



July 1, 2026

The Honorable Kathy Hochul
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

RE: ATA ACTION CONCERNS AND VETO REQUEST REGARDING S. 9269/A. 10357 – NEW YORK HEALTH INFORMATION PRIVACY ACT

Dear Governor Hochul,

On behalf of ATA Action, I am writing to share our concerns regarding S. 9269/A. 10357, the New York Health Information Privacy Act (“NY HIPA”). ATA Action previously engaged in opposition to the prior version of this legislation, S. 929/A. 2141, through standalone advocacy, authoring [an op-ed](#) raising our concerns and signing on to a coalition letter with almost 50 other organizations urging a veto of the legislation. While we appreciate the meaningful improvements made to this year’s version of the legislation, we believe that the NY HIPA remains unworkable and would request that you veto this legislation as well.

There were improvements made to this version of the bill with the removal of the 24-hour waiting period before seeking authorization and changes to the exemptions – particularly for HIPAA-covered entities and business associates – representing substantive steps forward. However, several core concerns from our prior opposition remain unresolved and, in some respects, have become more pronounced in this legislation. We remain concerned that the NY HIPA, as passed by the legislature, would impose sweeping obligations on telehealth providers and other health-adjacent entities that go well beyond any comparable consumer health data framework enacted in other states.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in health, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

The Definition of “Regulated Entities” Is Overbroad and Poses Operational Hurdles

The NY HIPA intends to apply to not only entities controlling the processing of data of New Yorkers, but also entities serving an individual that happens to be in New York when data is collected and entities located in New York that collect health care information *even when their consumers are not in New York or they do not offer services in New York*. This extraordinary breadth will require entities to perhaps process more geolocation data than they would otherwise collect to determine whether the Act’s provisions apply and may require entities to pause services for patients or consumers when they are in the state.

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Second, the Act confusingly says it applies to entities that process health information of an individual who is “seeking services or receiving services in New York if the entity is located in New York.” We are unclear what types of out-of-state consumers would specifically meet this definition in the telehealth context when a health care entity might be located in New York, given that the location of telehealth services is always where the patient is located. To the extent the Act intends for New York based health entities to apply the Act’s framework on a nationwide basis, this will lead to operational challenges, conflicts with other laws and disrupt the patient experience. This is particularly acute for telehealth entities that frequently deliver services out of state and will have already developed compliance frameworks to align with the privacy requirements of the state where the patient is located. We recommend the Governor narrow the scope of this legislation, consistent with laws across the country, to the regulated health information of New York consumers.

The expansion also places a heavier burden on New York-based organizations, which would have to apply NY HIPA requirements to every user interaction, including those involving individuals outside the state, creating a competitive disadvantage not faced by companies headquartered elsewhere.

The Definition of “Regulated Health Information” Remains Overbroad

The NY HIPA retains an extraordinarily broad definition of “regulated health information” and, in certain respects, expands it relative to S. 929. The new draft enumerates thirteen specific categories of covered information – including IP addresses, cookie identifiers, device identifiers, precise location information, and any data “derived or extrapolated from nonhealth information” through algorithms or machine learning – that capture routine technical data. Under this definition, a telehealth platform’s ordinary session logs, authentication records and technical support data could all qualify as regulated health information simply because they are collected in connection with a service that relates to health.

The bill’s broad definition of “regulated health information” also far exceeds the HIPAA definition of “protected health information.” By capturing not only an individual’s health-related data as the statute intends, but *any* data that *could* be used to create an inference around an individual’s health. ATA Action is concerned that providers and other online healthcare entities would be arbitrarily limited in their ability to communicate with current or potential New York residents about things such as reliable sexual health information, birth control options, obtaining over the counter medication or obtaining supplies. This is especially troubling for stigmatized conditions like sexual health, where online outreach and engagement might be the only way a patient would feel comfortable with treatment. Our organization believes the definition of “regulated health information” should be narrowed to track the definition of “protected health information” in the HIPAA Privacy Rule and to limit the reach to data of New York consumers. At a minimum, we strongly urge amendments to this definition to ensure it is narrowly tailored to achieve the legislation’s objectives and not unnecessarily restrict access to care.

