The State of New York enacted legislation that deregulates hospital rates. Effective January 1, 1997, all
payers, including but not limited to self-funded plans and HMO’s are able to negotiate discount arrangements
with New York state hospitals. *(This law is replacement to the current Diagnostic Related Group (DRG)
charges plus a 13% surcharge with a new set of surcharges.)*

Whether or not the self-funded plan or other plan has employees in New York, it is possible that plan
participants may at some time incur charges in a New York hospital or facility causing this new law to
impact your plan.

**Surcharge Options:** Under the law, there are two (2) possible methods for a self-funded plan to comply with
the surcharge requirement in the law.

“Default” Method: Under this method, the hospital or other facility will pay the surcharge to the state. Your
plan will pay the “Default” surcharge to the hospital or other facility. The “Default” surcharge includes:

a) A basic 9.63% of the service charges, plus
b) A surcharge of 24% of the service charge

This method is not the recommended method.

“Election” Method: The plan can elect to pay the required surcharges directly to the state rather than to the
hospital or other facility. In this case, the surcharge amount is substantially reduced. Under this method, the
surcharge includes:

a) A basic 9.63% of the service charge, plus
b) A monthly “Covered Lives” assessment based upon the number of New York
residents covered by the plan. The “Covered Lives” assessment will differ based
upon the various regions in New York. *(Note: If there are no New York residents
covered by the plan, the plan does not pay a “Covered Lives” assessment.)*

**GBS Recommendation:** We would recommend that you elect to pay the required surcharges directly to the
state under the “Election” method defined above.

It is definitely advantageous for the plan that does not cover any New York residents to elect to pay the
surcharge directly to the state as the plan will not pay the monthly covered lives assessment and if any of the
plan participants utilize a hospital or other facility in New York, the amount that the plan and the plan
participants will pay will be lower. Even if the plan does cover New York residents, the election will likely
result in lower costs to the plan as the plan will pay the basic charge and an assessment based on each New
York resident, but the plan will avoid the 24% surcharge.

**What you need to do to elect:** The plan must file with the state of New York an election form to pay the
surcharges and assessments directly to the state. Following you will find an election form, to complete.

GBS must submit an election form to the state along with your individual election form identifying methods
of payment. Both the plans’ individual election form and the election form for the Third Party Administrators
have to be submitted together in one package. It is, therefore, essential that you sign your election form so
that we can include it with our election.
HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: ____________________________

FEDERAL EMPLOYER IDENTIFICATION # (FEIN): ____________________________

PAYOR NAME: ________________________________________________________

D/B/A (IF APPLICABLE): _______________________________________________

ADDRESS: __________________________________________________________

CONTACT PERSON: ____________________________________________________

PHONE #: ___________________________________________________________

E-MAIL ADDRESS: _____________________________________________________

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

TPA/ASO NAME: ______________________________________________________

TPA/ASO FEIN: _______ 52-1200892 ______________________________________

By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department’s Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department’s Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory\footnote{For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.}, or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

\footnote{For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.}
4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department’s website posting of the above entity’s FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department’s Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department’s Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor’s membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature

Chief Financial Officer or Duly Authorized Individual

Title

Date

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.
HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

☐ New Request  ☐ Revision to Existing Account

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:
________________________________________________________

Federal Employer Identification # (FEIN): ________________________________

Operating Certificate # (FOR PROVIDERS ONLY): __________________________

Report(s) being filed electronically (check ALL that apply):
☐ Public Goods Pool
☐ 1% Statewide Assessment (for hospitals only)

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _______________________________________________________

Name (Please Print) ________________________________________________

Title _____________________________________________________________

Phone Number ____________________________________________________

Address __________________________________________________________

_______________________________________________________________

City ___________________________ State ___________ Zip Code __________

E-mail Address ____________________________________________________

Date __________________________

Note: All fields on this form are required to be accurately completed in order for your request to be processed.

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757