§ 2828(1) (requiring nursing homes to spend 70% of revenue on direct resident care and forty percent of revenue on resident-facing staffing). The implementation of these statutes was suspended by executive order; the suspension was lifted by Executive Order 4.7 (Mar. 31, 2022), https://www.governor.ny.gov/sites/default/files/2022-03/EO_4.7.pdf.

12. *See* N.Y. A.B. A191A (2021-2022 Session), https://www.nysenate.gov/legislation/bills/2021/a191/amendment/a.
13. *See* N.Y. Dept. of Health, Health Equity Reform Amendment Application (Sep. 2, 2022), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-pa-09152022.pdf.
14. New York State Department of Health, Press Release: State Health Commissioner Conducts First Town Hall Session with Department's New Office of Aging and Long-Term Care (Aug. 17, 2022), https://www.health.ny.gov/press/releases/2022/2022-08-17_first_town_hall_session.htm.
15. *Id.*
16. New York State Department of Health, Master Plan for Aging, https://www.health.ny.gov/community/aging/master_plan/#:~:text=Under%20the%20leadership%20of%20Governor,aging%20with%20dignity%20and%20independence.
17. N.Y. A.B. A3922A (2021-2022 Session), https://www.nysenate.gov/legislation/bills/2021/A3922.
18. U.S. Government Accountability Office, Telehealth in the Pandemic – How Has It Changed Health Care Delivery in Medicaid and Medicare? (Sep. 29, 2022), https://www.gao.gov/blog/telehealth-pandemic-how-has-it-changed-health-care-delivery-medicaid-and-medicare#:~:text=We%20found%20that%20the%20number,GAO's%20Medicaid%20expert%2C%20Carolyn%20Yocom.
19. N.Y. Pub. Health Law § 2999-cc.
20. *See, e.g.,* N.Y. Soc. Servs. Law § 367-u (payment parity for telehealth services provided to Medicaid beneficiaries).

A Conversation With Assembly Member Richard N. Gottfried on the Eve of His Retirement From Public Office

Interviewed by Robert N. Swidler
Edited by Jane Bello Burke

In 2022, Assemblymember Richard N. Gottfried, New York's longest-serving legislator and the Chair of the Assembly Health Committee since 1987, announced he had decided not to run for reelection. To mark the occasion, on November 3, 2022, the New York State Bar Association's Health Law Session held a full-day program to examine the impact of Assemblymember Gottfried's impact on New York's health care delivery system. The program focused on the Assemblymember's contributions in four areas: (i) health care access; (ii) civil liberties; (iii) health care decision making; and (iv) health care oversight.

At the end of the program, Robert N. Swidler, who had worked with the Assemblymember and his staff on New York's Family Health Care Decisions Act and several other legislative initiatives, sat down with Assemblymember Gottfried to ask a few questions.[1] The following is a transcript of the interview.

Robert N. Swidler: We set aside a little time for a few wrap-up questions. Thank you for sticking with us for this. Let's start with an easy one. What did you think of today's program?

Richard N. Gottfried: I really enjoyed it. A lot of it reminded me of things we worked on years and years ago. Programs like this, anything that gets my brain thinking about and organizing my thoughts, I always find to be an educational experience. I've found this really valuable and utterly delightful.

Q. But to get to the real point, did we convince you not to retire? That was the objective of today's program.

A. No. First, I didn't run for reelection, so it's a done deal. Second, while I love what I do, and a lot of today's discussion has reminded me of what I love to do, there have been a few meetings lately talking about, "what are we going to do about X next year," where I have quietly said to myself, "maybe I'm glad I'm retiring...I don't have to solve X next year." So I am very much looking forward to retiring next

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year. Although I have, as I said earlier, always loved and continue to love what I do.

Q. Let me turn to a couple of substantive areas. One that you've been working tirelessly on is a universal health care plan for New York,[2] a single-payor universal health care plan. Still not the law. I know your focus is rightfully on the benefit to patients, as it should be, but just looking for a moment at providers and/or insurers, is New York Health going to help providers or insurers? Or how does that work for the institutional part of the health care system?

