S T A T E O F N E W Y O R K

6390

2009-2010 Regular Sessions

I N A S S E M B L Y

March 3, 2009

Introduced by M. of A. JOHN, GOTTFRIED, SCHROEDER -- Multi-Sponsored by -- M. of A. KELLNER -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to labor-management health benefit fund participation in the Healthy New York program; and providing for the repeal of such provisions upon expiration thereof

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, subsection (b) as amended by chapter 342 of the laws of 2004, subparagraph (A) of paragraph 1 of subsection (c) and subparagraph (C) of paragraph 3 of subsection (c) as amended by chapter 419 of the laws of 2000, subsections (d-1), (d-2) and (d-3) as added by chapter 645 of the laws of 2005, is amended to read as follows:

S 4326. Standardized health insurance contracts for qualifying [small] employers and individuals. (a) A program is hereby established for the purpose of making standardized health insurance contracts OR HEALTH BENEFITS PROVIDED BY A HEALTH BENEFIT FUND available to qualifying [small] employers and qualifying individuals as defined in this section. Such program is designed to encourage [small] employers to offer health insurance coverage to their employees and to also make coverage available to uninsured employees whose employers do not provide group health insurance. FOR THE PURPOSES OF THIS SECTION, THE TERM "HEALTH BENEFIT FUND" SHALL MEAN A FEDERAL INTERNAL REVENUE SERVICE QUALIFIED MULTI-EMPLOYER HEALTH BENEFIT PLAN REGULATED BY THE FEDERAL DEPARTMENT OF LABOR PURSUANT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT.

(b) Participation in the program established by this section and section four thousand three hundred twenty-seven of this article is limited to corporations or insurers organized or licensed under this article or article forty-two of this chapter [and], health maintenance organizations issued a certificate of authority under article forty-four

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD08286-01-9

of the public health law or licensed under this article AND HEALTH BENEFIT FUNDS. Participation by all health maintenance organizations is mandatory, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. On and after January first, two thousand one, all health maintenance organizations shall offer qualifying group health insurance contracts and qualifying individual health insurance contracts as defined in this section. For the purposes of this section and section four thousand three hundred twenty-seven of this article, article forty-three corporations [or], article forty-two insurers, OR HEALTH BENEFIT FUNDS which voluntarily participate in compliance with the requirements of this program shall be eligible for reimbursement from the stop loss funds created pursuant to section four thousand three hundred twenty-seven of this article under the same terms and conditions as health maintenance organizations.

(c) The following definitions shall be applicable to the insurance contracts OR HEALTH BENEFIT PACKAGES offered under the program established by this section:

(1) A qualifying [small] employer is an employer that is either:

(A) An individual proprietor who is the only employee of the business:

(i) without health insurance which provides benefits on an expense reimbursed or prepaid basis in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(ii) resides in a household having a net household income at or below two hundred eight percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income;

(iii) except that the requirements set forth in item (i) of this subparagraph shall not be applicable where an individual proprietor had health insurance coverage during the previous twelve months and such coverage terminated due to one of the reasons set forth in items (i) through (viii) of subparagraph (C) of paragraph three of THIS subsection [(c) of this section]; or

(B) An employer with:

(i) not more than fifty eligible employees;

(ii) no group health insurance which provides benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(iii) at least thirty percent of its eligible employees receiving annual wages from the employer at a level equal to or less than thirty thousand dollars. The thirty thousand dollar figure shall be adjusted periodically pursuant to subparagraph (F) of this paragraph[.]; OR

(IV)(1) NOTWITHSTANDING THE OTHER PROVISIONS OF THIS SUBSECTION A FUND PARTICIPATION AGREEMENT OR COLLECTIVE BARGAINING AGREEMENT THAT REQUIRES

