"New York Health" Bill

Assembly bill A. 7860-A (Gottfried), S. 5425-A (Duane)

Underlined text is new law to be added. Text in brackets **[ ]** is existing law being repealed. Footnotes are only for explanation and are not be part of the actual bill.

AN ACT to amend the public health law and the state finance law, in relation to establishing New York Health[1]

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

Section 1. Legislative findings and intent. 1. The state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." (Article XVII, § 3.) The legislature finds and declares that all residents of the state have the right to health care. New Yorkers – as individuals, employers, and taxpayers – have experienced a rapid rise in the cost of health care and coverage in recent years. This increase has resulted in a large number of people without health coverage. Businesses have also experienced extraordinary increases in the costs of health care benefits for their employees. An unacceptable number of New Yorkers have no health coverage, and many more are severely underinsured. Health care providers are also affected by inadequate health coverage in New York state. A large portion of voluntary and public hospitals, health centers and other providers now experience substantial losses due to the provision of care that is uncompensated. Individuals often find that they are deprived of affordable care and choice because of decisions by health plans guided by the plan's economic needs rather than their health care needs. To address the fiscal crisis facing the health care system and the state and to assure New Yorkers can exercise their right to health care, affordable and comprehensive health coverage must be provided. Pursuant to the state constitution's charge to the legislature to provide for the health of New Yorkers, this legislation is an enactment of state concern for the purpose of establishing a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state of New York.[2]

2. It is the intent of the Legislature to create the New York Health program to provide a universal health plan for every New Yorker, funded by broad-based revenue based on ability to pay.

The state shall work to obtain waivers relating to Medicaid, Family Health Plus, Child

[1] In each state, the single-payer bill would presumably have a localized name.

[2] This subdivision is meant to lay a constitutional foundation.

Health Plus, Medicare, the Patient Protection and Affordable Care Act, and any other appropriate federal programs, under which federal funds and other subsidies that would otherwise be paid to New York State and New Yorkers for health coverage that will be equaled or exceeded by New York Health will be paid by the federal government to New York State and deposited in the New York Health trust fund. Under such a waiver, health coverage under those programs will be replaced and merged into New York Health, which will operate as a true single-payer program.

If such a waiver is not obtained, the state shall use state plan amendments and seek waivers to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus, even where other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers.

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

3. This act does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.[3]

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

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

ARTICLE 51

NEW YORK HEALTH

[3] This subdivision is meant to make clear that this does not violate ERISA.

[4] This language, and similar language in the body of the bill, lays the foundation for a "state-action" exemption from anti-trust laws.

Section 5100. Definitions.

5101. Program created.

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

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5109. Provisions relating to federal health programs.

§ 5110. Additional provisions.

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

1. "Board" means the board of trustees of the New York Health program created by section 5102 of this article, and "trustee" means a trustee of the board.

2. "Care coordination" means services provided by a care coordinator under paragraph (b) of subdivision 3 of section 5105 of this article.

3. "Care coordinator " means an individual or entity approved to provide care coordination under paragraph (b) of subdivision 3 of section 5105 of this article.

4. "Federally-matched public health program" means the medical assistance program under title 11 of article 5 of the social services law, the family health plus program[5] under title 11-D of article 5 of the social services law, and the child health plus program[6] under title 1-A of article 25 of this chapter.

5. "Health care organization" means an entity that is approved by the commissioner[7] under section 5106 of this article to provide health care services to members under the program.

[5] New York's Medicaid expansion program.

[6] New York's CHIP program.

[7] In the Public Health Law, "commissioner" is defined to mean the Commissioner of Health.

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

7. "Implementation period" means the period under subdivision 4 of section 5101 of this article during which the program will be subject to special eligibility and financing provisions until it is fully implemented under that section.

8. “Long term care” means long term care, treatment, maintenance, or services not covered under family health plus or child health plus, as appropriate, with the exception of short term rehabilitation, as defined by the commissioner.

9. "Medicaid" or "medical assistance" means title 11 of article 5 of the social services law and the program thereunder. "Family health plus" means title 11-D of the social services law and the program thereunder. "Child health plus" means title 1-A of article 25 of this chapter and the program thereunder. “Medicare” means title XVIII of the federal social security act and the programs thereunder.

