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

4106

2011-2012 Regular Sessions

I N A S S E M B L Y

February 1, 2011

Introduced by M. of A. MORELLE, SCHIMMINGER, CYMBROWITZ, PERRY, CANESTRARI, ORTIZ, HIKIND -- Multi-Sponsored by -- M. of A. BOYLAND, COLTON, DESTITO, LATIMER, LUPARDO, MAGEE, ROBINSON, TOWNS, WRIGHT -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to establishment of freedom health insurance plans; to amend the tax law, in relation to providing a tax credit for the purchase of certain health insurance; and to amend the public health law, in relation to the health maintenance organization direct pay market program

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

Section 1. Subsection (l) of section 3216 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(l) On and after January first, nineteen hundred ninety-seven, no insurer shall offer major medical, comprehensive or other comparable individual contracts, other than for purposes of conversion, unless the benefits of such contracts, including deductibles and coinsurance, are identical to the out-of-plan benefits of the contracts described in section four thousand three hundred twenty-two of this chapter. Such contracts must include a prescription drug benefit complying with the requirements of that section. THE REQUIREMENTS OF THIS SUBSECTION SHALL NOT APPLY TO A POLICY INTENDED TO QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003. SUCH POLICIES SHALL BE KNOWN AS "FREEDOM POLICIES".

S 2. Section 3221 of the insurance law is amended by adding a new subsection (s) to read as follows:

(S) NO GROUP OR BLANKET ACCIDENT AND HEALTH INSURANCE POLICY ISSUED OR ISSUED FOR DELIVERY IN THIS STATE FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 SHALL BE REQUIRED TO MEET THE

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

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REQUIREMENTS OF THIS SECTION, OR REGULATIONS ISSUED BY THE SUPERINTENDENT, WITH REGARD TO COVERED HEALTH CARE SERVICES WHICH MUST BE INCLUDED IN THE POLICY. SUCH POLICIES SHALL BE KNOWN AS "FREEDOM POLICIES".

S 3. Subsection (l) of section 4304 of the insurance law, as added by chapter 504 of the laws of 1995, is amended to read as follows:

(l) On and after January first, nineteen hundred ninety-seven, no insurer shall offer major medical, comprehensive or other comparable individual contracts on a direct payment basis, other than for purposes of conversion, unless the benefits of such contracts, including deductibles and coinsurance, are identical to the out-of-plan benefits of the contracts described in section four thousand three hundred twenty-two of this article. Such contracts must include a prescription drug benefit complying with the requirements of such section. THE REQUIREMENTS OF THIS SUBSECTION SHALL NOT APPLY TO A POLICY INTENDED TO QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003. SUCH POLICIES SHALL BE KNOWN AS "FREEDOM POLICIES".

S 4. Section 4304 of the insurance law is amended by adding a new subsection (n) to read as follows:

(N) NO POLICY ISSUED TO A REMITTING AGENT ON BEHALF OF A GROUP PURSUANT TO SUBSECTION (A) OF THIS SECTION, AND NO POLICY ISSUED TO A GROUP PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED FIVE OF THIS ARTICLE, FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 SHALL BE REQUIRED TO MEET THE REQUIREMENTS OF THIS SECTION OR SECTION FOUR THOUSAND THREE HUNDRED FIVE OF THIS ARTICLE, OR REGULATIONS ISSUED BY THE SUPERINTENDENT, WITH REGARD TO COVERED HEALTH CARE SERVICES WHICH MUST BE INCLUDED IN THE POLICY. SUCH POLICIES SHALL BE KNOWN AS "FREEDOM POLICIES".