THAT THE EMPLOYER MAINTAIN A CONTRIBUTION FOR EMPLOYEE GROUP HEALTH BENEFITS TO A HEALTH BENEFIT FUND OR HEALTH BENEFIT PLAN, NINETY PERCENT OF WHOSE MEMBERS RECEIVE GROSS INCOME FROM A CONTRIBUTING EMPLOYER OF THIRTY-THREE THOUSAND DOLLARS OR LESS, OR (2) AN EMPLOYER WITH THREE HUNDRED OR FEWER EMPLOYEES, BUT MORE THAN TWO HUNDRED, OF WHOM AT LEAST SEVENTY-FIVE PERCENT RECEIVE GROSS INCOME FROM THAT EMPLOYER OF THIRTY-THREE THOUSAND DOLLARS PER YEAR OR LESS OR, (3) AN EMPLOYER WITH TWO HUNDRED OR FEWER EMPLOYEES, BUT MORE THAN FIFTY, OF WHOM AT LEAST FIFTY PERCENT RECEIVE GROSS INCOME FROM THAT EMPLOYER OF THIRTY-THREE THOUSAND DOLLARS OR LESS OR, (4) AN EMPLOYER WITH FIFTY OR FEWER EMPLOYEES OF WHOM THIRTY PERCENT RECEIVE GROSS INCOME FROM THAT EMPLOYER OF THIRTY-THREE THOUSAND DOLLARS OR LESS. SALARY FIGURES SHALL BE ADJUSTED PERIODICALLY PURSUANT TO SUBPARAGRAPH (F) OF THIS PARAGRAPH. FOR THE PURPOSES OF THIS SECTION, THE SUPERINTENDENT MAY ALSO CALCULATE THE NUMBER OF EMPLOYEES OF AN EMPLOYER BASED ON THE EMPLOYMENT AT A WORKSITE LOCATED WITHIN THE STATE OF NEW YORK.

(C) The requirements set forth in item (i) of subparagraph (A) of this paragraph and in item (ii) of subparagraph (B) of this paragraph shall not be applicable where an individual proprietor or employer is transferring from a health insurance contract issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law or from health care coverage issued pursuant to a regional pilot project for the uninsured established by section one thousand one hundred eighteen of this chapter.

(D) The twelve month period set forth in item (i) of subparagraph (A) of this paragraph and in item (ii) of subparagraph (B) of this paragraph may be adjusted by the superintendent from twelve months to eighteen months if he OR SHE determines that the twelve month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying group health insurance contracts.

(E) An individual proprietor or employer shall cease to be a qualifying [small] employer if any health insurance which provides benefits on an expense reimbursed or prepaid basis covering the individual proprietor or an employer's employees, other than qualifying group health insurance purchased pursuant to this section, is purchased or otherwise takes effect subsequent to purchase of qualifying group health insurance under the program established by this section.

(F) The wage levels utilized in subparagraph (B) of this paragraph shall be adjusted annually, beginning in two thousand two. The adjustment shall take effect on July first of each year. For July first, two thousand two, the adjustment shall be a percentage of the annual wage figure specified in subparagraph (B) of this paragraph. For subsequent years, the adjustment shall be a percentage of the annual wage figure which took effect on July first of the prior year. The percentage adjustment shall be the same percentage by which the current year's non-farm federal poverty level, as defined and updated by the federal department of health and human services, for a family unit of four persons for the forty-eight contiguous states and Washington, D.C., changed from the same level established for the prior year.

(2) A qualifying group health insurance contract is a group contract purchased from a health maintenance organization, corporation or insurer by a qualifying [small] employer which provides the benefits set forth in subsection (d) of this section OR A HEALTH BENEFITS PACKAGE WHICH PROVIDES THE BENEFITS SET FORTH IN SUBSECTION (D) OF THIS SECTION, PROVIDED BY A HEALTH BENEFITS FUND. The contract OR BENEFIT PACKAGE must

insure OR PROVIDE THE BENEFITS SET FORTH IN SUBSECTION (D) OF THIS SECTION TO not less than fifty percent of the employees eligible for coverage.

(3)(A) A qualifying individual is an employed person:

(i) who does not have and has not had health insurance with benefits on an expense reimbursed or prepaid basis during the twelve month period prior to the individual's application for health insurance under the program established by this section OR HAS HAD SUCH TWELVE MONTH PERIOD WAIVED BY THE SUPERINTENDENT PURSUANT TO THIS SECTION. IN NO EVENT SHALL SUCH EMPLOYER CONTRIBUTION BE LESS THAN FIFTY PERCENT OF THE TOTAL PREMIUM COST, AND FOR THE PURPOSES OF THIS SECTION, FUNDS FOR DIRECT CARE WORKER RECRUITMENT AND RETENTION PROGRAMS PROVIDED TO PERSONAL CARE SERVICE PROVIDERS PURSUANT TO SECTION THREE HUNDRED SIXTY-SEVEN-Q OF THE SOCIAL SERVICES LAW SHALL BE DEEMED EMPLOYER CONTRIBUTIONS;

(ii) whose employer does not provide group health insurance and has not provided group health insurance with benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to the individual's application for health insurance under the program established by this section OR HAS HAD SUCH TWELVE MONTH PERIOD WAIVED BY THE SUPERINTENDENT PURSUANT TO THE PROVISIONS OF THIS SECTION;

(iii) resides in a household having a net household income at or below two hundred eight percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income; and

(iv) is ineligible for Medicare.

