioner shall by regulation increase the income eligibil-
14 ity level, increase or eliminate the resource test for eligibility,
15 simplify any procedural or documentation requirement for enrollment, and
16 increase the benefits for any federally-matched public health program,
17 and for any program to reduce or eliminate an individual's coinsurance,
18 cost-sharing or premium obligations or increase an individual's eligi-
19 bility for any federal financial support related to Medicare or the
20 affordable care act notwithstanding any law or regulation to the contra-
21 ry. The commissioner may act under this paragraph upon a finding,
22 approved by the director of the budget, that the action (i) will help to
23 increase the number of members who are eligible for and enrolled in
24 federally-matched public health programs, or for any program to reduce
25 or eliminate an individual's coinsurance, cost-sharing or premium obli-
26 gations or increase an individual's eligibility for any federal finan-
27 cial support related to Medicare or the affordable care act; (ii) will
28 not diminish any individual's access to any health care service, benefit
29 or right the individual would otherwise have; (iii) is in the interest
30 of the program; and (iv) does not require or has received any necessary
31 federal waivers or approvals to ensure federal financial participation.
32 Actions under this paragraph shall not apply to eligibility for payment
33 for long term care.
34 (e) To enable the commissioner to apply for coverage under any feder-
35 ally-matched public health program or Medicare on behalf of any member
36 and enroll the member in the federally-matched public health program or
37 Medicare if the member is eligible for it, the commissioner may require
38 that every member or applicant to be a member shall provide information
39 to enable the commissioner to determine whether the applicant is eligi-
40 ble for a federally-matched public health program and for Medicare (and
41 any program or benefit under Medicare). The program shall make a reason-
42 able effort to notify members of their obligations under this paragraph.
43 After a reasonable effort has been made to contact the member, the
44 member shall be notified in writing that he or she has sixty days to
45 provide such required information. If such information is not provided
46 within the sixty day period, the member's coverage under the program may
47 be terminated.
48 (f) To the extent necessary for purposes of this section, as a condi-
49 tion of continued eligibility for health care services under the
50 program, a member who is eligible for benefits under Medicare shall
51 enroll in Medicare, including parts A, B and D.
52 (g) The program shall provide premium assistance for all members
53 enrolling in a Medicare part D drug coverage under section 1860D of
54 Title XVIII of the federal social security act limited to the low-income
55 benchmark premium amount established by the federal centers for Medicare
56 and Medicaid services and any other amount which such agency establishes

1 under its de minimis premium policy, except that such payments made on
2 behalf of members enrolled in a Medicare advantage plan may exceed the
3 low-income benchmark premium amount if determined to be cost effective
4 to the program.
5 (h) If the commissioner has reasonable grounds to believe that a
6 member could be eligible for an income-related subsidy under section
7 1860D-14 of Title XVIII of the federal social security act, the member
8 shall provide, and authorize the program to obtain, any information or
9 documentation required to establish the member's eligibility for such
10 subsidy, provided that the commissioner shall attempt to obtain as much
11 of the information and documentation as possible from records that are
12 available to him or her.
13 (i) The program shall make a reasonable effort to notify members of
14 their obligations under this subdivision. After a reasonable effort has
15 been made to contact the member, the member shall be notified in writing
16 that he or she has sixty days to provide such required information. If
17 such information is not provided within the sixty day period, the
18 member's coverage under the program may be terminated.
19 § 5110. Additional provisions. 1. The commissioner shall contract
20 with not-for-profit organizations to provide:
21 (a) consumer assistance to individuals with respect to selection and
22 changing selection of a care coordinator or health care organization,
23 enrolling, obtaining health care services, and other matters relating to
24 the program;
25 (b) health care provider assistance to health care providers providing
26 and seeking or considering whether to provide, health care services
27 under the program, with respect to participating in a health care organ-
28 ization and dealing with a health care organization; and
29 (c) care coordinator assistance to individuals and entities providing
30 and seeking or considering whether to provide, care coordination to
31 members.
32 2. The commissioner shall provide grants from funds in the New York
33 Health trust fund or otherwise appropriated for this purpose, to health
34 systems agencies under section twenty-nine hundred four-b of this chap-
35 ter to support the operation of such health systems agencies.