10. "Member" means an individual who is enrolled in the program.

11. “New York Health trust fund” means the New York Health trust fund established under section 89-h of the state finance law.[8]

12. "Participating provider" means any individual or entity that is a health care provider that provides health care services to members under the program, or a health care organization.

13. "Patient protection and affordable care act" means the federal patient protection and affordable care act, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and any regulations or guidance issued thereunder.

14. "Person" means any individual or natural person, trust, partnership, association, unincorporated association, corporation, company, limited liability company, proprietorship, joint venture, firm, joint stock association, department, agency, authority, or other legal entity, whether for-profit, not-for-profit or governmental.

15. "Prescription and non-prescription drugs" shall mean prescription drugs as defined in section 270 of the public health law, and non-prescription smoking cessation products or devices.

16. "Program" means the New York Health program created by section 5101 of this article.

17. "Resident" means an individual whose primary place of abode is in the state, as determined according to regulations of the commissioner.

[8] See below in the bill.

§ 5101. Program created. 1. The New York Health program is hereby created in the department. The commissioner shall establish and implement the program under this article. The program shall provide comprehensive health coverage to every resident who enrolls in the program.

2. The commissioner shall, to the maximum extent possible, organize, administer and market the program and services as a single program under the name "New York Health" or such other name as the commissioner shall determine, regardless of under which law or source the definition of a benefit is found, including (on a voluntary basis) retiree[9] health benefits. In implementing this subdivision, the commissioner shall avoid jeopardizing federal financial participation in any program and shall take care to promote public understanding and awareness of available benefits and programs.

3. The commissioner shall determine when individuals may begin enrolling in the program. There shall be an implementation period, which shall begin on the date that individuals may begin enrolling in the program and shall end as determined by the commissioner.

4. An insurer authorized to provide coverage pursuant to the insurance law or a health maintenance organization certified under this chapter may, if otherwise authorized, offer benefits that do not duplicate coverage offered to an individual under the program, but may not offer benefits that duplicate coverage offered to an individual under the program. Provided, however, that this subdivision shall not prohibit (a) the offering of any benefits to or for individuals, including their families, who are employed or self-employed in the state but are not residents of the state, or (b) the offering of benefits during the implementation period to individuals who enrolled as members of the program, or (c) the offering of retiree health benefits.

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

§ 5102. Board of trustees. 1. The New York Health board of trustees is hereby created in the department. The board of trustees shall, at the request of the commissioner, consider any matter to effectuate the provisions and purposes of this article, and may advise the commissioner thereon; and it may, from time to time, submit to the commissioner, any recommendations to effectuate the provisions and purposes of this article. The commissioner may propose regulations under this article and amendments thereto for consideration by the board. The board of trustees shall have no executive, administrative or appointive duties except as otherwise provided by law. The board of trustees shall have power to establish, and from time to time, amend regulations to effectuate the provisions and purposes of this article, subject to approval by the commissioner.[10]

[9] Retiree health benefits require further work. They are covered by contracts and ERISA. §5102(7)(b) requires the board to develop a proposal for dealing with retiree benefits.

[10] This subdivision is modeled largely on the Public Health and Health Planning Council.

2. The board shall be composed of:

(a) the commissioner, the superintendent of financial services,[11] and the director of the budget, or their designees, as ex officio members;

(b) seventeen trustees appointed by the governor:

(i) five of whom shall be representatives of health care consumer advocacy organizations which have a statewide or regional constituency, who have been involved in activities related to health care consumer advocacy, including issues of interest to low- and moderate-income individuals;

(ii) two of whom shall be representatives of professional organizations representing physicians;

(iii) two of whom shall be representatives of professional organizations representing licensed or registered health care professionals other than physicians;

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

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

(vi) two of whom shall be representatives of health care organizations;

(viii) two of whom shall be representatives of organized labor;

(c) three trustees appointed by the speaker of the assembly; three trustees appointed by the temporary president of the senate; one trustee appointed by the minority leader of the assembly; and one trustee appointed by the minority leader of the senate.

After the end of the implementation period, no person shall be a trustee unless he or she is a member of the program, except the ex officio trustees. Each trustee shall serve at the pleasure of the appointing officer, except the ex officio trustees.