S 5. Subsection (a) of section 4322 of the insurance law, as amended by chapter 342 of the laws of 2004, is amended to read as follows:

(a) On and after January first, nineteen hundred ninety-six, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer to individuals, in addition to the standardized contract required by section four thousand three hundred twenty-one of this article, a standardized individual enrollee direct payment contract on an open enrollment basis as prescribed by section four thousand three hundred seventeen of this article and section four thousand four hundred six of the public health law, and regulations promulgated thereunder, with an out-of-plan benefit system, 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] TWENTY-ONE of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. The out-of-plan benefit system shall either be provided by the health maintenance organization pursuant to subdivision two of section four thousand four hundred six of the public health law or through an accompanying insurance contract provid-

ing out-of-plan benefits offered by a company appropriately licensed pursuant to this chapter. On and after January first, nineteen hundred ninety-six, the contracts issued pursuant to this section and section four thousand three hundred twenty-one of this article shall be the only contracts offered by health maintenance organizations to individuals; PROVIDED, HOWEVER, THIS LIMITATION SHALL NOT APPLY TO ONE OR MORE POLICIES INTENDED TO QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003. SUCH POLICIES SHALL BE KNOWN AS "FREEDOM POLICIES". The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-one of this article shall also be the only contracts issued by the health maintenance organization for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prohibit health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

S 6. Section 210 of the tax law is amended by adding a new subdivision 43 to read as follows:

43. (A) A TAXPAYER WHO IS A QUALIFIED SMALL EMPLOYER SHALL BE ALLOWED A CREDIT AGAINST THE TAX IMPOSED BY THIS ARTICLE EQUAL TO THE APPLICABLE PERCENTAGE OF PREMIUMS PAID DURING THE TAXABLE YEAR FOR HEALTH INSURANCE BY SUCH EMPLOYER. THE APPLICABLE PERCENTAGE SHALL BE (I) FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, (II) TEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND TWELVE, (III) FIFTEEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, (IV) TWENTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, (V) TWENTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN, (VI) THIRTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, (VII) THIRTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SEVENTEEN, (VIII) FORTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND EIGHTEEN, AND (IX) FORTY-THREE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND NINETEEN.

(B) THE CREDIT ALLOWED UNDER THIS SUBDIVISION FOR ANY YEAR SHALL NOT REDUCE THE TAX DUE FOR SUCH YEAR TO LESS THAN THE HIGHER OF THE AMOUNTS PRESCRIBED IN PARAGRAPHS (C) AND (D) OF SUBDIVISION ONE OF THIS SECTION. IF, HOWEVER, THE AMOUNT OF CREDIT ALLOWABLE UNDER THIS SUBDIVISION FOR ANY TAXABLE YEAR REDUCES THE TAX TO SUCH AMOUNT, ANY AMOUNT OF CREDIT NOT DEDUCTIBLE IN SUCH TAXABLE YEAR MAY BE CARRIED OVER TO THE FOLLOWING YEAR OR YEARS AND MAY BE DEDUCTED FROM THE TAXPAYER'S TAX FOR SUCH YEAR OR YEARS.

(C) FOR THE PURPOSES OF THIS SUBDIVISION "QUALIFIED SMALL EMPLOYER" SHALL MEAN AN INDIVIDUAL PROPRIETOR WHO IS THE SOLE EMPLOYEE OF THE BUSINESS OR AN EMPLOYER WITH NOT MORE THAN FIFTY EMPLOYEES WHO IS A "SMALL BUSINESS TAXPAYER" AS DEFINED IN PARAGRAPH (F) OF SUBDIVISION ONE OF THIS SECTION.

(D) FOR THE PURPOSES OF THIS SUBDIVISION, THE TERM "HEALTH INSURANCE" MEANS AN ACCIDENT AND HEALTH INSURANCE POLICY SUBJECT TO THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN, THREE THOUSAND TWO HUNDRED TWENTY-ONE, FOUR THOUSAND THREE HUNDRED THREE OR FOUR THOUSAND

EIGHT HUNDRED ONE OF THE INSURANCE LAW, AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND SHALL INCLUDE "FREEDOM POLICIES" WHICH QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003.