36 3. The commissioner shall provide funds from the New York Health trust
37 fund or otherwise appropriated for this purpose to the commissioner of
38 labor for a program for retraining and assisting job transition for
39 individuals employed or previously employed in the field of health
40 insurance and other third-party payment for health care or providing
41 services to health care providers to deal with third-party payers for
42 health care, whose jobs may be or have been ended as a result of the
43 implementation of the New York Health program, consistent with otherwise
44 applicable law.
45 4. The commissioner shall, directly and through grants to not-for-pro-
46 fit entities, conduct programs using data collected through the New York
47 Health program, to promote and protect the quality of health care
48 services, patient outcomes, and public, environmental and occupational
49 health, including cooperation with other data collection and research
50 programs of the department, consistent with this article, the protection
51 of the security and confidentiality of individually identifiable patient
52 information, and otherwise applicable law.
53 § 5111. Regional advisory councils. 1. The New York Health regional
54 advisory councils (each referred to in this article as a "regional advi-
55 sory council") are hereby created in the department.

1 2. There shall be a regional advisory council established in each of
2 the following regions:
3 (a) Long Island, consisting of Nassau and Suffolk counties;
4 (b) New York City;
5 (c) Hudson Valley, consisting of Delaware, Dutchess, Orange, Putnam,
6 Rockland, Sullivan, Ulster, Westchester counties;
7 (d) Northern, consisting of Albany, Clinton, Columbia, Essex, Frank-
8 lin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga,
9 Schenectady, Schoharie, Warren, Washington counties;
10 (e) Central, consisting of Broome, Cayuga, Chemung, Chenango, Cort-
11 land, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Oneida,
12 Onondaga, Ontario, Oswego, Schuyler, Seneca, St. Lawrence, Steuben,
13 Tioga, Tompkins, Wayne, Yates counties; and
14 (f) Western, consisting of Allegany, Cattaraugus, Chautauqua, Erie,
15 Genesee, Niagara, Orleans, Wyoming counties.
16 3. Each regional advisory council shall be composed of not fewer than
17 twenty-seven members, as determined by the commissioner and the board,
18 as necessary to appropriately represent the diverse needs and concerns
19 of the region. Members of a regional advisory council shall be residents
20 of or have their principal place of business in the region served by the
21 regional advisory council.
22 4. Appointment of members of the regional advisory councils.
23 (a) The twenty-seven members shall be appointed as follows:
24 (i) nine members shall be appointed by the governor;
25 (ii) six members shall be appointed by the governor on the recommenda-
26 tion of the speaker of the assembly;
27 (iii) six members shall be appointed by the governor on the recommen-
28 dation of the temporary president of the senate;
29 (iv) three members shall be appointed by the governor on the recommen-
30 dation of the minority leader of the assembly; and
31 (v) three members shall be appointed by the governor on the recommen-
32 dation of the minority leader of the senate.
33 Where a regional advisory council has more than twenty-seven members,
34 additional members shall be appointed and recommended by these officials
35 in the same proportion as the twenty-seven members.
36 (b) Regional advisory council membership shall include but not be
37 limited to:
38 (i) representatives of health care consumer advocacy organizations
39 with a regional constituency, who shall represent at least one third of
40 the membership of each regional council;
41 (ii) representatives of professional organizations representing physi-
42 cians;
43 (iii) representatives of professional organizations representing
44 health care professionals other than physicians;
45 (iv) representatives of general hospitals, including public hospitals;
46 (v) representatives of community health centers;
47 (vi) representatives of mental health, behavioral health (including
48 substance use), physical disability, developmental disability, rehabili-
49 tation, home care and other service providers;
50 (vii) representatives of women's health service providers;
51 (viii) representatives of health care organizations;
52 (ix) representatives of organized labor;
53 (x) representatives of employers; and
54 (xi) representatives of municipal and county government.
55 5. Members of a regional advisory council shall be appointed for terms
56 of three years provided, however, that of the members first appointed,

1 one-third shall be appointed for one year terms and one-third shall be
2 appointed for two year terms. Vacancies shall be filled in the same
3 manner as original appointments for the remainder of any unexpired term.
4 No person shall be a member of a regional advisory council for more than
5 six years in any period of twelve consecutive years.