(B) The requirements set forth in items (i) and (ii) of subparagraph (A) of this paragraph shall not be applicable where an individual is transferring from a health insurance contract issued pursuant to the voucher insurance program established by section one thousand one hundred twenty-one of this chapter, a health insurance contract issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law or health care coverage issued pursuant to a regional pilot project for the uninsured established by section one thousand one hundred eighteen of this chapter.

(C) The requirements set forth in items (i) and (ii) of subparagraph (A) of this paragraph shall not be applicable where an individual had health insurance coverage during the previous twelve months and such coverage terminated due to:

(i) loss of employment due to factors other than voluntary separation;

(ii) death of a family member which results in termination of coverage under a health insurance contract under which the individual is covered;

(iii) change to a new employer that does not provide group health insurance with benefits on an expense reimbursed or prepaid basis;

(iv) change of residence so that no employer-based health insurance with benefits on an expense reimbursed or prepaid basis is available;

(v) discontinuation of a group health insurance contract with benefits on an expense reimbursed or prepaid basis covering the qualifying individual as an employee or dependent;

(vi) expiration of the coverage periods established by the continuation provisions of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq. and the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq. established by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or the continuation provisions of subsection (m) of section three thousand two hundred twen-

ty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of this chapter;

(vii) legal separation, divorce or annulment which results in termination of coverage under a health insurance contract under which the individual is covered; or

(viii) loss of eligibility under a group health plan.

(D) The twelve month period set forth in items (i) and (ii) of subparagraph (A) of this paragraph may be adjusted by the superintendent from twelve months to eighteen months if he OR SHE determines that the twelve month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

(4) A qualifying individual health insurance contract is an individual contract issued directly to a qualifying individual and which provides the benefits set forth in subsection (d) of this section. At the option of the qualifying individual, such contract may include coverage for dependents of the qualifying individual.

(d) The contracts issued pursuant to this section by health maintenance organizations, corporations [or], insurers OR, THE HEALTH BENEFIT PACKAGE WHICH PROVIDES THE BENEFITS SET FORTH IN THIS SUBSECTION PROVIDED BY HEALTH BENEFIT FUNDS and approved by the superintendent shall only provide in-plan benefits, except for emergency care or where services are not available through a plan provider. Covered services shall include only the following:

(1) inpatient hospital services consisting of daily room and board, general nursing care, special diets and miscellaneous hospital services and supplies;

(2) outpatient hospital services consisting of diagnostic and treatment services;

(3) physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services (including breast reconstruction surgery after a mastectomy), anesthesia services, second surgical opinion, and a second opinion for cancer treatment;

(4) outpatient surgical facility charges related to a covered surgical procedure;

(5) preadmission testing;

(6) maternity care;

(7) adult preventive health services consisting of mammography screening; cervical cytology screening; periodic physical examinations no more than once every three years; and adult immunizations;

(8) preventive and primary health care services for dependent children including routine well-child visits and necessary immunizations;

(9) equipment, supplies and self-management education for the treatment of diabetes;

(10) diagnostic x-ray and laboratory services;

(11) emergency services;

(12) therapeutic services consisting of radiologic services, chemotherapy and hemodialysis;

(13) blood and blood products furnished in connection with surgery or inpatient hospital services; and

(14) prescription drugs obtained at a participating pharmacy. In addition to providing coverage at a participating pharmacy, health maintenance organizations may utilize a mail order prescription drug program. Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must

implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician.

(d-1) Covered services shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that: (1) any denial of coverage pursuant to this subsection shall provide the enrollee with the means of obtaining additional information concerning both the denial and the means of challenging such denial; (2) all drugs, procedures and supplies for the treatment of erectile dysfunction may be subject to prior authorization by corporations, insurers or health maintenance organizations for the purposes of implementing this subsection; and (3) the superintendent shall promulgate regulations to implement the denial of coverage pursuant to this subsection giving health maintenance organizations, corporations and insurers at least sixty days following promulgation of the regulations to implement their denial procedures pursuant to this subsection.

