(ii) the last day of the month in which the child reaches the age of six.

§ 3. This act shall take effect January 1, 2025.

PART N

Intentionally Omitted

PART O

Section 1. Subdivision 1 of section 2807-k of the public health law is amended by adding a new paragraph (h) to read as follows:

(h) "Underinsured" shall mean an individual with out of pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income.

§ 2. Subdivision 9 of section 2807-k of the public health law, as amended by section 1 of subpart C of part Y of chapter 57 of the laws of 2023, is amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures approved by the commissioner, utilizing only a uniform financial assistance form developed and provided by the department. All general hospitals that do not participate in the indigent care pool shall also utilize only the uniform financial assistance form and otherwise comply with subdivision nine-a of this section governing the provision of financial assistance and hospital collection procedures.

§ 3. Subdivision 9-a of section 2807-k of the public health law, as added by section 39-a of part A of chapter 57 of the laws of 2006 and paragraph (k) as added by section 43 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

9-a. (a) [~~As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for~~] For periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand seven, establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance or underinsured individuals, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance under this section.

(b) Such reductions from charges for [~~uninsured~~] patients with incomes below at least [~~three~~] four hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed [~~the greater of~~] the amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services~~] provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes [~~at or~~] below at least [~~one~~] two hundred percent of the federal poverty level, the hospital shall [~~collect no more than a nominal payment amount, consistent with guidelines established by the commissioner~~] waive all charges. No nominal payment shall be collected;

(ii) For patients with incomes between at least [~~one~~] two hundred [~~one~~] percent and [~~one~~] up to three hundred [~~fifty~~] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases [~~from the nominal amount described in subparagraph (i) of this paragraph~~] in equal increments as the income of the patient increases, up to a maximum of [~~twenty~~] ten percent of the [~~greater of the~~] amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services~~] provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of ten percent of the amount that would have been paid pursuant to such patient's insurance cost sharing;

(iii) For patients with incomes between at least [~~one~~] three hundred [~~fifty-one~~] one percent and [~~two~~] four hundred [~~fifty~~] percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the [~~twenty~~] ten percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of [~~the greater~~] twenty percent of the amount that would have been paid for the same services [~~by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services~~] provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of twenty percent of the amount that would have been paid pursuant to such patient's insurance cost sharing; [~~and~~

~~(iv) For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid).~~

~~(v) For the purposes of this paragraph, "highest volume payor" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.~~

~~(vi) A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the~~

~~requirements described in subparagraphs (i) and (ii) of this paragraph based upon the existence of significant assets owned by the patient that should be taken into account in determining the appropriate payment amount for that patient's care, provided, however, that such proposed policies and procedures shall be subject to the prior review and approval of the commissioner and, if approved, shall be included in the hospital's financial assistance policy established pursuant to this section, and provided further that, if such approval is granted, the maximum amount that may be collected shall not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid). In the event that a general hospital reviews a patient's assets in determining payment adjustments such policies and procedures shall not consider as assets a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.~~

~~(vii)~~] (iv) Nothing in this paragraph shall be construed to limit a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified herein and/or to provide greater payment discounts for eligible patients than those required by this paragraph.

(c) Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures [~~upon request~~]. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the written notification of patients during the intake and registration process, and during discharge of the patient, and through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and during discharge of the patient, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

(d) Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to

adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the [~~hospital's~~] financial assistance policy. The monthly payment under such a plan shall not exceed [~~ten~~] five percent of the gross monthly income of the patient[~~, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments~~]. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed [~~the rate for a ninety-day security issued by the United States Department of Treasury, plus .5~~] two percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance [~~within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application~~] at any time during the collection process. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation in support of their application, provided, however, that such application process shall not be unduly burdensome or complex. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. Application forms shall be printed in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers, or (ii) spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another publicly subsidized insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another publicly subsidized insurance program, and upon the patient's cooperation in following the [~~hospital's~~] financial assistance application requirements, including the provision of information needed to make a determination on the patient's application in accordance with the hospital's financial assistance policy, provided, however, that this requirement shall not apply to any

patient that would otherwise not qualify for coverage based on their immigration status.

(f) Such policies and procedures shall provide that patients with incomes below [~~three~~] four hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such policies and procedures shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum:

(i) prohibit a hospital from developing or altering its primary service area in a manner designed to avoid medically underserved communities or communities with high percentages of uninsured residents;

(ii) ensure that every geographic area of the state is included in at least one general hospital's primary service area so that eligible patients may access care and financial assistance; and

(iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-l of this article.