3. The chair of the board shall be appointed and may be removed as chair by the governor from among the trustees. The board shall meet at least four times each calendar year. Meetings shall be held upon the call of the chair and as provided by the board. A majority of the appointed trustees shall be a quorum of the board, and the affirmative vote of a majority of the trustees voting, but not less than ten, shall be necessary for any action to be taken by the board. The board may establish an executive committee to exercise any powers or duties of the board as it may provide, and other committees to assist the board or the executive committee. The chair of the board shall chair the executive committee and shall appoint the chair and members of all other committees. The board of trustees may appoint one or more advisory committees. Members of advisory committees need not be members of the board of trustees.

[11] The Dept. of Financial Services includes the former Dept. of Insurance.

4. Trustees shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the board.

5. Notwithstanding any provision of law to the contrary, no officer or employee of the state or any local government shall forfeit or be deemed to have forfeited his or her office or employment by reason of being a trustee.

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

7. No later than five years after the effective date of the act enacting this section:

(a) The board shall develop a proposal, consistent with the principles of this article, for provision by the program of long term care coverage, including the development of a proposal for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chair of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, labor, and other interested parties. The board shall present its proposal to the governor and the legislature.

(b) The board shall develop a proposal for incorporating retiree health benefits into New York Health.

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

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

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

(a) family health plus;

(b) for every member under the age of twenty-one, child health plus;

(c) Medicaid;

(d) Medicare;[12]

(e) article 44 of this chapter or article 32 or 43 of the insurance law;[13]

[12] This makes sure that (a) Medicare beneficiaries do not lose anything by being in the program, and (b) non-Medicare-eligible members get the same benefits as Medicare-eligible members.

(f) article 11 of the civil service law, as of the date one year before the beginning of the implementation period ;[14]

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

(h) provided that none of the above shall include long term care, until a proposal under paragraph (a) of subdivision 7 of section 5102 of this article is enacted into law.

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

3. The program shall provide for payment under the program for emergency and temporary health care services provided to members or individual entitled to become members who have not had a reasonable opportunity to become a member or to enroll with a care coordinator.

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

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

2. Care coordination. (a) Health care services provided to a member shall not be subject to payment under the program unless the member is enrolled with a care coordinator at the time the health care service is provided, except where provided under subdivision 3 of section 5104 of this article. Every member shall enroll with a care coordinator that agrees to provide care coordination to the member, prior to receiving health care services to be paid for under the program. The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. The commissioner shall provide, by regulation, that members have the right to change their care coordinator on terms at least as permissive as the provisions of section 364-j of the social services law relating to an individual changing his or her primary care provider or managed care provider.

(b) Care coordination shall be provided to the member by the member's care

[13] This makes sure that all of New York's current insurance mandated benefits continue under New York Health.

[14] State employee health benefits.

coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the commissioner. Care coordination shall include but not be limited to managing, referring to, locating, coordinating, and monitoring health care services for the member to assure that all medically necessary health care services are made available to and are effectively used by the member in a timely manner, consistent with patient autonomy. Care coordination is not a requirement for prior authorization for health care services and referral shall not be required for a member to receive a health care service. However: (i) a health care organization may establish rules relating to care coordination for members in the health care organization, different from this subdivision but otherwise consistent with this article and other applicable law; and (ii) nothing in this subdivision shall authorize any individual to engage in any act in violation of title 8 of the education law (the professions).[15]

(c) Where a member receives chronic mental health care services, at the option of the member, the member may enroll with a care coordinator for his or her mental health care services and another care coordinator approved for his or her other health care services, consistent with standards established by the commissioner in consultation with the commissioner of mental health. In such a case, the two care coordinator s shall work in close consultation with each other.

(d) A care coordinator may be an individual or entity that is approved by the program that is:

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

(ii) an entity licensed under article 28 of this chapter[16] or certified under article 36 of this chapter[17], a managed long term care plan under section 4403-f of this chapter or other program model under paragraph (b) of subdivision 7 of that section,[18] or, with respect to a member who receives chronic mental health care services, an entity licensed under article 31 of the mental hygiene law or other entity approved by the commissioner in consultation with the commissioner of mental health.