(d-2) No person or entity authorized to provide coverage under this section shall be subject to any civil or criminal liability for damages for any decision or action pursuant to subsection (d-1) of this section, made in the ordinary course of business if that authorized person or entity acted reasonably and in good faith with respect to such information.

(d-3) Notwithstanding any other provision of law, if the commissioner of health makes a finding pursuant to subdivision twenty-three of section two hundred six of the public health law, the superintendent is authorized to remove a drug, procedure or supply from the services covered by the standardized health insurance contract established by this section for those persons required to register as sex offenders pursuant to article six-C of the correction law.

(e) The benefits provided in the contracts described in subsection (d) of this section shall be subject to the following deductibles and copayments:

(1) in-patient hospital services shall have a five hundred dollar copayment for each continuous hospital confinement;

(2) surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence;

(3) outpatient surgical facility charges shall be subject to a facility copayment charge of seventy-five dollars per occurrence;

(4) emergency services shall have a fifty dollar copayment which must be waived if hospital admission results from the emergency room visit;

(5) prescription drugs shall have a one hundred dollar calendar year deductible per individual. After the deductible is satisfied, each thirty-four day supply of a prescription drug will be subject to a copayment. The copayment will be ten dollars if the drug is generic. The copayment for a brand name drug will be twenty dollars plus the difference in cost between the brand name drug and the equivalent generic drug. If a mail order drug program is utilized, a twenty dollar copayment shall be imposed on a ninety day supply of generic prescription drugs. A forty dollar copayment plus the difference in cost between the brand name drug and the equivalent generic drug shall be imposed on a ninety day supply of brand name prescription drugs. In no event shall the copayment exceed the cost of the prescribed drug;

(6) the maximum coverage for prescription drugs shall be three thousand dollars per individual in a calendar year; and

(7) all other services shall have a twenty dollar copayment with the exception of prenatal care which shall have a ten dollar copayment.

(f) Except as included in the list of covered services in subsection (d) of this section, the mandated and make-available benefits set forth in sections three thousand two hundred sixteen, three thousand two hundred twenty-one of this chapter and four thousand three hundred three of this article shall not be applicable to the contracts issued pursuant to this section. Mandated benefits included in such contracts shall be subject to the deductibles and copayments set forth in subsection (e) of this section.

(g) The superintendent shall be authorized to modify, by regulation, the copayment and deductible amounts described in this section if the superintendent determines such amendments are necessary to facilitate implementation of this section. On or after January first, two thousand two, the superintendent shall be authorized to establish, by regulation, one or more additional standardized health insurance benefit packages, INCLUDING PACKAGES FOR PART-TIME EMPLOYEES, if the superintendent determines additional benefit packages with different levels of benefits are necessary to meet the needs of the public. THE SUPERINTENDENT SHALL ESTABLISH A PACKAGE BY REGULATION IN ADDITION TO OTHER PACKAGES ESTABLISHED PURSUANT TO THIS SECTION THAT SHALL PROVIDE MENTAL HEALTH, ALCOHOL, AND SUBSTANCE ABUSE BENEFITS EQUIVALENT TO THOSE PROVIDED FOR IN SECTION THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW.

(h) A health maintenance organization, corporation, HEALTH BENEFIT FUND or insurer must offer the benefit package [without change or additional benefits] PROVIDED HOWEVER THAT THE SUPERINTENDENT MAY APPROVE ADDITIONAL OR IMPROVED BENEFITS THAT ARE IN THE PUBLIC INTEREST. Qualifying [small] employers shall be issued the benefit package in a qualifying group health insurance contract. Qualifying individuals shall be issued the benefit package in a qualifying individual health insurance contract.

(i) A HEALTH BENEFIT FUND, health maintenance organization, corporation or insurer shall obtain from the employer or individual written certification at the time of initial application and annually thereafter ninety days prior to the contract renewal date that such employer or individual meets the requirements of a qualifying [small] employer or a qualifying individual pursuant to this section. [A] SUCH PLAN OR A health maintenance organization, corporation or insurer may require the submission of appropriate documentation in support of the certification.

