STATE OF NEW YORK

4828

2017-2018 Regular Sessions

IN SENATE

March 2, 2017

Introduced by Sen. PERSAUD -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

AN ACT to amend the insurance law, in relation to providing health insurance protection to New Yorkers in the event that the federal Affordable Care Act is repealed

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The insurance law is amended by adding a new section 3217-i to read as follows:

§ 3217-i. Essential health benefits package. (a) Coverage required. No insurer subject to this article shall decline to provide an essential health benefits package as required by this section.

(b) Definition. The term "essential health benefits package" means, with respect to any health plan, coverage that provides for the essential health benefits as defined by the superintendent under subsection (c) of this section; limits cost-sharing for such coverage in accordance with subsection (d) of this section; and subject to subsection (d) of this section, provides either bronze, silver, gold or platinum level of coverage as described in subsection (e) of this section.

(c) Superintendent's powers and duties with respect to essential health benefits. (1) Subject to paragraph two of this subsection, the superintendent shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within such categories: (i) ambulatory patient services, (ii) emergency services, (iii) hospitalization, (iv) maternity and newborn care, (v) mental health and substance use disorder services, including behavioral health treatment, (vi) prescription drugs, (vii) rehabilitative and habilitative services and devices, (viii) laboratory services, (ix) preventive and wellness services and chronic disease management, and (x) pediatric services, including oral and vision care.

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

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(2) The superintendent shall ensure that the scope of the essential health benefits under paragraph one of this subsection is equal to the scope of benefits provided under a typical employer plan, as determined by the superintendent. In defining the essential health benefits under paragraph one of this subsection, the superintendent shall:

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in paragraph one of this subsection so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph one of this subsection unless the plan provides that:

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, is the same requirement that would apply if such services were provided in-network;

(F) provide that if a stand-alone dental benefits plan is offered through an exchange, another health plan offered through such exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under subparagraph (G) of this paragraph; and

(G) periodically update the essential health benefits under paragraph one of this subsection to address any gaps in access to coverage.

(d) Cost-sharing requirements. (1) There shall be an annual limitation on cost-sharing. (A) The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in two thousand fourteen shall not exceed the dollar amounts in effect for self-only and family coverage, respectively, for taxable years beginning in two thousand fourteen.

(B) In the case of any plan year beginning in a calendar year after two thousand fourteen, the limitation under this paragraph shall:

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) of this paragraph for self-only coverage for plan years beginning in two thousand fourteen, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph three of this subsection for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i) of this subparagraph. If the amount of any increase under clause (i) of this subparagraph is not a multiple of fifty dollars, such increase shall be rounded to the next lowest multiple of fifty dollars.

(2) (A) The term "cost-sharing" shall include:

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense with respect to essential health benefits covered under the plan.

(B) Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(3) For purposes of clause (i) of subparagraph (B) of paragraph one of this subsection, the premium adjustment percentage for any calendar year is the percentage, if any, by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds such average per capita premium for the year two thousand thirteen.

(e) Levels of coverage. (1) Levels of coverage described in this subsection are as follows:

(A) Bronze level. A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level. A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level. A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level. A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to ninety percent of the full actuarial value of the benefits provided under the plan.

(2) (A) Actuarial value. Under regulations issued by the superintendent, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (c) of this section shall be provided to a standard population and without regard to the population the plan may actually provide benefits to.

(B) Employer contributions. The superintendent shall issue regulations under which employer contributions to a health savings account may be taken into account.

§ 2. The insurance law is amended by adding a new section 4306-h to read as follows:

§ 4306-h. Essential health benefits package. (a) Coverage required. No corporation subject to this article shall decline to provide an essential health benefits package as required by this section.

(b) Definition. The term "essential health benefits package" means, with respect to any health plan, coverage that provides for the essential health benefits as defined by the superintendent under subsection (c) of this section; limits cost-sharing for such coverage in accordance with subsection (d) of this section; and subject to subsection (d) of this section, provides either bronze, silver, gold or platinum level of coverage as described in subsection (e) of this section.

(c) Superintendent's powers and duties with respect to essential health benefits. (1) Subject to paragraph two of this subsection, the superintendent shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within such categories: (i) ambulatory patient services, (ii) emergency services, (iii) hospitalization, (iv) maternity and newborn care, (v) mental health and substance use disorder services, including behavioral health treatment, (vi) prescription drugs, (vii) rehabilitative and habilitative services and devices, (viii) laboratory services, (ix) preventive and wellness services and chronic disease management, and (x) pediatric services, including oral and vision care.