[15] Title 8 establishes various licensed professions. Many care coordination functions – e.g., reminding patients about appointments – do not require any license, but many do.

[16] Article 28 facilities are hospitals, community health centers, many ambulatory surgery centers, nursing homes, etc.

[17] Home health care agencies.

[18] MLTCs are similar to an HMO or ACO or health care organization, but focused on long term care.

(iii) a health care organization.

(iv) a Taft-Hartley fund, with respect to its members and their family members; provided that this clause shall not preclude a Taft-Hartley fund from becoming a care coordinator under subparagraph (v) of this paragraph or a health care organization under section 5106 of this article;

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

(e) The commissioner shall develop and implement procedures and standards for an individual or entity to be approved to be a care coordinator in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a care coordinator in the program for economic purposes and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working on care coordination or similar models, including health care practitioners, hospitals, clinics, and consumers and their representatives. When developing and implementing standards of approval of care coordinator s for individuals receiving chronic mental health care services, the commissioner shall consult with the commissioner of mental health. An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

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

3. Health care providers. The commissioner shall establish and maintain procedures and standards for health care providers to be qualified to participate in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of qualification to participate on a determination that the health care provider is an incompetent provider of specific health care services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit health care provider participation in the program for economic purposes and shall be consistent with good professional practice. Any health care provider who is qualified to participate under Medicaid, family health plus, child health plus or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified under this sentence shall follow the procedures to become qualified under the program by the end of

the implementation period.

4. Payment for health care services. (a) Health care services provided to members under the program shall be paid for on a fee-for-service basis, except for care coordination. However, the commissioner may establish by regulation other payment methodologies for health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of health care service.

(b) The program shall engage in good faith negotiations with health care providers' representatives under title III of article 49 of this chapter, including, but not limited to, in relation to rates of payment and payment methodologies.[19]

(c) Notwithstanding any provision of law to the contrary, payment for drugs provided by pharmacies under the program shall be made pursuant to article two-A of this chapter and subdivision 4 of section 365-a of the social services law. However, the program shall provide for payment for prescription drugs under section 340B of the federal public service act where applicable. Payment for prescription drugs provided by health care providers other than pharmacies shall be pursuant to other provisions of this article.[20]

(d) Payment for health care services established under this article shall be considered payment in full. A participating provider shall not charge any rate in excess of the payment established under this article for any health care service under the program provided to a member, and shall not solicit or accept payment from any member or third party for any such service except as provided under this article. However, this paragraph shall not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer where permitted under this article.[21]

(e) The program may provide in payment methodologies for payment for capital related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities certified under article 28 of this chapter. Any capital related expense generated by a capital expenditure that requires or required approval under article 28 of this

[19] Established under the bill, below.

[20] This is the Preferred Drug Program, which until recently governed all Medicaid prescription drugs. Under the 2011 state budget, prescriptions were put under control of the various Medicaid managed care organizations, and the PDP only applies to fee-for-service Medicaid recipients. This would un-do that change.

[21] The phrases "except as provided under this article" and "where permitted under this article" refer to things like Medicare continuing to be the primary payer for Medicare beneficiaries if we don't work out a system in which Medicare pays a lump sum to the state, and retiree health benefits until we work something out there.

chapter must have received that approval for the capital related expense to be paid for under the program.

5. (a) For purposes of this subdivision, "income-eligible member" means a member who is enrolled in a federally-matched public health program and (i) there is federal financial participation in the individual's health coverage, or (ii) the member is eligible to enroll in the federally-matched public health program by reason of income, age, and resources (where applicable) under state law in effect on the effective date of this section, but there is no federal financial participation in the individual's health coverage. A person who is eligible to enroll in a federally-matched public health program solely by reason of section 369-ff of the social services law (employer partnerships for family health plus) is not an income-eligible member.

(b) The program, with respect to income-eligible members, shall be considered an federally-matched public health program or government payor under article 28 of this chapter with respect to the following provisions, and with respect to those members who are not income-eligible members, shall not be considered a federally-matched public health program or governmental payor under article 28 of this chapter with respect to the following provisions:

(i) patient services payments in accordance with section 2807-j of this chapter;

(ii) professional education pool funding under section 2807-s of this chapter; or

(iii) assessments on covered lives under section 2807-t of this chapter.[22]

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

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

(a) an accountable care organization under article 29-E of this chapter; or

(b) a Taft-Hartley fund (i) with respect to its members and their family members, and (ii) if allowed by applicable law and approved by the commissioner, for other members of the program; provided that the commissioner shall provide by regulation that where a Taft-Hartley fund is acting under this clause (ii), there are protections for health care providers and patients comparable to those applicable to accountable care organizations.