S 7. Subparagraph (B) of paragraph 1 of subsection (i) of section 606 of the tax law, is amended by adding a new clause (xxxii) to read as follows:

(XXXII) SMALL EMPLOYER HEALTH CARE INSURANCE CREDIT UNDER SUBSECTION (SS)	CREDIT UNDER SUBDIVISION FORTY-THREE OF SECTION TWO HUNDRED TEN

S 8. Section 606 of the tax law is amended by adding a new subsection (ss) to read as follows:

(SS) SMALL EMPLOYER HEALTH CARE INSURANCE CREDIT. (1) A TAXPAYER WHO IS A QUALIFIED SMALL EMPLOYER SHALL BE ALLOWED A CREDIT AGAINST THE TAX IMPOSED BY THIS ARTICLE EQUAL TO THE APPLICABLE PERCENTAGE OF THE PREMIUMS PAID DURING THE TAXABLE YEAR FOR HEALTH INSURANCE BY SUCH EMPLOYER. THE APPLICABLE PERCENTAGE SHALL BE (A) FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, (B) TEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND TWELVE, (C) FIFTEEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, (D) TWENTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, (E) TWENTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN, (F) THIRTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, (G) THIRTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SEVENTEEN, (H) FORTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND EIGHTEEN, AND (I) FORTY-THREE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND NINETEEN. IF THE AMOUNT OF THE CREDIT ALLOWABLE UNDER THIS SUBSECTION FOR ANY TAXABLE YEAR SHALL EXCEED THE TAXPAYER'S TAX FOR SUCH YEAR, THE EXCESS MAY BE CARRIED OVER TO THE FOLLOWING YEAR OR YEARS AND MAY BE DEDUCTED FROM THE TAXPAYER'S TAX FOR SUCH YEAR OR YEARS.

(2) FOR THE PURPOSES OF THIS SUBSECTION "QUALIFIED SMALL EMPLOYER" SHALL MEAN AN INDIVIDUAL PROPRIETOR WHO IS THE SOLE EMPLOYEE OF THE BUSINESS OR AN EMPLOYER WITH NOT MORE THAN FIFTY EMPLOYEES WHO IS A "SMALL BUSINESS TAXPAYER" AS DEFINED IN PARAGRAPH (F) OF SUBDIVISION ONE OF SECTION TWO HUNDRED TEN OF THIS CHAPTER.

(3) FOR THE PURPOSES OF THIS SUBSECTION, THE TERM "HEALTH INSURANCE" MEANS AN ACCIDENT AND HEALTH INSURANCE POLICY SUBJECT TO THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN, THREE THOUSAND TWO HUNDRED TWENTY-ONE, FOUR THOUSAND THREE HUNDRED THREE OR FOUR THOUSAND EIGHT HUNDRED ONE OF THE INSURANCE LAW, AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND SHALL INCLUDE "FREEDOM POLICIES" WHICH QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003.

S 9. Section 1456 of the tax law is amended by adding a new subsection (f-1) to read as follows:

(F-1)(1) A TAXPAYER WHO IS A QUALIFIED SMALL EMPLOYER SHALL BE ALLOWED A CREDIT AGAINST THE TAX IMPOSED BY THIS ARTICLE EQUAL TO THE APPLICABLE PERCENTAGE OF THE PREMIUMS PAID DURING THE TAXABLE YEAR FOR HEALTH INSURANCE BY SUCH EMPLOYER. THE APPLICABLE PERCENTAGE SHALL BE (A) FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, (B) TEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND TWELVE, (C) FIFTEEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, (D)

TWENTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, (E) TWENTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN, (F) THIRTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, (G) THIRTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SEVENTEEN, (H) FORTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND EIGHTEEN, AND (I) FORTY-THREE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND NINETEEN.

(2) IN NO EVENT SHALL THE CREDIT HEREIN PROVIDED FOR, AND CARRYOVERS OF SUCH CREDIT, BE ALLOWED IN AN AMOUNT WHICH WILL REDUCE THE TAX PAYABLE TO LESS THAN THE DOLLAR AMOUNT FIXED AS A MINIMUM TAX BY SUBSECTION (B) OF SECTION FOURTEEN HUNDRED FIFTY-FIVE OF THIS ARTICLE. IF, HOWEVER, THE AMOUNT OF CREDIT OR CARRYOVERS OF SUCH CREDIT, OR BOTH, ALLOWABLE UNDER THIS SUBSECTION FOR ANY TAXABLE YEAR REDUCES THE TAX TO SUCH AMOUNT, ANY AMOUNT OF CREDIT OR CARRYOVERS OF SUCH CREDIT THUS NOT DEDUCTIBLE IN SUCH TAXABLE YEAR MAY BE CARRIED OVER TO THE FOLLOWING YEAR OR YEARS AND MAY BE DEDUCTED FROM THE TAXPAYER'S TAX FOR SUCH YEAR OR YEARS.