6 6. Members of the regional advisory councils shall serve without
7 compensation but shall be reimbursed for their necessary and actual
8 expenses incurred while engaged in the business of the advisory coun-
9 cils. The program shall provide financial support for such expenses and
10 other expenses of the regional advisory councils.
11 7. Each regional advisory council shall meet at least quarterly. Each
12 regional advisory council may form committees to assist it in its work.
13 Members of a committee need not be members of the regional advisory
14 council. The New York City regional advisory council shall form a
15 committee for each borough of New York City, to assist the regional
16 advisory council in its work as it relates particularly to that borough.
17 8. Each regional advisory council shall advise the commissioner,the
18 board, the governor and the legislature on all matters relating to the
19 development and implementation of the New York Health program.
20 9. Each regional advisory council shall adopt, and from time to time
21 revise, a community health improvement plan for its region for the
22 purpose of:
23 (a) promoting the delivery of health care services in the region,
24 improving the quality and accessibility of care, including cultural
25 competency, clinical integration of care between service providers
26 including but not limited to physical, mental, and behavioral health,
27 physical and developmental disability services, and long-term care;
28 (b) facility and health services planning in the region;
29 (c) identifying gaps in regional health care services; and
30 (d) promoting increased public knowledge and responsibility regarding
31 the availability and appropriate utilization of health care services.
32 Each community health improvement plan shall be submitted to the commis-
33 sioner and the board and shall be posted on the department's website.
34 10. Each regional advisory council shall hold at least four public
35 hearings annually on matters relating to the New York Health program and
36 the development and implementation of the community health improvement
37 plan.
38 11. Each regional advisory council shall publish an annual report to
39 the commissioner and the board on the progress of the community health
40 improvement plan. These reports shall be posted on the department's
41 website.
42 12. All meetings of the regional advisory councils and committees
43 shall be subject to article six of the public officers law.
44 § 4. Financing of New York Health. 1. The governor shall submit to the
45 legislature a revenue plan and legislative bills to implement the plan
46 (referred to collectively in this section as the "revenue proposal") to
47 provide the revenue necessary to finance the New York Health program, as
48 created by article 51 of the public health law and all provisions of
49 that article (referred to in this section as the "program"), taking into
50 consideration anticipated federal revenue available for the program. The
51 revenue proposal shall be submitted to the legislature as part of the
52 executive budget under article VII of the state constitution, for the
53 fiscal year commencing on the first day of April in the calendar year
54 after this act shall become a law. In developing the revenue proposal,
55 the governor shall consult with appropriate officials of the executive
56 branch; the temporary president of the senate; the speaker of the assem-

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1 bly; the chairs of the fiscal and health committees of the senate and
2 assembly; and representatives of business, labor, consumers and local
3 government.
4 2. (a) Basic structure. The basic structure of the revenue proposal
5 shall be as follows: Revenue for the program shall come from two taxes
6 (referred to collectively in this section as the "taxes"). First, there
7 shall be a progressively graduated tax on all payroll and self-employed
8 income (referred to in this section as the "payroll tax"), paid by
9 employers, employees and self-employed individuals. Second, there shall
10 be a progressively graduated tax on taxable income (such as interest,
11 dividends, and capital gains) not subject to the payroll tax (referred
12 to in this section as the "non-payroll tax"). Higher brackets of income
13 subject to the taxes shall be assessed at a higher marginal rate than
14 lower brackets. The taxes shall be set at levels anticipated to produce
15 sufficient revenue to finance the program, to be scaled up as enrollment
16 grows, taking into consideration anticipated federal revenue available
17 for the program. Provision shall be made for state residents (who are
18 eligible for the program) who are employed out-of-state, and non-resi-
19 dents (who are not eligible for the program) who are employed in the
20 state.
21 (b) Payroll tax. The income to be subject to the payroll tax shall be
22 all income subject to the Medicare Part A tax. The tax shall be set at a
23 percentage of that income, which shall be progressively graduated, so
24 the percentage is higher on higher brackets of income. For employed
25 individuals, the employer shall pay eighty percent of the tax and the
26 employee shall pay twenty percent of the tax, except that an employer
27 may agree to pay all or part of the employee's share. A self-employed
28 individual shall pay the full tax.