The Act Requires Onerous Authorization for Beneficial Uses That Are Permitted Under HIPAA

Under the proposed NY HIPA, a regulated entity would need a signed authorization to both collect and use a consumer’s data for any purpose other than what is “strictly necessary” to provide the product or service that the consumer requested, absent a few narrow exceptions. While the new draft adds product development, improvement and repair of a product or service *requested by an individual* to the list of permissible purposes, that exemption will be difficult to implement because the legislation still *specifically prohibits* internal “research and development.” We continue to be concerned about the NY HIPA’s authorization mandates for many routine functions will slow service delivery and disrupt core operations.

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For example, an entity would need to go through the Act’s onerous authorization process for a number of common and beneficial uses of data: researching consumer data to understand how patients book appointments on the website, directly sending a customer a coupon for future health products, using customer data to improve websites experience, informing their patients of new clinical services they might be offering and prohibit a regulated entity from sending communications about its additional products or services to the consumer. However, a HIPAA-covered entity – and in some situations their contracted business associates – could engage in these same activities with the consumer’s HIPAA protected health information without any need for specific authorization from the consumer under the HIPAA Privacy Rule.¹ This inconsistency not only undermines the stated intent of the Act, it would afford differing rights to New York consumers and unequal burdens on entities based solely on being subject to HIPAA.

For telehealth providers, this standard creates particular problems. Quality assurance review, care coordination tools and patient outreach programs are all standard components of telehealth delivery that may not qualify as “strictly necessary” under a narrow reading of the bill’s permissible purposes. Requiring patient-by-patient authorization for these baseline operational uses would create significant friction in care delivery and, paradoxically, could reduce the quality and continuity of care for the patients the bill aims to protect. We recommend replacing the “strictly necessary” standard with a proportionality or reasonable necessity standard consistent with peer state frameworks.

The Definition of “Sell” Does Not Exempt Routine Service Provider Transfers

As currently drafted, the NY HIPA defines “sell” to include any sharing of regulated health information for monetary or other valuable consideration, without exempting transfers to service providers. This omission conflicts with every other comprehensive privacy and consumer health data statute in the country – including those in Connecticut, New Jersey, California, and Washington – which expressly exclude disclosures to processors from the definition of “sale.”

For telehealth providers, this creates serious operational problems. Telehealth delivery inherently involves a network of technology vendors, cloud providers, electronic health record systems and clinical support platforms, all of which receive regulated health information under service agreements in exchange for valuable consideration. Treating these routine service provider relationships as “sales” would require consent for every such transfer, effectively making standard telehealth infrastructure untenable. Should this legislation advance a clear exemption for disclosures to service providers consistent with every comparable framework in the country must be added.

The Authorization Requirements Remain Operationally Burdensome

Although this year’s version of the NY HIPA removes the 24-hour waiting period that ATA Action and the broader coalition opposed in S. 929, the authorization requirements remain substantially more burdensome than those in any comparable state framework. The bill requires that each authorization request be made “separately from any other transaction,” present eleven discrete categories of information to the consumer, expire after no more than one year and be provided alongside detailed disclosure of all

¹ *Marketing*, U.S. Dept. of Health and Human Servs. (July 26, 2013), <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/marketing/index.html>.



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service providers and third parties, monetary consideration, revocation mechanisms and access and deletion rights.

For telehealth providers, this would require presenting patients with a dense, multi-element consent flow before routine data uses that are expected and unremarkable in a health care context. The cumulative effect of these requirements would create consent fatigue – patients dismissing detailed authorization requests for data uses that are genuinely routine – rather than meaningful privacy protection. We recommend streamlining the authorization requirements to focus on truly sensitive or non-obvious data uses and defining “transaction” to avoid requiring separate authorizations for closely related data processing activities.

ATA Action shares the Legislature’s commitment to protecting New Yorkers’ health information. We appreciate the meaningful improvements made to the NY HIPA relative to the prior version of this legislation. However, the core structural issues described above would impose obligations on telehealth providers and the broader health technology ecosystem that goes beyond what any other state has required and that cannot be implemented without seriously disrupting access to care for New York patients.

We welcome the opportunity to work with your office and the legislature to address these concerns through targeted amendments and to craft a framework that provides durable, meaningful protections without the operational consequences described above. If you have any questions or would like to discuss further the telehealth industry’s perspective, please contact me at hyoung@ataaction.org.

Kind regards,

A handwritten signature in black ink that reads "Hunter Young".

Hunter Young
Head of State Government Relations
ATA Action