(3) FOR THE PURPOSES OF THIS SECTION THE TERM "QUALIFIED SMALL EMPLOYER" SHALL MEAN AN INDIVIDUAL PROPRIETOR WHO IS THE SOLE EMPLOYEE OF THE BUSINESS OR AN EMPLOYER WITH NOT MORE THAN FIFTY EMPLOYEES WHO IS A "SMALL BUSINESS TAXPAYER" AS DEFINED IN PARAGRAPH (F) OF SUBDIVISION ONE OF SECTION TWO HUNDRED TEN OF THIS CHAPTER.

(4) FOR THE PURPOSES OF THIS SUBSECTION, THE TERM "HEALTH INSURANCE" MEANS AN ACCIDENT AND HEALTH INSURANCE POLICY SUBJECT TO THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN, THREE THOUSAND TWO HUNDRED TWENTY-ONE, FOUR THOUSAND THREE HUNDRED THREE OR FOUR THOUSAND EIGHT HUNDRED ONE OF THE INSURANCE LAW, AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND SHALL INCLUDE "FREEDOM POLICIES" WHICH QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003.

S 10. Section 1511 of the tax law is amended by adding a new subdivision (aa) to read as follows:

(AA) SMALL EMPLOYER HEALTH CARE INSURANCE CREDIT. (1) A TAXPAYER SHALL BE ALLOWED A CREDIT AGAINST THE TAX IMPOSED BY THIS ARTICLE EQUAL TO THE APPLICABLE PERCENTAGE OF THE PREMIUMS PAID DURING THE TAXABLE YEAR FOR HEALTH INSURANCE BY SUCH EMPLOYER. THE APPLICABLE PERCENTAGE SHALL BE (A) FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, (B) TEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND TWELVE, (C) FIFTEEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, (D) TWENTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, (E) TWENTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN, (F) THIRTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, (G) THIRTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SEVENTEEN, (H) FORTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND EIGHTEEN, AND (I) FORTY-THREE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND NINETEEN.

(2) IN NO EVENT SHALL THE CREDIT HEREIN PROVIDED FOR BE ALLOWED IN AN AMOUNT WHICH WILL REDUCE THE TAX PAYABLE TO LESS THAN THE MINIMUM FIXED BY SUBDIVISION (A) OF SECTION FIFTEEN HUNDRED TWO OF THIS ARTICLE. IF, HOWEVER, THE AMOUNT OF CREDIT ALLOWABLE UNDER THIS SUBDIVISION FOR ANY TAXABLE YEAR REDUCES THE TAX TO SUCH AMOUNT, ANY AMOUNT OF CREDIT NOT

DEDUCTIBLE IN SUCH TAXABLE YEAR MAY BE CARRIED OVER TO THE FOLLOWING YEAR OR YEARS AND MAY BE DEDUCTED FROM THE TAXPAYER'S TAX FOR SUCH YEAR OR YEARS.

(3) FOR THE PURPOSES OF THIS SUBDIVISION THE TERM "QUALIFIED SMALL EMPLOYER" SHALL MEAN AN INDIVIDUAL PROPRIETOR WHO IS THE SOLE EMPLOYEE OF THE BUSINESS OR AN EMPLOYER WITH NOT MORE THAN FIFTY EMPLOYEES WHO IS A "SMALL BUSINESS TAXPAYER" AS DEFINED IN PARAGRAPH (F) OF SUBDIVISION ONE OF SECTION TWO HUNDRED TEN OF THIS CHAPTER.

(4) FOR THE PURPOSES OF THIS SUBDIVISION, THE TERM "HEALTH INSURANCE" MEANS AN ACCIDENT AND HEALTH INSURANCE POLICY SUBJECT TO THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN, THREE THOUSAND TWO HUNDRED TWENTY-ONE, FOUR THOUSAND THREE HUNDRED THREE OR FOUR THOUSAND EIGHT HUNDRED ONE OF THE INSURANCE LAW, AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND SHALL INCLUDE "FREEDOM POLICIES" WHICH QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003.