(2) The superintendent shall ensure that the scope of the essential health benefits under paragraph one of this subsection is equal to the scope of benefits provided under a typical employer plan, as determined by the superintendent. In defining the essential health benefits under paragraph one of this subsection, the superintendent shall:

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in paragraph one of this subsection so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph one of this subsection unless the plan provides that:

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, is the same requirement that would apply if such services were provided in-network;

(F) provide that if a stand-alone dental benefits plan is offered through an exchange, another health plan offered through such exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under subparagraph (G) of this paragraph; and

(G) periodically update the essential health benefits under paragraph one of this subsection to address any gaps in access to coverage.

(d) Cost-sharing requirements. (1) There shall be an annual limitation on cost-sharing. (A) The cost-sharing incurred under a health plan with

respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in two thousand fourteen shall not exceed the dollar amounts in effect for self-only and family coverage, respectively, for taxable years beginning in two thousand fourteen.

(B) In the case of any plan year beginning in a calendar year after two thousand fourteen, the limitation under this paragraph shall:

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) of this paragraph for self-only coverage for plan years beginning in two thousand fourteen, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph three of this subsection for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i) of this subparagraph. If the amount of any increase under clause (i) of this subparagraph is not a multiple of fifty dollars, such increase shall be rounded to the next lowest multiple of fifty dollars.

(2) (A) The term "cost-sharing" shall include:

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense with respect to essential health benefits covered under the plan.

(B) Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(3) For purposes of clause (i) of subparagraph (B) of paragraph one of this subsection, the premium adjustment percentage for any calendar year is the percentage, if any, by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds such average per capita premium for the year two thousand thirteen.

(e) Levels of coverage. (1) Levels of coverage described in this subsection are as follows:

(A) Bronze level. A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under the plan.

(B) Silver level. A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan.

(C) Gold level. A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan.

(D) Platinum level. A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to ninety percent of the full actuarial value of the benefits provided under the plan.

(2) (A) Actuarial value. Under regulations issued by the superintendent, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (c) of this section shall be provided to a standard population and without regard to the population the plan may actually provide benefits to.

(B) Employer contributions. The superintendent shall issue regulations under which employer contributions to a health savings account may be taken into account.

§ 3. Subsection (e) of section 3217-f of the insurance law, as added by chapter 219 of the laws of 2011, is amended to read as follows:

(e) For purposes of this section, "essential health benefits" shall have the same meaning [~~ascribed by section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b)~~] as subsection (c) of section three thousand two hundred seventeen-i of this article.

§ 4. Subsection (h) and paragraph 19 of subsection (k) of section 3221 of the insurance law, subsection (h) as added by section 54 of part D of chapter 56 of the laws of 2013 and paragraph 19 of subsection (k) as amended by chapter 377 of the laws of 2014, are amended to read as follows:

(h) Every small group policy or association group policy delivered or issued for delivery in this state that provides coverage for hospital, medical or surgical expense insurance and is not a grandfathered health plan shall provide coverage for the essential health benefit package as required in section [~~2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~] three thousand two hundred seventeen-i of this article. For purposes of this subsection:

(1) "essential health benefits package" shall have the meaning set forth in [~~section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a)~~] subsection (c) of section three thousand two hundred seventeen-i of this article;

(2) "grandfathered health plan" means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status [~~in accordance with section 1251(e) of the affordable care act, 42 U.S.C. § 18011(e)~~];

(3) "small group" means a group of fifty or fewer employees or members exclusive of spouses and dependents; provided, however, that beginning January first, two thousand sixteen, "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

(4) "association group" means a group defined in subparagraphs (B), (D), (H), (K), (L) or (M) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, provided that:

(A) the group includes one or more individual members; or

(B) the group includes one or more member employers or other member groups that are small groups.

(19) Every group or blanket accident and health insurance policy delivered or issued for delivery in this state which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance as deemed appropriate by the superintendent. The coverage required by this paragraph shall be identical to, and shall not enhance or increase the coverage required as part of essential health benefits [~~as required pursuant to section 2707 (a) of the public health services act 42 U.S.C. 300 gg-6(a)~~] set forth in section three thousand two hundred seventeen-i of this article.

§ 5. Subsection (d) of section 3240 of the insurance law, as added by section 41 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(d) A student accident and health insurance policy or contract shall provide coverage for essential health benefits as defined in [~~section~~

~~1302(b) of the affordable care act, 42 U.S.C. § 18022(b)~~] subsection (c) of section three thousand two hundred seventeen-i of this article.