3. A health care organization may be responsible for all or part of the health care services to which its members are entitled under the program, consistent with the terms of its approval by the commissioner.

[22] These are provisions of the NY hospital reimbursement system that have special provisions for payments by "government agencies," which has meant Medicaid, Family Health Plus and Child Health Plus. This subdivision is necessary so these provisions do not apply to the coverage of all New Yorkers.

4. (a) The commissioner shall develop and implement procedures and standards for an entity to be approved to be a health care organization in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is incompetent to be a health care organization or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit approval to be a health care organization in the program for economic purposes and shall be consistent with good professional practice. In developing the procedures and standards, the commissioner shall: (i) consider existing standards developed by national accrediting and professional organizations; and (ii) consult with national and local organizations working in the field of health care organizations, including health care practitioners, hospitals, clinics, and consumers and their representatives. When developing and implementing standards of approval of health care organizations, the commissioner shall consult with the commissioner of mental health and the commissioner of developmental disabilities.

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

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

6. The provision of health care services directly or indirectly by a health care organization through health care providers shall not be considered the practice of a profession under title 8 of the education law by the health care organization.[23]

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

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

(b) relations between health care organizations or health care providers and members, including approval of health care services; and

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

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

[23] This protects an HCO from being accused of violating NY's rule against corporate practice of professions. It is modeled on a clause in the HMO statute.

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

(b) Primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and coordination and integration of health care services, including use of appropriate technology.

(c) Elimination of health care disparities.

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

(e) Accessibility of care coordination, health care organization services and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English, and the providing of health care organization services and health care services in a culturally competent manner.

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

4. Every participating provider shall furnish to the program such information to, and permit examination of its records by, the program, as may be reasonably required for purposes of utilization review, quality assurance, and cost containment, for the making of payments, and for statistical or other studies of the operation of the program.

5. In developing requirements and standards and making other policy determinations under this article, the commissioner shall consult with representatives of members, health care providers, health care organizations and other interested parties.

7. The program shall maintain the confidentiality of all data and other information collected under the program when such data would be normally considered confidential data between a patient and health care provider. Aggregate data of the program which is derived from confidential data but does not violate patient confidentiality shall be public information.

§ 5108. Regulations. The commissioner may approve regulations and amendments thereto, under subdivision 1 of section 5102 of this article. The commissioner may make regulations or amendments thereto to effectuate the provisions and purposes of this article on an emergency basis under section 202 of the state administrative procedure act, provided that such regulations or amendments shall not become permanent unless adopted under subdivision1 of section 5102 of this article.

§ 5109. Provisions relating to federal health programs. 1 . The commissioner shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments necessary to operate the program consistent with this article.

2. (a) The commissioner shall apply to the secretary of health and human services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally-matched public health program, the patient protection and affordable care act, and any other federal programs that provide federal funds for payment for health care services, that are necessary to enable all New York Health members to receive all benefits under the program through the program, to enable the state to implement this article, and to receive and deposit all federal payments under those programs (including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits) in the state treasury to the credit of the New York Health trust fund created under section 89-h of the state finance law and to use those funds for the New York Health program and other provisions under this article. To the extent possible, the commissioner shall negotiate arrangements with the federal government in which bulk or lump-sum federal payments are paid to New York Health in place of federal spending or tax benefits for federally-matched health programs or federal health programs.

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

3. (a) If actions taken under subdivision 2 of this section do not accomplish all results intended under that subdivision, then this subdivision shall apply and shall authorize additional actions to effectively implement New York Health to the maximum extent possible as a single-payer program consistent with this article.

(b) The commissioner may take actions consistent with this article to enable New York Health to administer Medicare in New York state and to be a provider of drug coverage under Medicare part D for eligible members of New York Health.