S 11. Section 606 of the tax law is amended by adding a new subsection (h-1) to read as follows:

(H-1) INDIVIDUAL ENROLLEE HEALTH INSURANCE CREDIT. A TAXPAYER SHALL BE ALLOWED A CREDIT AGAINST THE TAX IMPOSED BY THIS ARTICLE EQUAL TO THE APPLICABLE PERCENTAGE OF THE PREMIUM PAID DURING THE TAXABLE YEAR FOR HEALTH INSURANCE PURCHASED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED TWENTY-ONE OR FOUR THOUSAND THREE HUNDRED TWENTY-TWO OF THE INSURANCE LAW, INCLUDING "FREEDOM POLICIES" WHICH QUALIFY FOR USE IN A HEALTH SAVINGS ACCOUNT PURSUANT TO SECTION 1201 OF THE FEDERAL MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003. THE APPLICABLE PERCENTAGE SHALL BE (1) FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, (2) TEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND TWELVE, (3) FIFTEEN PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, (4) TWENTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, (5) TWENTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN, (6) THIRTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, (7) THIRTY-FIVE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND SEVENTEEN, (8) FORTY PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND EIGHTEEN, AND (9) FORTY-THREE PERCENT FOR TAXABLE YEARS BEGINNING ON OR AFTER JANUARY FIRST, TWO THOUSAND NINETEEN.

S 12. Subsection (c) of section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, subparagraph (A) of paragraph 1 and subparagraph (C) of paragraph 3 as amended by chapter 419 of the laws of 2000, is amended to read as follows:

(c) The following definitions shall be applicable to the insurance contracts 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] FIFTY 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.

(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 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. The contract must insure 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;

(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;

(iii) [resides] RESIDING in a household having a net household income at or below two hundred [eight] FIFTY 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)] WHO 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 twenty-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 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.

(5) A QUALIFYING INDIVIDUAL RESIDING IN A HOUSEHOLD HAVING A NET INCOME ABOVE TWO HUNDRED FIFTY PERCENT OF THE NON-FARM POVERTY LEVEL (AS DEFINED AND UPDATED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES) OR THE GROSS EQUIVALENT OF SUCH NET INCOME SHALL BE ELIGIBLE TO PURCHASE A QUALIFYING INDIVIDUAL HEALTH INSURANCE CONTRACT. PROVIDED, HOWEVER, PREMIUMS SHALL BE PAID TO THE INSURER OR HEALTH MAINTENANCE ORGANIZATION AT A RATE WHICH DOES NOT INCLUDE ACTUARIAL REDUCTIONS DERIVED FROM THE MARKET STABILIZATION POOLS CREATED PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED THIRTY-THREE OF THIS CHAPTER.

S 13. Paragraphs 4 and 6 of subsection (e) of section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, are amended to read as follows:

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

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

S 14. Subsection (g) of section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

(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] MAINTAIN THE PROGRAM. 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 if the superintendent determines additional benefit packages with different levels of benefits are necessary to meet the needs of the public.

S 15. Subsections (b) and (e) of section 4327 of the insurance law, as added by chapter 1 of the laws of 1999, are amended to read as follows:

(b) Commencing on January first, two thousand one, health maintenance organizations, corporations or insurers shall be eligible to receive reimbursement for ninety percent of claims paid between thirty thousand and one hundred thousand dollars AND COMMENCING JANUARY FIRST, TWO THOUSAND TWELVE, HEALTH MAINTENANCE ORGANIZATIONS, CORPORATIONS OR INSURERS SHALL BE ELIGIBLE FOR REIMBURSEMENT FOR NINETY PERCENT OF CLAIMS IN EXCESS OF FIVE HUNDRED 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.

(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.]