A. I think it will be a great benefit to almost all providers. We read about hospitals that have more billing clerks than they have nurses. And I don't think I've ever heard a practicing health care professional or hospital or nursing home official ever say anything complimentary about an insurance company.

People say, "well, under the New York State Health Act, they'll just be annoyed the hell out of by the government." But there are a couple of key differences between a single-payor, publicly accountable payor and the insurance industry. One is, if the insurance industry doesn't make money out of paying bills, it makes money out of encouraging people who are high utilizers of health care to go get insurance from the other company. So they make money by not paying for health care, and the people to whom they are accountable are their stockholders, who are delighted by that proposition.

A public universal health care provider is accountable not only to the public, but every member of the Legislature and every member of the Governor's administration is going to be covered by that plan. Yes, there will be downward pressure to save taxpayer dollars as much as possible, but there will also be upward pressure to make sure that my successor and my successor's family and my successor's doctor are as well treated as possible. I think that will make an enormous difference in terms of the relationship between health care providers and the New York Health Plan as payor versus the world they live in today.

Q. One type of scenario on my mind right now is in the Capital Region. I represent a health care provider system, and we're in contract negotiations with a big health care payor, a private commercial payor in that system.[3] The contract is coming to an end and we are fighting each other. We want somewhat higher rates and they don't want us to have somewhat higher rates. What would that scenario look like under New York Health?

A. There would be discussions that individual provider entities or individuals could have. There is also language in the bill that authorizes groups of providers to negotiate collectively with New York Health. You need statutory authorization to do that because otherwise it would be an anti-trust violation. There is language in the New York Health Act, largely based on the old Boren Amendment at the federal level,[4] requiring compensation levels for health care providers under the legislation to be reasonably related to the cost of efficiently providing the service and sufficient to ensure an adequate supply of service. There is nothing like that provision currently in the insurance world.

Thinking back to the days when New York regulated hospital prices, as I've occasionally reminded people from the hospital world, the reason we no longer have the NYPHRM[5] system is because there were political forces that prevailed on Governor Pataki to sunset it. The reason was that the Legislature was treating hospitals better than the business community thought we should. If I were a hospital, I think I'd rather rely on how well I'm going to be paid by a payor that is accountable to the public of New York, rather than a payor that is accountable to stockholders.

Q. One more question. I wouldn't have thought of it until your discussion with former Senate Health Chair Kemp Hannon this morning. How is New York Health better than a return to NYPHRM?

A. For one, NYPHRM only related to hospital rates. For another, even under NYPHRM, a given hospital still had to maintain an army of billing clerks to argue with the insurance company about whether or not this gallbladder was medically necessary and still had questions of "are we in-network or not in-network?"

Q. And I guess it didn't insure anybody, now that I am thinking about it, so it's not that great a question.

A. From the provider viewpoint, that price regulation, in my view, is better than not having price regulation. But the New York Health Act system would be even better.

Q. Let me turn to health care decision-making for a moment. I was in a discussion recently at the Empire State Bioethics Consortium about the limits of autonomy.[6] You've been fighting for greater autonomy for patients your whole career. I think the Medical Aid-in-Dying Act[7] is another extension of that fight for autonomy from your standpoint. But what shook a lot of us, and we were talking about in this conference, was to see case law on autonomy like *Schloendorff*,[8] and *Cruzan*,[9] and *Storar*[10] and these other landmark cases being invoked now by plaintiffs to refuse mandated vaccinations for health care workers or to demand Ivermectin. I haven't seen this in case law but I'm increasingly seeing instances of newborn moms and dads not accepting the state mandatory tests or prophylactic treatments for newborns. It seems all part of this attitude, "Hey, it's my right to not do any of these public health measures." It troubled me to see *Storar* invoked that

way. Is it troubling you? Do you see that as part of the natural extension of autonomy?