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

(d) The commissioner shall apply for coverage under any federally-matched public health program on behalf of any member and enroll the member in the federally-matched public health program if the member is eligible for it.[24] Enrollment in a federally-matched public health program shall not cause any member to lose any health care service provided by the program.

[24] This is to maximize federal matching. Since all New Yorkers are eligible for New York Health without paying any premium, there is little or no incentive for those who are income-eligible for federally-matched programs to apply for them, so the Commissioner will do it for them. The member will still get a "New York Health" card, but buried in the program's computers will be the fact that the person's coverage is eligible for federal matching funds.

(e) The commissioner shall by regulation increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally-matched public health program, notwithstanding any law or regulation to the contrary. The commissioner may act under this paragraph upon a finding, approved by the director of the budget, that the action (i) will help to increase the number of members who are eligible for and enrolled in federally-matched public health programs; (ii) will not diminish any individual's access to any health care service and (iii) does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.[25] Actions under this paragraph shall not apply to eligibility for payment for long term care.[26]

(f) To enable the commissioner to apply for coverage under any federally-matched public health program on behalf of any member and enroll the member in the federally-matched public health program if the member is eligible for it, the commissioner may require that every member or applicant to be a member shall provide information to enable the commissioner to determine whether the applicant is eligible for a federally-matched public health program and for Medicare (and any program or benefit under Medicare). The program shall make a reasonable effort to notify members of their obligations under this paragraph. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the member's coverage under the program may be terminated.

(g) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare shall enroll in Medicare, including parts A, B and D.

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

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

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[25] This is to make sure that New York Health receives as much federal matching funds as possible.

[26] When New York Health is expanded to include long term care down the road, this sentence would be deleted so those benefits would be federally matched as much as possible.

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

§ 5110. Additional provisions.

1. The commissioner shall contract with not-for-profit organizations to provide:

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

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

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

2. The commissioner shall provide grants, from funds in the New York Health trust fund or otherwise appropriated for this purpose, to health systems agencies under section 2904-b of this chapter to support the operation of such health systems agencies.

§ 3. Financing of New York Health. 1. The governor shall submit to the legislature a plan and legislative bills to implement the plan (referred to collectively in this section as the "revenue proposal") to provide the revenue necessary to finance the New York Health program, as created by article 51 of the public health law (referred to in this section as the "program"), taking into consideration anticipated federal revenue available for the program. The revenue proposal shall be submitted to the legislature as part of the executive budget under article VII[27] of the state constitution, for the fiscal year commencing on the first day of April in the calendar year after this act shall become a law. In developing the revenue proposal, the governor shall consult with appropriate officials of the executive branch; the temporary president of the senate; the speaker of the assembly; the chairs of the fiscal and health committees of the senate and assembly; and representatives of business, labor, consumers and local government.

2. (a) Basic structure. The basic structure of the revenue proposal shall be as follows: Revenue for the program shall come from two assessments (referred to collectively in this section as the "assessments"). First, there shall be an assessment on all payroll and self-employed income (referred to in this section as the "payroll assessment"), paid by employers, employees and self-employed, similar to the Medicare tax. Higher brackets of income subject to this assessment shall be assessed at a higher marginal rate than lower brackets. Second, there shall be a progressively-graduated assessment on taxable income (such as interest, dividends,

[27] The basic provision for the state budget process.

and capital gains) not subject to the payroll assessment (referred to in this section as the "non-payroll assessment"). The assessments will be set at levels anticipated to produce sufficient revenue to finance the program and other provisions of article 51 of the public health law, to be scaled up as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provision shall be made for state residents (who are eligible for the program) who are employed out-of-state, and non-residents (who are not eligible for the program) who are employed in the state.

(b) Payroll assessment. The income to be subject to the payroll assessment shall be all income subject to the Medicare tax. The assessment shall be set at a particular percentage of that income, which shall be progressively graduated, so the percentage is higher on higher brackets of income. For employed individuals, the employer shall pay eighty percent of the assessment and the employee shall pay twenty percent (unless the employer agrees to pay a higher percentage). A self-employed individual shall pay the full assessment.

(c) Non-payroll income assessment. There shall be a second assessment, on upper-bracket taxable income that is not subject to the payroll assessment. It shall be progressively graduated and structured as a percentage of the personal income tax on that income.