S 16. Subsections (a) and (c) of section 4321-a of the insurance law, as added by chapter 1 of the laws of 1999, are amended to read as follows:

(a) The superintendent shall establish a fund from which health maintenance organizations may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations for members covered under standardized individual enrollee direct payment contracts issued pursuant to section four thousand three hundred twenty-one of this article. The fund established by the superintendent pursuant to this section shall be known as the direct payment stop loss fund. Commencing in calendar year two thousand, health maintenance organizations shall be eligible to receive reimbursement from the direct payment stop loss fund for ninety percent of claims paid between twenty thousand and one hundred thousand dollars, AS WELL AS CLAIMS IN EXCESS OF FIVE HUNDRED THOUSAND DOLLARS, in a calendar year for any member covered under a contract issued pursuant to section four thousand three hundred twenty-one of this article. 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 direct payment contracts.

(c) Claims shall be reported and funds shall be distributed 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 member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in such calendar year shall be eligible for reimbursement UNTIL THE CLAIMS REACH FIVE HUNDRED THOUSAND DOLLARS.

S 17. Subsections (a) and (c) of section 4322-a of the insurance law, as added by chapter 1 of the laws of 1999, are amended to read as follows:

(a) The superintendent shall establish a fund from which health maintenance organizations may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations for members covered under standardized individual enrollee direct payment contracts which provide out-of-plan benefits issued pursuant to section four thousand three hundred twenty-two of this article. The fund established by the superintendent pursuant to this section shall be known as "the direct payment out-of-plan stop loss fund". Commencing in calendar year two thousand, health maintenance organizations shall be eligible to receive reimbursement from the direct payment out-of-plan stop loss fund for ninety percent of claims paid between twenty thousand and one hundred thousand dollars, AS WELL AS CLAIMS IN EXCESS OF FIVE HUNDRED THOUSAND DOLLARS, in a calendar year for any member covered under a contract issued pursuant to section four thousand three hundred twenty-two of this article. 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 contracts issued pursuant to section four thousand three hundred twenty-two of this article.

(c) Claims shall be reported and funds shall be distributed 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 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 UNTIL THE CLAIMS REACH FIVE HUNDRED THOUSAND DOLLARS.

S 18. Subsection (b) of section 3231 of the insurance law, as amended by chapter 557 of the laws of 2002, is amended to read as follows:

(b) Nothing herein shall prohibit the use of premium rate structures to establish different premium rates for individuals as opposed to family units or separate community rates for individuals as opposed to small groups. NOTHING HEREIN SHALL REQUIRE THAT ALL PRODUCTS IN THE SAME COMMUNITY POOL HAVE AN IDENTICAL CHANGE IN PREMIUM; AN INSURER MAY SUBSEQUENTLY INCREASE OR DECREASE THE PREMIUM OF ONE PRODUCT BY A DIFFERENT PERCENTAGE THAN ANOTHER PRODUCT BASED ON DIFFERING UTILIZATION OR OTHER FACTORS (AS DETERMINED BY THE INSURER), EVEN THOUGH BOTH PRODUCTS ARE IN THE SAME COMMUNITY POOL. If an insurer is required to issue a contract to individual proprietors pursuant to subsection (i) of this section, such policy shall be subject to subsection (a) of this section.

S 19. Subsection (b) of section 4317 of the insurance law, as amended by chapter 557 of the laws of 2002, is amended to read as follows:

(b) Nothing herein shall prohibit the use of premium rate structures to establish different premium rates for individuals as opposed to family units or separate community rates for individuals as opposed to small groups. NOTHING HEREIN SHALL REQUIRE THAT ALL PRODUCTS IN THE SAME COMMUNITY POOL HAVE AN IDENTICAL CHANGE IN PREMIUM; AN INSURER MAY SUBSEQUENTLY INCREASE OR DECREASE THE PREMIUM OF ONE PRODUCT BY A DIFFERENT PERCENTAGE THAN ANOTHER PRODUCT BASED ON DIFFERING UTILIZATION OR OTHER FACTORS (AS DETERMINED BY THE INSURER), EVEN THOUGH BOTH PRODUCTS ARE IN THE SAME COMMUNITY POOL. If a corporation is required to issue a contract to individual proprietors pursuant to subsection (f) of this section, such contract shall be subject to the requirements of subsection (a) of this section.