A. I think I share in your feeling troubled by that concept. You know, I would point to the *Jacobson*[11] decision about vaccination that goes back to the dawn of the 20th century, in which the Supreme Court spoke in terms of having to recognize public health exigencies. Typhoid Mary did not get to cite the *Scholendorff* decision as to why she should or shouldn't be confined to an island in the East River off Manhattan.[12] That was a public health issue. Public health, when based on good science and good values, I think properly outweighs an individual preference. That's been true for over a century in many vaccination circumstances. It's true on questions like whether the Health Commissioner with the stroke of a pen can quarantine an entire city. And the answer is "Yes, she can."

Patient autonomy is an enormously important value, but it is not the only value and there are times when both public health protection and the protection of minors step in. There are, and always have been, areas where the law can step in for the protection of the physical or emotional welfare of a minor, to the point of taking a child away from its parents. The ability to mandate vaccinations – and in some cases, other medical treatment – is part of that.

Q. That's interesting that you, almost verbatim, said the same thing that Daniel Callahan, the bioethicist with the Hastings Center,[13] used to say, "autonomy is an important value, it's not the only value." It's a good point to be made, particularly in the public health context.[14]

Moving on to pending legislation, I saw that you were sponsoring over 100 bills this session alone. Is there one or two you want to highlight and say, "I really would like to see these passed or have somebody finish the work on this," or something in there you feel particularly strongly about?

A. Well, as I mentioned earlier, certainly the New York Health Act by far.[15] And I talked about the Retail Clinic Bill,[16] which again, while it may look like a very small piece of the health care pie at the moment, addresses the potential for commercial control of clinics. And I'm not even talking about something like CitiMed, which is at least a somewhat corporate health care provider, but the potential for huge business entities that have nothing to do with health care to be hosting corporate-controlled full-blown medical practices.

Back before Toys "R" Us went bankrupt, I used to say, can you imagine the prospects of a family pediatrician trying to compete with the Toys "R" Us pediatric practice? How do you convince your child to go to doctor so and so instead of Geoffrey the Giraffe? The notion of even a group practice of doctors, or a doctor who is part of a faculty practice, trying to compete with the Walmart practice in town, with their advertising dollars, is hard to contemplate. But you know there is really nothing in New York law today that prevents Walmart or Macy's from opening up an entire floor of a full-blown multi-specialty medical practice, which it would not technically own. But that's kind of like saying "sharecroppers weren't really owned by the plantation." No, but they were pretty close to it. At any point, that day could begin to dawn in New York, and I really don't want that to happen. The Retail Clinic Bill is a small step to try and head that off.

Q. Is that co-sponsored and do you have a colleague that is going to be continuing that effort?

A. If I am remembering correctly, Senator Gustavo Rivera, who chairs the Senate Health Committee, carries the bill in the Senate, and Assemblymember Amy Paulin, who may well be the new Assembly Health Chair. She and I have always worked very closely together on the retail clinic issue, and I would expect the bill to be carried forward by her. It's not a very well-known proposition, but I hope that changes.

Q. A number of people today, including you, noted your love of words and the care and the attention you give to bill drafting. I remember on several occasions, working with you and discussing whether a comma ought to be removed...and if it was end-of-life legislation, I would think of that as an irreversible comma (I'm sorry, I had to work that in) but I thought you might comment more on the care with which you deal with words in bill drafting.

A. I've been giving a lot of thought to where that comes from, and I think I have a pretty good set of ideas. One is my father who, in addition to being an economist, was an editor and a very picky writer. I learned a lot from him. Second, my ninth grade English teacher at Junior High School 185 in Queens, who I will always refer to as the revered Mr. Littman. He was just an extraordinary teacher and really gave me a lot of my love for and appreciation for language. Just a wonderful teacher.

I guess we are up to law school – I was in the process of getting elected to the Legislature – that happened in the middle of law school, but I knew that was what I was going to be doing a year or so after my first semester (I was a very strange young person) – and I took courses in legislative drafting with the late professor Frank Grad, who ran the legislative drafting research service at Columbia. I realize what fun I was going to have in that course, but I was taking it because I expected I was going to be a legislator, so I figured I should take a course in legislative drafting.