(d) Phased-in rates. Early in the program, when enrollment is growing, the amount of the assessments shall be at an appropriate level, and shall be raised as anticipated enrollment grows, to cover the actual cost of the program and other provisions of article 51 of the public health law. The revenue proposal shall include a mechanism for determining the rates of the assessments.

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

(ii) Out-of-state residents employed in the state. (A) The payroll assessment shall apply to any out-of-state resident who is employed or self-employed in the state. (B) In the case of an out-of-state resident who is employed or self-employed in the state, such individual's employer (which term shall include a Taft-Hartley fund) shall be able to take a credit against the payroll assessments they would otherwise pay, for amounts they spend on health benefits that would otherwise be covered by the program. For employers, the credit shall be available regardless of the form of the health benefit (e.g., health insurance, a self-insured plan, direct services, or reimbursement for services), to make sure that the revenue proposal does not relate to employment benefits in violation of the federal ERISA. An employee may take the credit for his or her contribution to an employment-based health benefit. For non-employment-based spending by individuals, the credit shall be available for and limited to spending for health coverage (not out-of-pocket health spending). The credit shall be available without regard to how little is spent or how sparse the benefit. The credit may only be taken against the payroll assessments. Any excess amount may not be applied to other tax liability. For employment-based health benefits, the credit shall be distributed between the employer and employee in the same proportion as the spending by each for the benefit. The employer and employee may

each apply their respective portion of the credit to their respective portion of the assessment. If any provision of this clause (B) or any application of it shall be ruled to violate federal ERISA, the provision or the application of it shall be null and void and the ruling shall not affect any other provision or application of this section or the act that enacted it.

3. The revenue proposal shall include a plan and legislative provisions for ending the requirement for local social services districts to pay part of the cost of Medicaid[28] and replacing those payments with revenue from the assessments under the revenue proposal.

4. To the extent that the revenue proposal differs from the terms of subdivision 2 of this section, the revenue proposal shall state how it differs from those terms and reasons for and the effects of the differences.

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

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

TITLE III

COLLECTIVE NEGOTIATIONS BY HEALTH CARE PROVIDERS WITH NEW YORK HEALTH

§ 4920. Definitions. For purposes of this title:

1."New York Health" means the program under article 51 of the public health law.

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

[28] NY Medicaid has always required counties and New York City to pay a substantial part of the state share of the cost of Medicaid.

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

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

5. "Health care provider" means a person who is licensed, certified, or registered pursuant to title 8 of the education law and who practices as a health care provider as an independent contractor or who is an owner, officer, shareholder, or proprietor of a health care provider; or an entity that employs or utilizes health care providers to provide health care services, including but not limited to a hospital licensed under article 28 of the public health law or an accountable care organization under article 29-E of the public health law. A health care provider under title 8 of the education law who practices as an employee of a health care provider shall not be deemed a health care provider for purposes of this title.

§ 4921. Collective negotiation authorized. 1. Health care providers may meet and communicate for the purpose of collectively negotiating the following terms and conditions of provider contracts with New York Health:

(a) the details of the utilization review plan as defined pursuant to subdivision 10 of section 4900 of this article;

(b) the definition of medical necessity;

(c) the clinical practice guidelines used to make medical necessity and utilization review determinations;

(d) preventive care and other medical management practices;

(e) drug formularies and standards and procedures for prescribing off-formulary drugs;

(f) the details of risk transfer arrangements with providers;

(g) administrative procedures;

(h) procedures to be utilized to resolve disputes between New York Health and health care providers;

(i) patient referral procedures;

(j) the formulation and application of health care provider reimbursement procedures;

(k) quality assurance programs;

(l) the process for rendering utilization review determinations including: establishment of a process for rendering utilization review determinations which shall, at a minimum, include: written procedures to assure that utilization reviews and determinations are conducted within the timeframes established in this article; procedures to notify an enrollee,

an enrollee's designee and/or an enrollee's health care provider of adverse determinations; and procedures for appeal of adverse determinations, including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the enrollee;

(m) health care provider selection and termination criteria used by New York Health;

(n) the fees assessed by New York Health for services, including fees established through the application of reimbursement procedures;

(o) the conversion factors used by New York Health in a resource-based relative value scale reimbursement methodology or other similar methodology; provided the same are not otherwise established by state or federal law or regulation;

(p) the amount of any discount granted by New York Health on the fee of health care services to be rendered by health care providers;

(q) the dollar amount of capitation or fixed payment for health care services rendered by health care providers to New York Health members;

(r) the procedure code or other description of a health care service covered by a payment and the appropriate grouping of the procedure codes; and

(s) the amount of any other component of the reimbursement methodology for a health care service.