§ 6. Subsection (u-1) of section 4303 of the insurance law, as amended by chapter 377 of the laws of 2014, is amended to read as follows:

(u-1) A medical expense indemnity corporation or a health service corporation which provides medical coverage that includes coverage for physician services in a physician's office and every policy which provides major medical or similar comprehensive-type coverage shall include coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law. Such coverage shall be subject to annual deductibles and coinsurance as deemed appropriate by the superintendent. The coverage required by this subsection shall be identical to, and shall not enhance or increase the coverage required as part of essential health benefits as required pursuant to section [~~2707(a) of the public health services act 42 U.S.C. 300 gg-6(a)~~] four thousand three hundred six-h of this article.

§ 7. Subsection (e) of section 4306-e of the insurance law, as added by chapter 219 of the laws of 2011, is amended to read as follows:

(e) For purposes of this section, "essential health benefits" shall have the meaning ascribed by [~~section 1302(b) of the Affordable Care Act, 42 U.S.C. § 18022(b)~~] subsection (c) of section four thousand three hundred six-h of this article.

§ 8. Subsections (d) and (e) of section 4326 of the insurance law, as amended by section 56 of part D of chapter 56 of the laws of 2013, are amended to read as follows:

(d) A qualifying group health insurance contract shall provide coverage for the essential health benefit package as required [~~in section 2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~] by section four thousand three hundred six-h of this article. For purposes of this subsection "essential health benefits package" shall have the meaning set forth in [~~section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a)~~] subsection (c) of section four thousand three hundred six-h of this article.

(e) A qualifying group health insurance contract issued to a qualifying small employer prior to January first, two thousand fourteen that does not include all essential health benefits required pursuant to section [~~2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~] four thousand three hundred six-h of this article, shall be discontinued, including grandfathered health plans. For the purposes of this paragraph, "grandfathered health plans" means coverage provided by a corporation to individuals who were enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status [~~in accordance with section 1251(e) of the affordable care act, 42 U.S.C. § 18011(e)~~]. A qualifying small employer shall be transitioned to a plan that provides: (1) a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan; and (2) coverage for the essential health benefit package as required in section [~~2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~] four thousand three hundred six-h of this article. The superintendent shall standardize the benefit package and cost sharing requirements of qualified group health insurance contracts consistent with coverage offered through the health benefit exchange [~~established pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031~~].

§ 9. Paragraph 1 of subsection (b) of section 4328 of the insurance law, as added by section 46 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) The individual enrollee direct payment contract offered pursuant to this section shall provide coverage for the essential health benefit package as required in section [~~2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~] four thousand three hundred six-h of this article. For purposes of this paragraph, "essential health benefits package" shall have the meaning set forth in [~~section 1302(a) of the affordable care act, 42 U.S.C. § 18022(a)~~] subsection (c) of section four thousand three hundred six-h of this article.

§ 10. Paragraphs (f) and (g) of section 3232 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new paragraph (j) is added to read as follows:

(f) With respect to an individual under age nineteen, an insurer may not impose any pre-existing condition exclusion in an individual or group policy of hospital, medical, surgical or prescription drug expense insurance [~~pursuant to the requirements of section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3, as made effective by section 1255(2) of the Affordable Care Act,~~] except for an individual under age nineteen covered under an individual policy of hospital, medical, surgical or prescription drug expense insurance that is a grandfathered health plan.

(g) Beginning January first, two thousand fourteen[~~, pursuant to section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3,~~] an insurer may not impose any pre-existing condition exclusion in an individual or group policy of hospital, medical, surgical or prescription drug expense insurance except in an individual policy that is a grandfathered health plan.

(j) For purposes of subsections (f) and (g) of this section, "pre-existing condition" shall mean a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

§ 11. Subsections (f) and (g) of section 4318 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new subsection (j) is added to read as follows:

(f) With respect to an individual under age nineteen, a corporation may not impose any pre-existing condition exclusion in an individual or group contract of hospital, medical, surgical or prescription drug expense insurance pursuant to the requirements of section [~~2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3, as made effective by section 1255(2) of the Affordable Care Act~~] four thousand three hundred six-h of this article, except for an individual under age nineteen covered under an individual contract of hospital, medical, surgical or prescription drug expense insurance that is a grandfathered health plan.

(g) Beginning January first, two thousand fourteen, pursuant to section [~~2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3~~] four thousand three hundred six-h of this article, a corporation may not impose any pre-existing condition exclusion in an individual or group contract of hospital, medical, surgical or prescription drug expense insurance except in an individual contract that is a grandfathered health plan.

(j) For purposes of subsections (f) and (g) of this section, "pre-existing exclusion" shall mean a limitation or exclusion of benefits

relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

§ 12. This act shall take effect on such date as the affordable care act is fully repealed and at such time as the provisions of such act are no longer in force and effect; provided that the superintendent of financial services shall notify the legislative bill drafting commission upon the occurrence of the repeal of the federal Affordable Care Act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.