29 (c) Non-payroll income tax. There shall be a tax on income that is
30 subject to the personal income tax under article 22 of the tax law and
31 is not subject to the payroll tax. It shall be set at a percentage of
32 that income, which shall be progressively graduated, so the percentage
33 is higher on higher brackets of income.
34 (d) Phased-in rates. Early in the program, when enrollment is growing,
35 the amount of the taxes shall be at an appropriate level, and shall be
36 changed as anticipated enrollment grows, to cover the actual cost of the
37 program. The revenue proposal shall include a mechanism for determining
38 the rates of the taxes.
39 (e) Cross-border employees. (i) State residents employed out-of-state.
40 If an individual is employed out-of-state by an employer that is subject
41 to New York state law, the employer and employee shall be required to
42 pay the payroll tax as to that employee as if the employment were in the
43 state. If an individual is employed out-of-state by an employer that is
44 not subject to New York state law, either (A) the employer and employee
45 shall voluntarily comply with the tax or (B) the employee shall pay the
46 tax as if he or she were self-employed.
47 (ii) Out-of-state residents employed in the state. (A) The payroll
48 tax shall apply to any out-of-state resident who is employed or self-em-
49 ployed in the state. (B) In the case of an out-of-state resident who is
50 employed or self-employed in the state, such individual and individual's
51 employer shall be able to take a credit against the payroll taxes each
52 would otherwise pay as to that individual for amounts they spend respec-
53 tively on health benefits for the individual that would otherwise be
54 covered by the program if the individual were a member of the program.
55 For the employer, the credit shall be available regardless of the form
56 of the health benefit (e.g., health insurance, a self-insured plan,

1 direct services, or reimbursement for services), to make sure that the
2 revenue proposal does not relate to employment benefits in violation of
3 the federal ERISA. For non-employment-based spending by the individual,
4 the credit shall be available for and limited to spending for health
5 coverage (not out-of-pocket health spending). The credit shall be avail-
6 able without regard to how little is spent or how sparse the benefit.
7 The credit may only be taken against the payroll tax. Any excess amount
8 may not be applied to other tax liability. The credit shall be distrib-
9 uted between the employer and employee in the same proportion as the
10 spending by each for the benefit and may be applied to their respective
11 portion of the tax. (C) If any provision of this subparagraph or any
12 application of it shall be ruled to violate federal ERISA, the provision
13 or the application of it shall be null and void and the ruling shall not
14 affect any other provision or application of this section or the act
15 that enacted it.
16 3. (a) The revenue proposal shall include a plan and legislative
17 provisions for ending the requirement for local social services
18 districts to pay part of the cost of Medicaid and replacing those
19 payments with revenue from the taxes under the revenue proposal.
20 (b) The taxes under this section shall not supplant the spending of
21 other state revenue to pay for the Medicaid program as it exists as of
22 the enactment of the revenue proposal as amended, unless the revenue
23 proposal as amended provides otherwise.
24 4. To the extent that the revenue proposal differs from the terms of
25 subdivision two or paragraph (b) of subdivision three of this section,
26 the revenue proposal shall state how it differs from those terms and
27 reasons for and the effects of the differences.
28 5. All revenue from the taxes shall be deposited in the New York
29 Health trust fund account under section 89-i of the state finance law.
30 § 5. Article 49 of the public health law is amended by adding a new
31 title 3 to read as follows:
32 TITLE III
33 COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH
34 NEW YORK HEALTH
35 Section 4920. Definitions.
36 4921. Collective negotiation authorized.
37 4922. Collective negotiation requirements.
38 4923. Requirements for health care providers' representative.
39 4924. Certain collective action prohibited.
40 4925. Fees.
41 4926. Confidentiality.
42 4927. Severability and construction.
43 § 4920. Definitions. For purposes of this title:
44 1. "New York Health" means the program under article fifty-one of this
45 chapter.
46 2. "Person" means an individual, association, corporation, or any
47 other legal entity.
48 3. "Health care providers' representative" means a third party that is
49 authorized by health care providers to negotiate on their behalf with
50 New York Health over terms and conditions affecting those health care
51 providers.
52 4. "Strike" means a work stoppage in part or in whole, direct or indi-
53 rect, by a body of workers to gain compliance with demands made on an
54 employer.