(j) Applications for qualifying group health insurance contracts and qualifying individual health insurance contracts must be accepted from any qualifying individual and any qualifying [small] employer at all times throughout the year. The superintendent, by regulation, may require health maintenance organizations, corporations or insurers to give preference to qualifying [small] employers whose eligible employees have the lowest average salaries.

(k) All coverage under a qualifying group health insurance contract or a qualifying individual health insurance contract must be subject to a pre-existing condition limitation provision as set forth in sections three thousand two hundred thirty-two of this chapter and four thousand three hundred eighteen of this article, including the crediting requirements thereunder. The underwriting of such contracts may not involve more than the imposition of a pre-existing condition limitation.

(l) A qualifying [small] employer OR HEALTH BENEFIT FUND shall elect whether to make coverage under the qualifying group health insurance contract available to dependents of employees. Any employee or dependent

who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

(m) A qualifying [small] employer must pay at least fifty percent of the premium for employees covered under a qualifying group health insurance contract and must offer coverage to all employees receiving annual wages at a level of thirty thousand dollars or less, and at least one such employee shall accept such coverage. The thirty thousand dollar wage level shall be adjusted periodically in accordance with subparagraph (F) of paragraph one of subsection (c) of this section. The employer premium contribution must be the same percentage for all covered employees.

(n) Premium rate calculations for qualifying group health insurance contracts and qualifying individual health insurance contracts shall be subject to the following:

(1) coverage must be community rated and include rate tiers for individuals, two adult families and at least one other family tier. The rate differences must be based upon the cost differences for the different family units and the rate tiers must be uniformly applied. The rate tier structure used by a health maintenance organization, corporation or insurer for the contracts issued to qualifying [small] employers and to qualifying individuals must be the same;

(2) if geographic rating areas are utilized, such geographic areas must be reasonable and in a given case may include a single county. The geographic areas utilized must be the same for the contracts issued to qualifying [small] employers and to qualifying individuals. The superintendent shall not require the inclusion of any specific geographic region within the proposed community rated region selected by the health maintenance organization, corporation or insurer so long as the health maintenance organization, corporation or insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the health maintenance organization, corporation or insurer's community rates.

(3) claims experience under contracts issued to qualifying [small] employers and to qualifying individuals must be pooled for rate setting purposes. The premium rates for qualifying group health insurance contracts and qualifying individual health insurance contracts must be the same.

(o) A HEALTH BENEFIT FUND, health maintenance organization, corporation or insurer shall submit reports to the superintendent in such form and at times as may be reasonably required in order to evaluate the operations and results of the standardized health insurance OR HEALTH BENEFIT program established by this section.

(p) Notwithstanding any other provision of law, all individuals and small businesses that are participating in or covered by insurance contracts or policies issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law, the voucher insurance program established by section one thousand one hundred twenty-one of this chapter, or uninsured pilot programs established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight shall be eligible for participation in the standardized health insurance contracts established by this section, regardless of any of the eligibility requirements established pursuant to subsection (c) of this section.

S 2. Section 4327 of the insurance law, as added by chapter 1 of the laws of 1999, subsection (h) as amended by chapter 419 of the laws of 2000 and subsection (s) as amended and subsection (t) as added by chapter 441 of the laws of 2006, is amended to read as follows:

S 4327. Stop loss funds for standardized health insurance contracts issued to qualifying [small] employers and qualifying individuals OR FOR HEALTH BENEFIT PACKAGES WHICH PROVIDE THE BENEFITS SET FORTH IN SUBSECTION (D) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX OF THIS ARTICLE PROVIDED BY HEALTH BENEFIT FUNDS. (a) The superintendent shall establish a fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying group health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. This fund shall be known as the "[small] employer stop loss fund". The superintendent shall establish a separate and distinct fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers for members covered under qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. This fund shall be known as the "qualifying individual stop loss fund". FOR THE PURPOSES OF THIS SECTION, THE TERM "HEALTH BENEFIT FUND" SHALL MEAN A FEDERAL INTERNAL REVENUE SERVICE QUALIFIED MULTI-EMPLOYER HEALTH BENEFIT PLAN REGULATED BY THE FEDERAL DEPARTMENT OF LABOR PURSUANT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT.