We used a wonderful little book, which is long out of print, called "Legislative Drafting" by Reed Dickerson. It's a wonderful little book about the bill drafting process and

bill language and how to think it through and whatnot. After I got elected, having taken his regular course at Columbia, every semester you could essentially do a little individual writing seminar. And so, every semester I did that with Professor Grad. And I would draft bills, he would critique them and then I would go to Albany and introduce them. A very strange process. And I would turn to Professor Grad over the years on various topics and it was amazing. Every topic I turned to him on, it turned out he had written a book about it. When I became chairman of the Codes Committee, which deals with criminal justice, it turned out Frank Grad had been chief counsel to the New York State Temporary Commission on the Revision of the Penal Law, so he had a lot to tell me. All of that helped to increase my fascination and my sense of the importance of the drafting process.

Q. One comment and one last quick question. The comment is, I wish over your 35-year health chair career you had gotten the bill drafting people to amend the Public Health Law to go to numbers, rather than spelling out every section. You would have been able to get rid of at least two volumes of McKinney's if you did that.

A. That notion will be in my exit memo to the Legislative Bill Drafting Commission.

Q. Terrific! And the last thing is the legacy question. When you retire, and you're in your study at home, what pen certificate are you going to have on your wall?

A. The answer to that is none. By the way, if any of you would like a pen certificate or a frame in which to put in your favorite picture, I have dozens, and dozens, and dozens, and dozens of pen certificates sitting in a closet in my Albany office. Years ago, we took them down off the wall because there was no more wall space. But if your question is what are, let's say, two pieces of legislation that if I were to hang pen certificates on my wall, which would they be?

One, the law creating Child Health Care Plus.[17] A couple of years after Child Health Plus became law, I was introduced to a family with a lovely eight- or nine- year old son. They told me that when Child Health Care Plus became law, he was much younger and had never been to the doctor since his birth, because they couldn't afford it. Thanks to Child Health Plus – and I'm sorry I choke-up when I tell this story – they were able to take him to the doctor, and he was diagnosed with a brain tumor. Thanks to Child Health Plus, he was diagnosed early and cured, and there he was, a happy and healthy eight- or nine-year-old. It doesn't get much better than that.

In the non-health area, the 1998 legislation creating what is the Hudson River Park on the west side of Manhattan,[18] which took four bloody years to enact, is, I think, one of the other things I am proudest of. A lot of the crucial elements of that bill were not my idea, but I guess I had the good sense to see the sense in a lot of the pieces of that legislation, and I think it's worked out really well. Those would be the two pen certificates I would hang on my wall if I were hanging up pen certificates.

Q. Look, you said today, if the law is any good, no one ever comes forward to say thank you. I think for the past eight hours we've been saying, "thank you." So, thank you.

A. As people sometimes say, but with utter and complete profound sincerity, my pleasure.

Portions of the interview have been edited for brevity and clarity, and footnotes have been added for context.

Jane Bello Burke is a partner in the law firm Hodgson Russ LLP, where she focuses her practice on healthcare regulatory and litigation matters. She serves as Chair of the Health Law Section and Chair of the Section's Long-Term Care Committee, and she is the incoming Vice President for the Third Judicial District of the New York State Bar Association.

Robert N. Swidler is General Counsel to St. Peter's Health Partners in Albany and St. Joseph's Health in Syracuse. Previously, Mr. Swidler was Counsel to the Northeast Health, Counsel to the New York State Office of Mental Health, Assistant Counsel to Governor Mario Cuomo, and Staff Counsel to the New York State Task Force on Life and the Law. Mr. Swidler is also a past Chair of the NYSBA Health Law Section and former Editor-in-Chief of the NYSBA Health Law Journal.