55 5. "Health care provider" means a person who is licensed, certified,
56 registered or authorized to practice a health care profession pursuant

1 to title eight of the education law and who practices that profession as
2 a health care provider as an independent contractor or who is an owner,
3 officer, shareholder, or proprietor of a health care provider; or an
4 entity that employs or utilizes health care providers to provide health
5 care services, including but not limited to a hospital licensed under
6 article twenty-eight of this chapter or an accountable care organization
7 under article twenty-nine-E of this chapter. A health care provider
8 under title eight of the education law who practices as an employee or
9 independent contractor of another health care provider shall not be
10 deemed a health care provider for purposes of this title.
11 § 4921. Collective negotiation authorized. 1. Health care providers
12 may meet and communicate for the purpose of collectively negotiating
13 with New York Health on any matter relating to New York Health, includ-
14 ing but not limited to rates of payment and payment methodologies.
15 2. Nothing in this section shall be construed to allow or authorize an
16 alteration of the terms of the internal and external review procedures
17 set forth in law.
18 3. Nothing in this section shall be construed to allow a strike of New
19 York Health by health care providers.
20 4. Nothing in this section shall be construed to allow or authorize
21 terms or conditions which would impede the ability of New York Health to
22 obtain or retain accreditation by the national committee for quality
23 assurance or a similar body or to comply with applicable state or feder-
24 al law.
25 § 4922. Collective negotiation requirements. 1. Collective negotiation
26 rights granted by this title must conform to the following requirements:
27 (a) health care providers may communicate with other health care
28 providers regarding the terms and conditions to be negotiated with New
29 York Health;
30 (b) health care providers may communicate with health care providers'
31 representatives;
32 (c) a health care providers' representative is the only party author-
33 ized to negotiate with New York Health on behalf of the health care
34 providers as a group;
35 (d) a health care provider can be bound by the terms and conditions
36 negotiated by the health care providers' representatives; and
37 (e) in communicating or negotiating with the health care providers'
38 representative, New York Health is entitled to offer and provide differ-
39 ent terms and conditions to individual competing health care providers.
40 2. Nothing in this title shall affect or limit the right of a health
41 care provider or group of health care providers to collectively petition
42 a government entity for a change in a law, rule, or regulation.
43 3. Nothing in this title shall affect or limit collective action or
44 collective bargaining on the part of any health care provider with his
45 or her employer or any other lawful collective action or collective
46 bargaining.
47 § 4923. Requirements for health care providers' representative. Before
48 engaging in collective negotiations with New York Health on behalf of
49 health care providers, a health care providers' representative shall
50 file with the commissioner, in the manner prescribed by the commission-
51 er, information identifying the representative, the representative's
52 plan of operation, and the representative's procedures to ensure compli-
53 ance with this title.
54 § 4924. Certain collective action prohibited. 1. This title is not
55 intended to authorize competing health care providers to act in concert

1 in response to a health care providers' representative's discussions or
2 negotiations with New York Health except as authorized by other law.
3 2. No health care providers' representative shall negotiate any agree-
4 ment that excludes, limits the participation or reimbursement of, or
5 otherwise limits the scope of services to be provided by any health care
6 provider or group of health care providers with respect to the perform-
7 ance of services that are within the health care provider's lawful scope
8 or terms of practice, license, registration, or certificate.
9 § 4925. Fees. Each person who acts as the representative of negotiat-
10 ing parties under this title shall pay to the department a fee to act as
11 a representative. The commissioner, by regulation, shall set fees in
12 amounts deemed reasonable and necessary to cover the costs incurred by
13 the department in administering this title.
14 § 4926. Confidentiality. All reports and other information required to
15 be reported to the department under this title shall not be subject to
16 disclosure under article six of the public officers law.
17 § 4927. Severability and construction. If any provision or application
18 of this title shall be held to be invalid, or to violate or be incon-
19 sistent with any applicable federal law or regulation, that shall not
20 affect other provisions or applications of this title which can be given
21 effect without that provision or application; and to that end, the
22 provisions and applications of this title are severable. The provisions
23 of this title shall be liberally construed to give effect to the
24 purposes thereof.