S 20. Subdivision 3 of section 4401 of the public health law, as added by chapter 938 of the laws of 1976, is amended to read as follows:

3. "Comprehensive health services" means all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive health services. Such term may be further defined by agreement with enrolled populations providing additional benefits necessary, desirable or appropriate to meet their health care needs. NOTWITHSTANDING THE PRECEDING, IN THE CASE OF GROUPS WITH FIFTY-ONE OR MORE EMPLOYEES, SUBSCRIBERS OR MEMBERS, EXCLUSIVE OF SPOUSES AND DEPENDENTS, A HEALTH MAINTENANCE ORGANIZATION MAY OFFER CONTRACTS WITH THOSE DEDUCTIBLES, COINSURANCE, COPAYMENTS AND OTHER LIMITATIONS ON BENEFITS NECESSARY TO MATCH THE BENEFITS OF THE OTHER HEALTH BENEFIT OFFERINGS OF SUCH GROUPS AND THEREBY ATTEMPT TO AVOID ADVERSE SELECTION.

S 21. Subdivision 1 of section 4406 of the public health law, as amended by chapter 342 of the laws of 2004, is amended to read as follows:

1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of

the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of fifty or fewer employees or members, exclusive of spouses and dependents, or any employee or member of the group, including dependents, applying for such contract at any time throughout the year, and may include a pre-existing condition provision as provided for in section four thousand three hundred eighteen of the insurance law, 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] THE INSURANCE LAW due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four; AND PROVIDED FURTHER, HOWEVER, THAT IN THE CASE OF LARGE GROUPS NOT SUBJECT TO SECTION FOUR THOUSAND THREE HUNDRED SEVENTEEN OF THE INSURANCE LAW THE HEALTH MAINTENANCE ORGANIZATION MAY APPLY THE SAME MINIMUM PARTICIPATION AND OTHER ENROLLMENT STANDARDS AS AN INSURER IS PERMITTED TO APPLY PURSUANT TO THE INSURANCE LAW. Subject to the creditable coverage requirements of subsection (a) of section four thousand three hundred eighteen of the insurance law, the organization may, as an alternative to the use of a pre-existing condition provision, elect to offer contracts without a pre-existing condition provision to such groups but may require that coverage shall not become effective until after a specified affiliation period of not more than sixty days after the application for coverage is submitted. The organization is not required to provide health care services or benefits during such period and no premium shall be charged for any coverage during the period. After January first, nineteen hundred ninety-six, all individual direct payment contracts shall be issued only pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of the insurance law. Such contracts may not, with respect to an eligible individual (as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. S 300gg-41(b)), impose any pre-existing condition exclusion.

S 22. Section 4406 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. NOTWITHSTANDING ANY OTHER LAW, REGULATION OR DEPARTMENTAL POLICY, IN THE CASE OF OFFERINGS TO GROUPS WITH FIFTY-ONE OR MORE EMPLOYEES, SUBSCRIBERS OR MEMBERS, EXCLUSIVE OF SPOUSES AND DEPENDENTS, A HEALTH MAINTENANCE ORGANIZATION MAY ELECT NOT TO OFFER COVERAGE TO THE GROUP AS A WHOLE IF THE BENEFIT PACKAGES OF THE OTHER PLANS OFFERED BY THE GROUP, OR THE AMOUNTS CONTRIBUTED BY THE GROUP TOWARDS THE PREMIUMS, ARE LIKELY TO PROMOTE ADVERSE SELECTION.

S 23. Section 2406 of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) ALL FINES AND PENALTIES PAID AND COLLECTED PURSUANT TO THIS SECTION SHALL BE DEPOSITED IN AND DISTRIBUTED THROUGH POOLS CREATED PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED THIRTY-THREE OF THIS

CHAPTER ESTABLISHED AND OPERATED FOR THE PURPOSE OF MARKET STABILIZATION MECHANISMS FOR INDIVIDUAL, SMALL GROUP AND MEDICARE SUPPLEMENTAL INSURANCE.

S 24. This act shall take effect January 1, 2012.