Endnotes

1. The legislation included, among others, the New York Health Care Proxy Law, N.Y. Pub. Health Law Art. 29-C, and the Family Health Care Decisions Act, N.Y. Pub. Health Law Art. 29-CC. For more information on these statutes, *see* the New York State Bar Association Health Law Section's Family Health Care Decisions Act Resource Center at https://nysba.org/fhcda-resource-center/.
2. The proposed New York Health Act, A6058/S5474 (2021-2022), would establish the New York Health program, a comprehensive system of access to health insurance for New York state residents.
3. *See* Rachel Silberstein, *Patients in limbo as CDPHP, St. Peter's air contract fight*, Times Union, Nov. 1, 2022 (updated Nov. 2, 2022), https://www.timesunion.com/news/article/CDPHP-and-St-Peter-s-involve-patients-amid-17546990.php.
4. The Boren Amendment, part of the federal Omnibus Reconciliation Act of 1980, required Medicaid nursing home rates to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards." Soc. Sec. Act § 1902(a)(13), 42 U.S.C. 1396a(a)(13).
5. NYPHRM, the New York Prospective Hospital Reimbursement Methodology, *see* N.Y. Pub. Health Law §§ 2807-a, 2808-c, which evolved in phases over time, was a system for reimbursing general hospitals for the cost of providing inpatient care. For more information, *see* I. Frasier, *Rate Regulation as a Policy Tool: Lessons From New York State*, Health Care Financ Rev. 1995 Spring; 16(3): 151–175, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193515/.
6. The Empire State Bioethics Consortium, founded in 2020, is a not-for-profit membership organization of scholars, researchers, and practitioners dedicated to addressing ethical issues and inequities in health and health care across New York State. For more information, *see* https://www.empirestatebioethics.org/.
7. The proposed New York Medical Aid in Dying Act, S6471/A4321A (2021-2022), S3947/A2694 (2019-2020), S3151/A2383 (2017-2018), and S7579/A10059 (2015-2016), would allow mentally capable adults diagnosed with a terminal illness to make the decision to bring about an end to their life with the assistance of medication prescribed by a doctor.
8. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), abrogated in part on the grounds by *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3 (1957).
9. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).
10. *Matter of Storar*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981).
11. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).
12. Typhoid Mary was quarantined on North Brother Island, an island in the East River near Rikers Island. *See* Marineli F, Tsoucalas G, Karamanou M, Androutsos G., "Mary Mallon (1869-1938) and the history of typhoid fever," Ann. Gastroenterol. 2013;26(2):132-134, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3959940/.
13. The Hastings Center, founded in 1969 by philosopher Daniel Callahan and psychoanalyst Willard Gaylin, is a nonprofit organization addressing social and ethical issues in health care, science, and technology For more information, *see* https://www.thehastingscenter.org/who-we-are/.
14. *See*, *e.g.*, Daniel Callahan, *When Self-Determination Runs Amok,* Hastings Center Report 22 (March/April 1992) at 52-55 (https://users.manchester.edu/Facstaff/SSNaragon/Online/texts/235/Callahan,%20Self-Determination.pdf), and Daniel Callahan, "Autonomy: A Moral Good, Not a Moral Obsession," Hastings Center Report, Oct. 1994 at 40, https://www.jstor.org/stable/3561098.
15. *See* note 2, *supra*.
16. Proposed A.216 (Gottfried) / S.9276 (Rivera) (2021-2022) relates to the regulation of retail clinics.
17. The Child Health Plus program, which the New York State Legislature enacted in 1990, *see* Pub. Health Law §§ 2510, *et seq*., served as a blueprint for the federal State Children's Health Insurance Program (S-CHIP) statute, enacted as part of the federal Balanced Budget Act of 1997, to provide health insurance for children.
18. The Hudson River Park Act, L. 1998, ch. 592, formally designated a 550-acre expanse running along over four miles of waterfront on the west side of Manhattan as a park and established the Hudson River Park Trust to continue the planning, construction, management, and operation of the park. For more information, *see* https://hudsonriverpark.org/.