(b) Commencing on January first, two thousand one, health maintenance organizations, HEALTH BENEFIT FUNDS, corporations or insurers shall be eligible to receive reimbursement for ninety percent of claims paid between [thirty] FIVE thousand and [one hundred] SEVENTY-FIVE thousand dollars in a calendar year for any member covered under a standardized contract issued pursuant to section four thousand three hundred twenty-six of this article. Claims paid for members covered under qualifying group health insurance contracts shall be reimbursable from the [small] employer stop loss fund. Claims paid for members covered under qualifying individual health insurance contracts shall be reimbursable from the qualifying individual stop loss fund. For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to such standardized contracts.

(c) The superintendent shall promulgate regulations that set forth procedures for the operation of the [small] employer stop loss fund and the qualifying individual stop loss fund and distribution of monies therefrom.

(d) The [small] employer stop loss fund shall operate separately from the qualifying individual stop loss fund. Except as specified in subsection (b) of this section with respect to calendar year two thousand one, the level of stop loss coverage for the qualifying group health insurance contracts and the qualifying individual health insurance contracts need not be the same. The two stop loss funds need not be structured or operated in the same manner, except as specified in this section. The monies available for distribution from the stop loss funds may be reallocated between the [small] employer stop loss fund and the

qualifying individual stop loss fund if the superintendent determines that such reallocation is warranted due to enrollment trends.

(e) Claims shall be reported and funds shall be distributed from the [small] employer stop loss fund and from the qualifying individual stop loss fund on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(f) Each health maintenance organization, corporation, HEALTH BENEFIT FUND or insurer shall submit a request for reimbursement from each of the stop loss funds on forms prescribed by the superintendent. Each of the requests for reimbursement shall be submitted no later than April first following the end of the calendar year for which the reimbursement requests are being made. The superintendent may require health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers to submit such claims data in connection with the reimbursement requests as he OR SHE deems necessary to enable him OR HER to distribute monies and oversee the operation of the [small] employer and qualifying individual stop loss funds. The superintendent may require that such data be submitted on a per member, aggregate and/or categorical basis. Data shall be reported separately for qualifying group health insurance contracts and qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article.

(g) For each stop loss fund, the superintendent shall calculate the total claims reimbursement amount for all health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds funds available for distribution for claims paid during that same calendar year, the superintendent shall provide for the pro-rata distribution of the available funds. Each health maintenance organization, corporation, HEALTH BENEFIT FUND or insurer shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's, corporation's, HEALTH BENEFIT FUND'S or insurer's total eligible claims paid bears to the total eligible claims paid by all health maintenance organizations, corporations or insurers.

(2) In the event that funds available for distribution for claims paid by all health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations, corporations or insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year. Such excess funds shall be in addition to the monies appropriated for the stop loss fund in the next calendar year.

(h) Upon the request of the superintendent, each health maintenance organization shall be required to furnish such data as the superintendent deems necessary to oversee the operation of the [small] employer and qualifying individual stop loss funds. Such data shall be furnished in a form prescribed by the superintendent. Each health maintenance organization, corporation, HEALTH BENEFIT FUND or insurer shall provide the superintendent with monthly reports of the total enrollment OF THE HEALTH BENEFIT FUND OR THE ENROLLMENT under the qualifying group health

insurance contracts and the qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. The reports shall be in a form prescribed by the superintendent.

(i) The superintendent shall separately estimate the per member annual cost of total claims reimbursement from each stop loss fund for qualifying individual health insurance contracts and for qualifying group health insurance contracts based upon available data and appropriate actuarial assumptions. Upon request, each health maintenance organization, corporation or insurer shall furnish to the superintendent claims experience data for use in such estimations.

(j) The superintendent shall determine total eligible enrollment under qualifying group health insurance contracts and qualifying individual health insurance contracts. For qualifying group health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the [small] employer stop loss fund by the estimated per member annual cost of total claims reimbursement from the [small] employer stop loss fund. For qualifying individual health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the qualifying individual stop loss fund by the estimated per member annual cost of total claims reimbursement from the qualifying individual stop loss fund.

(k) The superintendent shall suspend the enrollment of new employers under qualifying group health insurance contracts if he OR SHE determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the [small] employer stop loss fund in excess of the total funds available for distribution from such stop loss fund. The superintendent shall suspend the enrollment of new individuals under qualifying individual health insurance contracts if he OR SHE determines that the total enrollment reported by all health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the qualifying individual stop loss fund in excess of the total funds available for distribution from such stop loss fund.