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

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

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

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

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

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

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

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

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

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

2. Nothing in this title shall be construed to prohibit or limit collective action or collective bargaining on the part of any health care provider with his or her employer or any other lawful collective action or collective bargaining.

§ 4923. Requirements for health care providers' representative. Before engaging in collective negotiations with New York Health on behalf of health care providers, a health care providers' representative shall file with the commissioner, in the manner prescribed by the commissioner, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this title.

§ 4924. Certain collective action prohibited. 1. This title is not intended to authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with New York Health.

2. No health care providers' representative shall negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

§ 4925. Fees. Each person who acts as the representative or negotiating parties under this title shall pay to the department a fee to act as a representative. The commissioner, by rule, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the department in administering this title.

§ 4926. Confidentiality. All reports and other information required to be reported to the department under this title shall not be subject to disclosure under article 6 of the public officers law[29] or article 31 of the civil practice law and rules[30].

§ 4927. Severability and construction. If any provision or application of this title shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this title which can be given effect without that provision or application; and to that end, the provisions and applications of

[29] NY's freedom of information law.

[30] Disclosure in litigation.

this title are severable. The provisions of this title shall be liberally construed to give effect to the purposes thereof.

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

11. "State public health plan" means the medical assistance program established by title 11 of article 5 of the social services law (referred to in this article as "Medicaid"), the elderly pharmaceutical insurance coverage program established by title 3 of article 2 of the elder law (referred to in this article as "EPIC"), **[**~~and~~**]** the family health plus program established by section 369-ee of the social services law to the extent that section provides that the program shall be subject to this article, and the New York Health program established by article 51 of this chapter.[31]

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

§ 89-h. New York Health trust fund. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "New York Health trust fund", hereinafter known as "the fund". The definitions in section 5100 of the public health law shall apply to this section.

2. The fund shall consist of:

(a) all monies obtained from assessments pursuant to legislation enacted as proposed under section 3 of the act that enacted this section;

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

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

(d) all surcharges that are imposed on residents of this state to replace payments made by the residents under the cost-sharing provisions of Medicare;

(e) federal, state and local funds for purposes of the provision of services authorized under title XX of the federal social security act that would otherwise be covered under article 51 of the public health law; and

(f) state and local government monies that would otherwise be appropriated to any

[31] This closes the loop to put New York Health under the preferred drug program.

governmental agency, office, program, instrumentality or institution which provides health services, for services and benefits covered under New York Health. Payments to the fund pursuant to this paragraph shall be in an amount equal to the money appropriated for such purposes in the fiscal year immediately preceding the effective date of article 51 of the public health law.

3. Monies in the fund shall only be used for purposes established under article 51 of the public health law.

§ 7. Temporary commission on implementation. 1. There is hereby established a temporary commission on implementation of the New York Health program, hereinafter to be known as the commission, consisting of fifteen members: five members, including the chair, shall be appointed by the governor; four members shall be appointed by the temporary president of the senate, one member shall be appointed by the senate minority leader; four members shall be appointed by the speaker of the assembly, and one member shall be appointed by the assembly minority leader. The commissioner of health, the superintendent of financial services, and the commissioner of taxation and finance, or their designees shall serve as non-voting ex-officio members of the commission.

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

3. The commission shall examine the laws and regulations of the state and make such recommendations as are necessary to conform the laws and regulations of the state and article 51 of the public health law establishing the New York Health program and other provisions of law relating to the New York Health program, and to improve and implement the program. The commission shall report its recommendations to the governor and the legislature.

§ 9. Severability. If any provision or application of this act shall be held to be invalid, or to violate or be inconsistent with any applicable federal law or regulation, that shall not affect other provisions or applications of this act which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 10. This act shall take effect immediately.