NOTICE OF JOINT SENATE AND ASSEMBLY PUBLIC HEARING

SUBJECT: The New York Health Act

PURPOSE: To gather feedback and recommendations from health care providers, patient advocates, health coverage providers, labor, employers and other stakeholders about the New York Health Act and its specific provisions.

NOTE NEW LOCATION

Albany

Tuesday, May 28, 2019
10:00 AM
Hearing Room B
Legislative Office Building, 2nd Floor
Albany, New York 12248

Cost remains a primary obstacle to accessing health care, and those who are able to access care are often left with significant debt as a result. The New York Health Act, A.5248/S.3577, would replace traditional health insurance coverage and public health coverage programs with comprehensive single-payer health coverage, including long-term care, for all New Yorkers. The program would be publicly funded, including existing federal support for Medicaid and Medicare. New Yorkers would no longer have to pay premiums, deductibles, co-pays, out-of-network charges, or have limited provider networks. This hearing is the first of a series of hearings that will provide an opportunity for comments and suggestions from stakeholders around the state on the New York Health Act.

Persons wishing to present pertinent testimony to the Committees in these hearings should complete and return the enclosed reply form as soon as possible. It is important that the reply form be fully completed and returned so that persons may be notified in the event of emergency postponement or cancellation.

Oral testimony will be limited to TEN (10) minutes’ duration. All testimony will be under oath. In preparing the order of witnesses, the Committees will attempt to accommodate individual requests to speak at particular times in view of special circumstances. These requests should be made on the attached reply form or communicated to Committee staff as early as possible.

Twenty (20) copies of any prepared testimony should be submitted at the hearing registration desk. The Committees would appreciate advance receipt of prepared statements.

In order to meet the needs of those who may have a disability, the New York State Legislature, in accordance with its policies of non-discrimination on the basis of disability, as well as the 1990 Americans with Disabilities Act (ADA), has made its facilities and services available to all individuals with disabilities. For individuals with disabilities, accommodations will be provided, upon reasonable request, to afford such individuals access and admission to the Legislature’s facilities and activities.

Richard N. Gottfried
Member of Assembly
Chair
Committee on Health

Gustavo Rivera
Member of Senate
Chair
Committee on Health
Persons wishing to present testimony at the public hearing on the New York Health Act are requested to complete this reply form as soon as possible and mail, email or fax it to:

<table>
<thead>
<tr>
<th>Anthony Kergaravat</th>
<th>Carolyn Sheridan</th>
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<tbody>
<tr>
<td>Principal Analyst</td>
<td>Policy Analyst</td>
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<tr>
<td>Assembly Program and Counsel</td>
<td>Senate Majority Counsel’s Office</td>
</tr>
<tr>
<td>Room 520 – Capitol</td>
<td>Room 500 – Capitol</td>
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<tr>
<td>Albany, New York 12248</td>
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<td>Phone: (518) 455-4311</td>
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<tr>
<td>Fax: (518) 455-7095</td>
<td>Fax: (518) 455-6995</td>
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</tbody>
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☐ I plan to attend the following public hearing on the New York Health Act to be conducted by the New York State Assembly Committee on Health and the Senate Committee on Health on Tuesday, May 28, 2019.

☐ I plan to make a public statement at the hearing. My statement will be limited to 10 minutes, and I will answer any questions which may arise. I will provide 20 copies of my prepared statement. I will address my remarks to the following subjects:

☐ I do not plan to attend the above hearing.

☐ I would like to be added to the Committee mailing list for notices and reports.

☐ I would like to be removed from the Committee mailing list.

☐ I will require assistance and/or handicapped accessibility information. Please specify the type of assistance required: __________________________________________________________

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NAME: _____________________________________________________________________

TITLE: _____________________________________________________________________

ORGANIZATION: ______________________________________________________________

ADDRESS: _________________________________________________________________

E-MAIL: ____________________________________________________________________

TELEPHONE: _______________________________________________________________

FAX TELEPHONE: ___________________________________________________________