(l) The superintendent shall provide the health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data. The superintendent's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.

(m) If at any point during a suspension of enrollment of new qualifying [small] employers and/or qualifying individuals, the superintendent determines that funds are sufficient to provide for the addition of new enrollments, the superintendent shall be authorized to reactivate new enrollments and to notify all health maintenance organizations, corporations, HEALTH BENEFIT FUNDS or insurers that enrollment of new employers and/or individuals may again commence. The superintendent's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.

(n) The suspension of issuance of qualifying group health insurance contracts to new qualifying [small] employers shall not preclude the

addition of new employees of an employer already covered under such a contract or new dependents of employees already covered under such contracts.

(o) The suspension of issuance of qualifying individual health insurance contracts to new qualifying individuals shall not preclude the addition of new dependents to an existing qualifying individual health insurance contract.

(p) The premiums for qualifying group health insurance contracts must factor in the availability of reimbursement from the [small] employer stop loss fund. The premiums for qualifying individual health insurance contracts must factor in the availability of reimbursement from the qualifying individual stop loss funds.

(q) The superintendent may obtain the services of an organization to administer the stop loss funds established by this section. If the superintendent deems it appropriate, he or she may utilize a separate organization for administration of the [small] employer stop loss fund and the qualifying individual stop loss fund. The superintendent shall establish guidelines for the submission of proposals by organizations for the purposes of administering the funds. The superintendent shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the funds. An organization approved to administer the funds shall submit reports to the superintendent in such form and at times as may be required by the superintendent in order to facilitate evaluation and ensure orderly operation of the funds, including, but not limited to, an annual report of the affairs and operations of the fund, such report to be delivered to the superintendent and to the chairs of the senate finance committee and the assembly ways and means committee. An organization approved to administer the funds shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent. The superintendent shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the stop loss coverage funds. An organization approved to administer the funds may be removed by the superintendent and must cooperate in the orderly transition of services to another approved organization or to the superintendent.

(r) If the superintendent deems it appropriate for the proper administration of the [small] employer stop loss fund and/or the qualifying individual stop loss fund, the administrator of the fund, on behalf of and with the prior approval of the superintendent, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss funds established by this section.

(s) The superintendent may access funding from the [small] employer stop loss fund and/or the qualifying individual stop loss fund for the purposes of developing and implementing public education, outreach and facilitated enrollment strategies targeted to [small] employers and working adults without health insurance. The superintendent may contract with marketing organizations to perform or provide assistance with such education, outreach, and enrollment strategies. The superintendent shall determine the amount of funding available for the purposes of this subsection which in no event shall exceed eight percent of the annual

funding amounts for the [small] employer stop loss fund and the qualifying individual stop loss fund.

(t) Brooklyn healthworks pilot program and upstate healthworks pilot program. Commencing on July first, two thousand six, the superintendent shall access funding from the [small] employer stop loss fund and the qualifying individual stop loss fund for the purpose of support and expansion of the existing pilot program Brooklyn healthworks approved by the superintendent and for the establishment and operation of a pilot program to be located in upstate New York. For the purpose of this subsection, in no event shall the amount of funding available exceed two percent of the annual funding amounts for the [small] employer stop loss fund and the qualifying individual stop loss fund.

S 3. The superintendent of insurance shall have the power to audit and provide for the proper expenditure and use of state funds by a health benefit fund that agrees to participate in the health benefit programs authorized by this act. Such participation shall not subject the plan to regulation by the superintendent of insurance or the commissioner of health concerning matters under the jurisdiction of the federal department of labor pursuant to the Employee Retirement Income Security Act.

S 4. The superintendent of insurance shall complete a study by July 1, 2010 which shall examine the efficacy of this act in reducing the large number of uninsured low wage employees, and in reducing the number of low wage employees that enroll in the Medicaid and Family Health Plus programs as a result of gaining access to employer provided health insurance. The superintendent may contract with an organization for the completion of the study. The study shall be provided to the temporary president of the senate and the speaker of the assembly.

S 5. Severability. If any clause, sentence, subdivision, paragraph, section or part of this act be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, subdivision, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

S 6. This act shall take effect immediately and shall expire July 1, 2010 when upon such date the provisions of this act shall be deemed repealed.