25 § 6. Subdivision 11 of section 270 of the public health law, as
26 amended by section 2-a of part C of chapter 58 of the laws of 2008, is
27 amended to read as follows:
28 11. "State public health plan" means the medical assistance program
29 established by title eleven of article five of the social services law
30 (referred to in this article as "Medicaid"), the elderly pharmaceutical
31 insurance coverage program established by title three of article two of
32 the elder law (referred to in this article as "EPIC"), and the [family
33 health plus program established by section three hundred sixty-nine-ee
34 of the social services law to the extent that section provides that the
35 program shall be subject to this article] New York Health program estab-
36 lished by article fifty-one of this chapter.
37 § 7. The state finance law is amended by adding a new section 89-i to
38 read as follows:
39 § 89-i. New York Health trust fund. 1. There is hereby established in
40 the joint custody of the state comptroller and the commissioner of taxa-
41 tion and finance a special revenue fund to be known as the "New York
42 Health trust fund", referred to in this section as "the fund". The defi-
43 nitions in section fifty-one hundred of the public health law shall
44 apply to this section.
45 2. The fund shall consist of:
46 (a) all monies obtained from taxes pursuant to legislation enacted as
47 proposed under section three of the New York Health act;
48 (b) federal payments received as a result of any waiver or other
49 arrangements agreed to by the United States secretary of health and
50 human services or other appropriate federal officials for health care
51 programs established under Medicare, any federally-matched public health
52 program, or the affordable care act;
53 (c) the amounts paid by the department of health that are equivalent
54 to those amounts that are paid on behalf of residents of this state
55 under Medicare, any federally-matched public health program, or the

1 affordable care act for health benefits which are equivalent to health
2 benefits covered under New York Health;
3 (d) federal and state funds for purposes of the provision of services
4 authorized under title XX of the federal social security act that would
5 otherwise be covered under article fifty-one of the public health law;
6 and
7 (e) state monies that would otherwise be appropriated to any govern-
8 mental agency, office, program, instrumentality or institution which
9 provides health services, for services and benefits covered under New
10 York Health. Payments to the fund pursuant to this paragraph shall be in
11 an amount equal to the money appropriated for such purposes in the
12 fiscal year beginning immediately preceding the effective date of the
13 New York Health act.
14 3. Monies in the fund shall only be used for purposes established
15 under article fifty-one of the public health law.
16 § 8. Temporary commission on implementation. 1. There is hereby estab-
17 lished a temporary commission on implementation of the New York Health
18 program, referred to in this section as the commission, consisting of
19 fifteen members: five members, including the chair, shall be appointed
20 by the governor; four members shall be appointed by the temporary presi-
21 dent of the senate, one member shall be appointed by the senate minority
22 leader; four members shall be appointed by the speaker of the assembly,
23 and one member shall be appointed by the assembly minority leader. The
24 commissioner of health, the superintendent of financial services, and
25 the commissioner of taxation and finance, or their designees shall serve
26 as non-voting ex-officio members of the commission.
27 2. Members of the commission shall receive such assistance as may be
28 necessary from other state agencies and entities, and shall receive
29 reasonable and necessary expenses incurred in the performance of their
30 duties. The commission may employ staff as needed, prescribe their
31 duties, and fix their compensation within amounts appropriated for the
32 commission.
33 3. The commission shall examine the laws and regulations of the state
34 and make such recommendations as are necessary to conform the laws and
35 regulations of the state and article 51 of the public health law estab-
36 lishing the New York Health program and other provisions of law relating
37 to the New York Health program, and to improve and implement the
38 program. The commission shall report its recommendations to the governor
39 and the legislature. The commission shall immediately begin development
40 of proposals consistent with the principles of article 51 of the public
41 health law for provision of long-term care coverage; health care
42 services covered under the workers' compensation law; and incorporation
43 of retiree health benefits, as described in paragraphs (a), (b) and (c)
44 of subdivision 8 of section 5102 of the public health law. The commis-
45 sion shall provide its work product and assistance to the board estab-
46 lished pursuant to section 5102 of the public health law upon completion
47 of the appointment of the board.
48 § 9. Severability. If any provision or application of this act shall
49 be held to be invalid, or to violate or be inconsistent with any appli-
50 cable federal law or regulation, that shall not affect other provisions
51 or applications of this act which can be given effect without that
52 provision or application; and to that end, the provisions and applica-
53 tions of this act are severable.
54 § 10. This act shall take effect immediately.

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