(g) Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area. For patients determined to be eligible for financial aid under the terms of a hospital's financial aid policy, such policies and procedures shall prohibit any limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) Such policies and procedures shall prohibit the denial of admission or denial of treatment for services that are reasonably anticipated to be medically necessary because the patient has an unpaid medical bill. Such policies and procedures shall [~~not permit~~] prohibit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures shall prohibit the sale of medical debt accumulated pursuant to this section to a third party, unless the third party explicitly purchases such medical debt in order to relieve the debt of the patient. Such policies and procedures shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection

agency obtain the hospital's written consent prior to commencing a legal action. Such policies and procedures shall prohibit a hospital from commencing a legal action related to the recovery of medical debt or unpaid bills against patients with incomes below four hundred percent of the federal poverty level. In any legal action related to the recovery of medical debt or unpaid bills by or on behalf of a hospital, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that based upon the hospital's reasonable effort to determine the patient's income, the patient whom they are taking legal action against does not have an income below four hundred percent of the federal poverty level. Such policies and procedures shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in such policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with such policies and procedures. Such policies and procedures shall require that any collection agency under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. Such policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

(i) a report on hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance[~~, including the amount of care provided for a nominal payment amount,~~] during the period covered by the report;

(ii) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

(iii) the number of patients, organized according to United States postal service zip code, who applied for financial assistance pursuant to the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied;

(iv) the number of patients, including their age, race, ethnicity, gender and insurance status, who applied for financial assistance under the hospital's financial assistance policy, and the number of patients, including their age, race, ethnicity, gender and insurance status, whose applications were approved and denied;

(v) the reimbursement received for indigent care from the pool established pursuant to this section;

[~~(v)~~] (vi) the amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose of providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts;

[~~(vi)~~] (vii) for hospitals located in social services districts in which the district allows hospitals to assist patients with such applications, the number of applications for eligibility under title XIX of the social security act (medicaid) that the hospital assisted patients in completing and the number denied and approved; and

[~~(vii)~~] (viii) the hospital's financial losses resulting from services provided under medicaid[~~; and~~

~~(viii) the number of liens placed on the primary residences of patients through the collection process used by a hospital~~].

(j) Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.

(k) [~~In the event it is determined by the commissioner that the state will be unable to secure all necessary federal approvals to include, as part of the state's approved state plan under title nineteen of the federal social security act, a requirement, as set forth in paragraph one of this subdivision, that compliance with this subdivision is a condition of participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article, then such condition of participation shall be deemed null and void and, notwithstanding~~] Notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

(l) A hospital or its collection agent shall not commence a civil action against a patient or delegate a collection activity to a debt collector for nonpayment for at least one hundred eighty days after the first post-service bill is issued and until a hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance.

§ 4. The public health law is amended by adding a new section 18-c to read as follows:

§ 18-c. Separate patient consent for treatment and payment for health care services. Informed consent from a patient to provide any treatment, procedure, examination or other direct health care services shall be obtained separately from such patient's consent to pay for the services. Consent to pay for any health care services by a patient shall not be given prior to the patient receiving such services and discussing treatment costs. For purposes of this section, "consent" means an action which: (a) clearly and conspicuously communicates the individual's authorization of an act or practice; (b) is made in the absence of any mechanism in the user interface that has the purpose or substantial effect of obscuring, subverting, or impairing decision-making or choice to obtain consent; and (c) cannot be inferred from inaction.

§ 5. The general business law is amended by adding two new sections 349-g and 519-a to read as follows:

§ 349-g. Restrictions on applications for and use of credit cards and medical financial products. 1. For purposes of this section, the following terms shall have the following meanings:

(a) "Medical financial products" shall mean medical credit cards and third-party medical installment loans.

(b) "Health care provider" shall mean a health care professional licensed, registered or certified pursuant to title eight of the education law.

(c) "Medical credit card" shall mean a credit card issued under an open-end or closed-end plan offered specifically for the payment of health care services, products, or devices provided to a person.

2. It shall be prohibited for any hospital or health care provider, or employee or agent of a hospital or health care provider, to complete any portion of an application for medical financial products for the patient or otherwise arrange for or establish an application that is not completely filled out by the patient.

§ 519-a. Credit cards and payment for health care services. 1. For purposes of this section, the term "credit card" shall have the same meaning as in section five hundred eleven of this article.

2. No hospital or health care provider shall require credit card preauthorization nor require the patient to have a credit card on file prior to providing emergency or medically necessary medical services to such patient.

3. Hospitals and health care providers shall notify all patients about the risks of paying for medical services with a credit card. Such notification shall highlight the fact that by using a credit card to pay for medical services, the patient is forgoing state and federal protections that regard medical debt. The commissioner of health shall have the authority and sole discretion to set requirements for the contents of such notices.

§ 6. This act shall take effect six months after it shall have become a law; provided, however, that if section 1 of subpart C of part Y of chapter 57 of the laws of 2023 shall not have taken effect on or before such date then section two of this act shall take effect on the same date and in the same manner as such chapter of the laws of 2023 takes effect. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART P

Section 1. Section 8 of part C of chapter 57 of the laws of 2022 amending the public health law and the education law relating to allowing pharmacists to direct limited service laboratories and order and administer COVID-19 and influenza tests and modernizing nurse practitioners, is amended to read as follows:

§ 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2022; provided, however, that sections one, two, three, four, six and seven of this act shall expire and be deemed repealed [~~two years after it shall have become a law~~] July 1, 2026.

§ 2. Section 5 of chapter 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended