

STATE OF NEW YORK

S. 1507--A

A. 2007--A

SENATE - ASSEMBLY

January 18, 2019

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

IN ASSEMBLY -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the social services law, in relation to reimbursement of transportation costs, reimbursement of emergency transportation services and supplemental transportation payments; and to repeal certain provisions of such law relating thereto (Part A); to amend the social services law and the public health law, in relation to updating copayments; to amend the public health law, in relation to extending and enhancing the Medicaid drug cap and to reduce unnecessary pharmacy benefit manager costs to the Medicaid program; and to repeal certain provisions of the social services law relating thereto (Part B); to amend the social services law, in relation to extension of the National Diabetes Prevention Program and in relation to supplemental medicaid managed care payments (Part C); to amend chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to extending the medicaid global cap (Part D); to amend chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to extending the provisions thereof; to amend chapter 56 of the laws of the laws of 2013, amending the social services law relating to eligibility conditions, in relation to extending the provisions thereof; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to amend chapter 109 of the laws of 2010, amending the social

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

LBD12571-02-9

services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medical expenditures, in relation to extending the provisions thereof; to amend the public health law, in relation to hospital assessments; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative costs; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to rates of payments; to amend the public health law, in relation to reimbursement rate promulgation for residential health care facilities; to amend the public health law, in relation to residential health care facility, and certified home health agency services payments; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to transfer of funds and the effectiveness thereof; and to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof (Part E); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend

part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part F); to amend the social services law, in relation to eliminating the ability of legally responsible spouses to refuse to support non-institutionalized spouses; to create a state fiscal intermediary for the consumer directed personal assistance program; and to repeal certain provisions of such law relating thereto (Part G); to amend the public health law, in relation to waiver of certain regulations; to amend the public health law in relation to certain rates and payment methodologies; and to repeal certain provisions of such law relating thereto (Part H); to amend the insurance law, in relation to registration and licensing of pharmacy benefit managers (Part I); to amend the insurance law and the public health law, in relation to guaranteed availability, pre-existing conditions and employee welfare funds; and to repeal certain provisions of the insurance law relating thereto (Subpart A); to amend the insurance law, in relation to actuarial value requirements and essential health benefits (Subpart B); to amend the insurance law, in relation to coverage for medically necessary abortions, and exceptions thereto (Subpart C); to amend the insurance law, in relation to prescription drug coverage (Subpart D); to amend the insurance law, in relation to discrimination based on sex and gender identity (Subpart E); and to amend the insurance law, in relation to insurance certificate delivery (Subpart F) (Part J); to amend the public health law, in relation to the medical indemnity fund; and to amend chapter 517 of the laws of 2016 amending the public health law relating to payments from the New York state medical indemnity fund, in relation to the effectiveness thereof (Part K); to amend the insurance law, in relation to in-vitro fertilization (Part L); to amend the insurance law and the social services law, in relation to requiring health insurance policies to include coverage of all FDA-approved contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow up services and prohibiting a health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage (Part M); to establish a universal access commission to consider the options for achieving universal access to health care (Part N); to amend the public health law, in relation to the general public health work program (Part O); to amend the public health law, in relation to lead levels in residential rental properties (Part P); to amend the public health law, in relation to the healthcare facility transformation program state III authorizing additional awards for statewide II applications (Part Q); to amend the public health law, in relation to maternal mortality review boards and the maternal mortality and morbidity advisory council (Part R); to amend the public health law, in relation to enacting the reproductive health act and revising existing provisions of law regarding abortion; to amend the penal law, the criminal procedure law, the county law and the judiciary law, in relation to abortion; to repeal certain provisions of the public health law relating to abortion; to repeal certain provisions of the education law relating to the sale of contraceptives; and to repeal certain provisions of the penal law relating to abortion (Part S); to amend the public health law, in relation to codifying the creation of NY State of Health, the official Health Plan Marketplace within the department of health (Part T); to

amend the elder law, in relation to the private pay program (Part U); to amend the social services law, in relation to compliance of managed care organizations and providers participating in the Medicaid program (Part V); to amend part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part W); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings; and providing for the repeal of such provisions upon expiration thereof (Part X); to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to the inclusion and development of certain cost of living adjustments (Part Y); to amend the public health law and the mental hygiene law, in relation to integrated services (Part Z); to amend the social services law, in relation to the definition of a facility or a provider agency (Part AA); to amend the insurance law, in relation to mental health and substance use disorder health insurance parity; to amend the public health law, in relation to health maintenance organizations; and to repeal certain provisions of the insurance law relating thereto (Subpart A); to amend the public health law, in relation to general hospital policies for substance use disorder treatment (Subpart B); to repeal subparagraph (v) of paragraph (a) of subdivision 2 of section 3343-a of the public health law relating to general hospital prescription drug monitoring (Subpart C); to amend the social services law, in relation to court ordered substance use disorder treatment (Subpart D); and to amend the public health law, in relation to including fentanyl analogs as controlled substances (Subpart E)(Part BB); to amend the public health law, in relation to prescriber assistance in allowing unlicensed certified pharmacy technicians to assist in dispensing of drugs (Part CC); and to authorize a uniform across the board reduction to the Department of Health Medicaid claims (Part DD)

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

1 Section 1. This act enacts into law major components of legislation
2 which are necessary to implement the state fiscal plan for the 2019-2020
3 state fiscal year. Each component is wholly contained within a Part
4 identified as Parts A through DD. The effective date for each particular
5 provision contained within such Part is set forth in the last section of
6 such Part. Any provision in any section contained within a Part, includ-
7 ing the effective date of the Part, which makes a reference to a section
8 "of this act", when used in connection with that particular component,
9 shall be deemed to mean and refer to the corresponding section of the
10 Part in which it is found. Section three of this act sets forth the
11 general effective date of this act.

12 PART A

13 Section 1. Subdivision 4 of section 365-h of the social services law,
14 as separately amended by section 50 of part B and section 24 of part D
15 of chapter 57 of the laws of 2015, is amended to read as follows:

1 4. The commissioner of health is authorized to assume responsibility
2 from a local social services official for the provision and reimburse-
3 ment of transportation costs under this section. If the commissioner
4 elects to assume such responsibility, the commissioner shall notify the
5 local social services official in writing as to the election, the date
6 upon which the election shall be effective and such information as to
7 transition of responsibilities as the commissioner deems prudent. The
8 commissioner is authorized to contract with a transportation manager or
9 managers to manage transportation services in any local social services
10 district, other than transportation services provided or arranged for
11 enrollees of ~~[managed long term care plans issued certificates of~~
12 ~~authority under section forty four hundred three f of the public health~~
13 ~~law]~~ a program designated as a Program of All-Inclusive Care for the
14 Elderly (PACE) as authorized by Federal Public law 105-33, subtitle I of
15 title IV of the Balanced Budget Act of 1997. Any transportation manager
16 or managers selected by the commissioner to manage transportation
17 services shall have proven experience in coordinating transportation
18 services in a geographic and demographic area similar to the area in New
19 York state within which the contractor would manage the provision of
20 services under this section. Such a contract or contracts may include
21 responsibility for: review, approval and processing of transportation
22 orders; management of the appropriate level of transportation based on
23 documented patient medical need; and development of new technologies
24 leading to efficient transportation services. If the commissioner elects
25 to assume such responsibility from a local social services district, the
26 commissioner shall examine and, if appropriate, adopt quality assurance
27 measures that may include, but are not limited to, global positioning
28 tracking system reporting requirements and service verification mech-
29 anisms. Any and all reimbursement rates developed by transportation
30 managers under this subdivision shall be subject to the review and
31 approval of the commissioner.

32 § 2. The opening paragraph of subdivision 1 and subdivision 3 of
33 section 367-s of the social services law, as amended by section 53 of
34 part B of chapter 57 of the laws of 2015, are amended to read as
35 follows:

36 Notwithstanding any provision of law to the contrary, a supplemental
37 medical assistance payment shall be made on an annual basis to providers
38 of emergency medical transportation services in an aggregate amount not
39 to exceed four million dollars for two thousand six, six million dollars
40 for two thousand seven, six million dollars for two thousand eight, six
41 million dollars for the period May first, two thousand fourteen through
42 March thirty-first, two thousand fifteen, and six million dollars [~~annu-~~
43 ~~ally beginning with~~] on an annual basis for the period April first, two
44 thousand fifteen through March thirty-first, two thousand [~~sixteen~~]
45 nineteen pursuant to the following methodology:

46 3. If all necessary approvals under federal law and regulation are not
47 obtained to receive federal financial participation in the payments
48 authorized by this section, payments under this section shall be made in
49 an aggregate amount not to exceed two million dollars for two thousand
50 six, three million dollars for two thousand seven, three million dollars
51 for two thousand eight, three million dollars for the period May first,
52 two thousand fourteen through March thirty-first, two thousand fifteen,
53 and three million dollars [~~annually beginning with~~] on an annual basis
54 for the period April first, two thousand fifteen through March thirty-
55 first, two thousand [~~sixteen~~] nineteen. In such case, the multiplier
56 set forth in paragraph (b) of subdivision one of this section shall be

1 deemed to be two million dollars or three million dollars as applicable
2 to the annual period.

3 § 3. Subdivision 5 of section 365-h of the social services law is
4 REPEALED.

5 § 4. This act shall take effect immediately and shall be deemed to
6 have been in full force and effect on and after April 1, 2019; provided,
7 however, that section one of this act shall take effect October 1, 2019;
8 provided, further that the amendments to subdivision 4 of section 365-h
9 of the social services law made by section one of this act shall not
10 affect the repeal of such section and shall expire and be deemed
11 repealed therewith.

12 PART B

13 Section 1. Paragraph (a) of subdivision 4 of section 365-a of the
14 social services law, as amended by chapter 493 of the laws of 2010, is
15 amended to read as follows:

16 (a) drugs which may be dispensed without a prescription as required by
17 section sixty-eight hundred ten of the education law; provided, however,
18 that the state commissioner of health may by regulation specify certain
19 of such drugs which may be reimbursed as an item of medical assistance
20 in accordance with the price schedule established by such commissioner.
21 Notwithstanding any other provision of law, ~~additions~~ modifications to
22 the list of drugs reimbursable under this paragraph may be filed as
23 regulations by the commissioner of health without prior notice and
24 comment;

25 § 2. Paragraph (c) of subdivision 6 of section 367-a of the social
26 services law is amended by adding a new subparagraph (v) to read as
27 follows:

28 (v) Notwithstanding any other provision of this paragraph, co-payments
29 charged for drugs dispensed without a prescription as required by
30 section sixty-eight hundred ten of the education law but which are reim-
31 bursed as an item of medical assistance pursuant to paragraph (a) of
32 subdivision four of section three hundred sixty-five-a of this title
33 shall be one dollar.

34 § 3. Paragraph (b) of subdivision 3 of section 273 of the public
35 health law, as added by section 10 of part C of chapter 58 of the laws
36 of 2005, is amended to read as follows:

37 (b) In the event that the patient does not meet the criteria in para-
38 graph (a) of this subdivision, the prescriber may provide additional
39 information to the program to justify the use of a prescription drug
40 that is not on the preferred drug list. The program shall provide a
41 reasonable opportunity for a prescriber to reasonably present his or her
42 justification of prior authorization. ~~[If, after consultation with the~~
43 ~~program, the prescriber, in his or her reasonable professional judgment,~~
44 ~~determines that the use of a prescription drug that is not on the~~
45 ~~preferred drug list is warranted, the prescriber's determination shall~~
46 ~~be final.]~~ The program will consider the additional information and the
47 justification presented to determine whether the use of a prescription
48 drug that is not on the preferred drug list is warranted.

49 § 4. Subdivisions 25 and 25-a of section 364-j of the social services
50 law are REPEALED.

51 § 5. Paragraphs (b) and (c) of subdivision 2 of section 280 of the
52 public health law, paragraph (b) as amended and paragraph (c) as added
53 by section 8 of part D of chapter 57 of the laws of 2018, are amended
54 and a new paragraph (d) is added to read as follows:

(b) for state fiscal year two thousand eighteen--two thousand nineteen, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars; ~~[and]~~

(c) for state fiscal year two thousand nineteen--two thousand twenty, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars~~[-]; and~~

(d) for state fiscal year two thousand twenty--two thousand twenty-one, be limited to the ten-year rolling average of the medical component of the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars.

§ 6. Subdivision 3 of section 280 of the public health law, as amended by section 8 of part D of chapter 57 of the laws of 2018, is amended to read as follows:

3. The department and the division of the budget shall assess on a quarterly basis the projected total amount to be expended in the year on a cash basis by the Medicaid program for each drug, and the projected annual amount of state funds Medicaid drug expenditures on a cash basis for all drugs, which shall be a component of the projected department of health state funds Medicaid expenditures calculated for purposes of sections ninety-one and ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven. For purposes of this section, state funds Medicaid drug expenditures include amounts expended for drugs in both the Medicaid fee-for-service program and Medicaid managed care programs, minus the amount of any drug rebates or supplemental drug rebates received by the department, including rebates pursuant to subdivision five of this section with respect to rebate targets. ~~[The department and the division of the budget shall report quarterly to the drug utilization review board the projected state funds Medicaid drug expenditures including the amounts, in aggregate thereof, attributable to the net cost of: changes in the utilization of drugs by Medicaid recipients; changes in the number of Medicaid recipients; changes to the cost of brand name drugs and changes to the cost of generic drugs. The information contained in the report shall not be publicly released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial competitive, or proprietary nature of the information.]~~

(a) In the event the director of the budget determines, based on Medicaid drug expenditures for the previous quarter or other relevant information, that the total department of health state funds Medicaid drug expenditure is projected to exceed the annual growth limitation imposed by subdivision two of this section, the commissioner may identify and refer drugs to the drug utilization review board established by section three hundred sixty-nine-bb of the social services law for a recommendation as to whether a target supplemental Medicaid rebate should be paid by the manufacturer of the drug to the department and the target amount of the rebate.

(b) If the department intends to refer a drug to the drug utilization review board pursuant to paragraph (a) of this subdivision, the department shall notify the manufacturer of such drug and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review. Such rebate may be based on evidence-based research, including, but not limited to, such research operated or conducted by or for other state

1 governments, the federal government, the governments of other nations,
2 and third party payers or multi-state coalitions.

3 ~~(c) [In the event that the commissioner and the manufacturer have~~
4 ~~previously agreed to a supplemental rebate for a drug pursuant to para-~~
5 ~~graph (b) of this subdivision or paragraph (e) of subdivision seven of~~
6 ~~section three hundred sixty-seven a of the social services law, the drug~~
7 ~~shall not be referred to the drug utilization review board for any~~
8 ~~further supplemental rebate for the duration of the previous rebate~~
9 ~~agreement.~~

10 ~~(d)]~~ The department shall consider a drug's actual cost to the state,
11 including current rebate amounts, prior to seeking an additional rebate
12 pursuant to paragraph (b) ~~[or (c)]~~ of this subdivision ~~[and shall take~~
13 ~~into consideration whether the manufacturer of the drug is providing~~
14 ~~significant discounts relative to other drugs covered by the Medicaid~~
15 ~~program].~~

16 ~~[(e)]~~ (d) The commissioner shall be authorized to take the actions
17 described in this section only so long as total Medicaid drug expendi-
18 tures are projected to exceed the annual growth limitation imposed by
19 subdivision two of this section.

20 § 7. Paragraph (a) of subdivision 5 of section 280 of the public
21 health law, as amended by section 8 of part D of chapter 57 of the laws
22 of 2018, is amended to read as follows:

23 (a) If the drug utilization review board recommends a target rebate
24 amount on a drug referred by the commissioner, the ~~[commissioner shall~~
25 ~~require]~~ department shall negotiate with the drug's manufacturer for a
26 supplemental rebate to be paid by the ~~[drug's]~~ manufacturer in an amount
27 not to exceed such target rebate amount. ~~[With respect to a]~~ A rebate
28 ~~[required in state fiscal year two thousand seventeen-two thousand~~
29 ~~eighteen, the rebate]~~ requirement shall apply beginning with the ~~[month~~
30 ~~of April, two thousand seventeen,]~~ first day of the state fiscal year
31 during which the rebate was required without regard to the date the
32 department enters into the rebate agreement with the manufacturer.

33 § 8. Paragraph (a) of subdivision 7 of section 280 of the public
34 health law, as amended by section 8 of part D of chapter 57 of the laws
35 of 2018, is amended to read as follows:

36 (a) If, after taking into account all rebates and supplemental rebates
37 received by the department, including rebates received to date pursuant
38 to this section, total Medicaid drug expenditures are still projected to
39 exceed the annual growth limitation imposed by subdivision two of this
40 section, the commissioner may: subject any drug of a manufacturer
41 referred to the drug utilization review board under this section to
42 prior approval in accordance with existing processes and procedures when
43 such manufacturer has not entered into a supplemental rebate agreement
44 as required by this section; ~~[directing]~~ direct managed care plans to
45 remove from their Medicaid formularies those drugs that the drug utili-
46 zation review board recommends a target rebate amount for and the
47 manufacturer has failed to enter into a rebate agreement required by
48 this section; ~~[promoting]~~ promote the use of cost effective and clin-
49 ically appropriate drugs other than those of a manufacturer who has a
50 drug that the drug utilization review board recommends a target rebate
51 amount and the manufacturer has failed to enter into a rebate agreement
52 required by this section; ~~[allowing]~~ allow manufacturers to accelerate
53 rebate payments under existing rebate contracts; and such other actions
54 as authorized by law. The commissioner shall provide written notice to
55 the legislature thirty days prior to taking action pursuant to this
56 paragraph, unless action is necessary in the fourth quarter of a fiscal

1 year to prevent total Medicaid drug expenditures from exceeding the
2 limitation imposed by subdivision two of this section, in which case
3 such notice to the legislature may be less than thirty days.

4 § 9. Subdivision 8 of section 280 of the public health law, as added
5 by section 8 of part D of chapter 57 of the laws of 2018, is amended to
6 read as follows:

7 8. The commissioner shall report by [~~February~~] July first annually to
8 the drug utilization review board on savings achieved through the drug
9 cap in the last fiscal year. Such report shall provide data on what
10 savings were achieved through actions pursuant to subdivisions three,
11 five and seven of this section, respectively, and what savings were
12 achieved through other means and how such savings were calculated and
13 implemented.

14 § 10. Section 4406-c of the public health law is amended by adding a
15 new subdivision 10 to read as follows:

16 10. (a) Any contract or other arrangement entered into by a health
17 care plan for pharmacy benefit management services on behalf of individ-
18 uals enrolled in a managed care provider as defined in section three
19 hundred sixty-four-j of the social services law shall include provisions
20 that ensure the following:

21 (i) Payment to the pharmacy benefit manager for pharmacy benefit
22 management services is limited to the actual ingredient costs, a
23 dispensing fee, and an administrative fee for each claim processed. The
24 department of health may establish a maximum administrative fee;

25 (ii) The pharmacy benefit manager identifies all sources of income
26 related to the provision of pharmacy benefit management services on
27 behalf of the health care plan, including, but not limited to, any
28 discounts or supplemental rebates, and that any portion of such income
29 is passed through to the health care plan in full to reduce the report-
30 able ingredient cost; and

31 (iii) The pharmacy benefit manager shall not retain any portion of
32 spread pricing. For purposes of this subdivision "spread pricing" means
33 any amount charged or claimed by the pharmacy benefit manager in excess
34 of the amount paid to pharmacies on behalf of the health care plan less
35 an administrative fee as described in this paragraph. Any such excess
36 amount shall be remitted to the health care plan on a quarterly basis.

37 (b) The commissioner may promulgate regulations as necessary to estab-
38 lish additional standards for contracts or other arrangements related to
39 the services described in this subdivision.

40 § 11. Health care plans subject to subdivision 10 of section 4406-c of
41 the public health law, as added by section ten of this act, shall
42 provide evidence of compliance with such section to the department of
43 health, and in a manner and form determined by the department of health,
44 within 90 days and again within 180 days of the effective date of this
45 act. The department of health shall take no enforcement action with
46 regards to the requirements of subdivision 10 of section 4406-c of the
47 public health law, as added by section ten of this act, prior to the
48 passage of 180 days from the effective date of this act, nor shall
49 enforcement action be taken related to any non-compliance occurring
50 prior to the passage of the same 180 days.

51 § 12. This act shall take effect immediately and shall be deemed to
52 have been in full force and effect on and after April 1, 2019; provided,
53 however, that sections one and two of this act shall take effect July 1,
54 2019; and provided further, however, that the amendments to paragraph
55 (c) of subdivision 6 of section 367-a of the social services law made by

1 section two of this act shall not affect the repeal of such paragraph
2 and shall be deemed repealed therewith.

3 PART C

4 Section 1. Subdivision 2 of section 365-a of the social services law
5 is amended by adding a new paragraph (ff) to read as follows:

6 (ff) evidence-based prevention and support services recognized by the
7 federal Centers for Disease Control (CDC), provided by a community-based
8 organization, and designed to prevent individuals at risk of developing
9 diabetes from developing Type 2 diabetes.

10 § 2. Subparagraph (ii) of paragraph (d) of subdivision 1 of section
11 367-a of the social services law, as amended by section 1 of part J1 of
12 chapter 63 of the laws of 2003, is amended to read as follows:

13 (ii) Amounts payable under this title for medical assistance for items
14 and services provided to eligible persons who are also beneficiaries
15 under part B of title XVIII of the federal social security act and items
16 and services provided to qualified medicare beneficiaries under part B
17 of title XVIII of the federal social security act shall not [~~be less~~
18 ~~than the amount of any deductible liability of such eligible persons or~~
19 ~~for which such eligible persons or such qualified medicare beneficiaries~~
20 ~~would be liable under federal law were they not eligible for medical~~
21 ~~assistance or were they not qualified medicare beneficiaries with~~
22 ~~respect to such benefits under such part B.~~] exceed the amount that
23 otherwise would be made under this title if provided to an eligible
24 person other than a person who is also a beneficiary under part B or is
25 a qualified medicare beneficiary minus the amount payable under part B.

26 § 3. Subparagraph (iii) of paragraph (d) of subdivision 1 of section
27 367-a of the social services law, as amended by section 31 of part B of
28 chapter 57 of the laws of 2015, is amended to read as follows:

29 (iii) With respect to items and services provided to eligible persons
30 who are also beneficiaries under part B of title XVIII of the federal
31 social security act and items and services provided to qualified medi-
32 care beneficiaries under part B of title XVIII of the federal social
33 security act, the amount payable for services covered under this title
34 shall be the amount of any co-insurance liability of such eligible
35 persons pursuant to federal law were they not eligible for medical
36 assistance or were they not qualified medicare beneficiaries with
37 respect to such benefits under such part B, but shall not exceed the
38 amount that otherwise would be made under this title if provided to an
39 eligible person other than a person who is also a beneficiary under part
40 B or is a qualified medicare beneficiary minus the amount payable under
41 part B; provided, however, amounts payable under this title for items
42 and services provided to eligible persons who are also beneficiaries
43 under part B or to qualified medicare beneficiaries by [~~an ambulance~~
44 ~~service under the authority of an operating certificate issued pursuant~~
45 ~~to article thirty of the public health law, a psychologist licensed~~
46 ~~under article one hundred fifty-three of the education law, or]~~ a facil-
47 ity under the authority of an operating certificate issued pursuant to
48 article sixteen, thirty-one or thirty-two of the mental hygiene law and
49 with respect to outpatient hospital and clinic items and services
50 provided by a facility under the authority of an operating certificate
51 issued pursuant to article twenty-eight of the public health law, shall
52 not be less than the amount of any co-insurance liability of such eligi-
53 ble persons or such qualified medicare beneficiaries, or for which such
54 eligible persons or such qualified medicare beneficiaries would be

1 liable under federal law were they not eligible for medical assistance
2 or were they not qualified medicare beneficiaries with respect to such
3 benefits under part B.
4 § 4. This act shall take effect July 1, 2019.

5 PART D

6 Section 1. Subdivision 1 of section 92 of part H of chapter 59 of the
7 laws of 2011, amending the public health law and other laws relating to
8 known and projected department of health state fund medicaid expendi-
9 tures, as amended by section 2 of part K of chapter 57 of the laws of
10 2018, is amended to read as follows:

11 1. For state fiscal years 2011-12 through [~~2019-20~~] 2020-2021, the
12 director of the budget, in consultation with the commissioner of health
13 referenced as "commissioner" for purposes of this section, shall assess
14 on a monthly basis, as reflected in monthly reports pursuant to subdivi-
15 sion five of this section known and projected department of health state
16 funds medicaid expenditures by category of service and by geographic
17 regions, as defined by the commissioner, and if the director of the
18 budget determines that such expenditures are expected to cause medicaid
19 disbursements for such period to exceed the projected department of
20 health medicaid state funds disbursements in the enacted budget finan-
21 cial plan pursuant to subdivision 3 of section 23 of the state finance
22 law, the commissioner of health, in consultation with the director of
23 the budget, shall develop a medicaid savings allocation plan to limit
24 such spending to the aggregate limit level specified in the enacted
25 budget financial plan, provided, however, such projections may be
26 adjusted by the director of the budget to account for any changes in the
27 New York state federal medical assistance percentage amount established
28 pursuant to the federal social security act, changes in provider reven-
29 ues, reductions to local social services district medical assistance
30 administration, minimum wage increases, and beginning April 1, 2012 the
31 operational costs of the New York state medical indemnity fund and state
32 costs or savings from the basic health plan. Such projections may be
33 adjusted by the director of the budget to account for increased or expe-
34 dited department of health state funds medicaid expenditures as a result
35 of a natural or other type of disaster, including a governmental decla-
36 ration of emergency.

37 § 2. This act shall take effect immediately and shall be deemed to
38 have been in full force and effect on and after April 1, 2019.

39 PART E

40 Section 1. Section 4 of chapter 505 of the laws of 1995, amending the
41 public health law relating to the operation of department of health
42 facilities, as amended by section 27 of part D of chapter 57 of the laws
43 of 2015, is amended to read as follows:

44 § 4. This act shall take effect immediately; provided, however, that
45 the provisions of paragraph (b) of subdivision 4 of section 409-c of the
46 public health law, as added by section three of this act, shall take
47 effect January 1, 1996 and shall expire and be deemed repealed [~~twenty-~~
48 ~~four~~] twenty-nine years from the effective date thereof.

49 § 2. Subdivision p of section 76 of part D of chapter 56 of the laws
50 of 2013, amending the social services law relating to eligibility condi-
51 tions, is amended to read as follows:

p. the amendments [~~made~~] to subparagraph [~~(7)~~] 7 of paragraph (b) of subdivision 1 of section 366 of the social services law made by section one of this act shall expire and be deemed repealed October 1, [~~2019~~] 2024.

§ 3. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 1 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

§ 11. This act shall take effect immediately and:

(a) sections one and three shall expire on December 31, 1996,

(b) sections four through ten shall expire on June 30, [~~2019~~] 2024, and

(c) provided that the amendment to section 2807-b of the public health law by section two of this act shall not affect the expiration of such section 2807-b as otherwise provided by law and shall be deemed to expire therewith.

§ 4. Section 3 of chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, as amended by section 16 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

§ 3. This act shall take effect immediately, provided, however, that subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of 1973, as added by section one of this act, shall expire and be deemed repealed June 30, [~~2019~~] 2024; and provided further, however, that the expiration and repeal of such subdivision 15-a shall not affect or impair in any manner any health facilities bonds issued, or any lease or purchase of a health facility executed, pursuant to such subdivision 15-a prior to its expiration and repeal and that, with respect to any such bonds issued and outstanding as of June 30, [~~2019~~] 2024, the provisions of such subdivision 15-a as they existed immediately prior to such expiration and repeal shall continue to apply through the latest maturity date of any such bonds, or their earlier retirement or redemption, for the sole purpose of authorizing the issuance of refunding bonds to refund bonds previously issued pursuant thereto.

§ 5. Subdivision (a) of section 40 of part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, as amended by section 8 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; and provided further that section twenty of this act shall be deemed repealed [~~eight~~] thirteen years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section 367-h of the social services law 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;

§ 6. Subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, as

1 amended by section 4 of part D of chapter 59 of the laws of 2016, is
2 amended to read as follows:

3 (f) section twenty-five of this act shall expire and be deemed
4 repealed April 1, ~~[2019]~~ 2024;

5 § 7. Subdivision (c) of section 122 of part E of chapter 56 of the
6 laws of 2013 amending the public health law relating to the general
7 public health work program, as amended by section 5 of part D of chapter
8 59 of the laws of 2016, is amended to read as follows:

9 (c) section fifty of this act shall take effect immediately ~~[and shall~~
10 ~~expire six years after it becomes law]~~;

11 § 8. Subdivision (i) of section 111 of part H of chapter 59 of the
12 laws of 2011, amending the public health law and other laws relating to
13 known and projected department of health state fund medical expendi-
14 tures, as amended by section 19 of part D of chapter 57 of the laws of
15 2015, is amended to read as follows:

16 (i) the amendments to paragraph (b) and subparagraph (i) of paragraph
17 (g) of subdivision 7 of section 4403-f of the public health law made by
18 section forty-one-b of this act shall expire and be repealed April 1,
19 ~~[2019]~~ 2024;

20 § 9. Subparagraph (vi) of paragraph (b) of subdivision 2 of section
21 2807-d of the public health law, as amended by section 3 of part I of
22 chapter 57 of the laws of 2017, is amended to read as follows:

23 (vi) Notwithstanding any contrary provision of this paragraph or any
24 other provision of law or regulation to the contrary, for residential
25 health care facilities the assessment shall be six percent of each resi-
26 dential health care facility's gross receipts received from all patient
27 care services and other operating income on a cash basis for the period
28 April first, two thousand two through March thirty-first, two thousand
29 three for hospital or health-related services, including adult day
30 services; provided, however, that residential health care facilities'
31 gross receipts attributable to payments received pursuant to title XVIII
32 of the federal social security act (medicare) shall be excluded from the
33 assessment; provided, however, that for all such gross receipts received
34 on or after April first, two thousand three through March thirty-first,
35 two thousand five, such assessment shall be five percent, and further
36 provided that for all such gross receipts received on or after April
37 first, two thousand five through March thirty-first, two thousand nine,
38 and on or after April first, two thousand nine through March thirty-
39 first, two thousand eleven such assessment shall be six percent, and
40 further provided that for all such gross receipts received on or after
41 April first, two thousand eleven through March thirty-first, two thou-
42 sand thirteen such assessment shall be six percent, and further provided
43 that for all such gross receipts received on or after April first, two
44 thousand thirteen through March thirty-first, two thousand fifteen such
45 assessment shall be six percent, and further provided that for all such
46 gross receipts received on or after April first, two thousand fifteen
47 through March thirty-first, two thousand seventeen such assessment shall
48 be six percent, and further provided that for all such gross receipts
49 received on or after April first, two thousand seventeen through March
50 thirty-first, two thousand nineteen such assessment shall be six
51 percent, and further provided that for all such gross receipts received
52 on or after April first, two thousand nineteen through March thirty-
53 first, two thousand twenty-four such assessment shall be six percent.

54 § 10. Subdivision 1 of section 194 of chapter 474 of the laws of 1996,
55 amending the education law and other laws relating to rates for residen-

1 tial health care facilities, as amended by section 4 of part I of chap-
2 ter 57 of the laws of 2017, is amended to read as follows:

3 1. Notwithstanding any inconsistent provision of law or regulation,
4 the trend factors used to project reimbursable operating costs to the
5 rate period for purposes of determining rates of payment pursuant to
6 article 28 of the public health law for residential health care facili-
7 ties for reimbursement of inpatient services provided to patients eligi-
8 ble for payments made by state governmental agencies on and after April
9 1, 1996 through March 31, 1999 and for payments made on and after July
10 1, 1999 through March 31, 2000 and on and after April 1, 2000 through
11 March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and
12 on and after April 1, 2007 through March 31, 2009 and on and after April
13 1, 2009 through March 31, 2011 and on and after April 1, 2011 through
14 March 31, 2013 and on and after April 1, 2013 through March 31, 2015,
15 and on and after April 1, 2015 through March 31, 2017, and on and after
16 April 1, 2017 through March 31, 2019, and on and after April 1, 2019
17 through March 31, 2024 shall reflect no trend factor projections or
18 adjustments for the period April 1, 1996, through March 31, 1997.

19 § 11. Subdivision 1 of section 89-a of part C of chapter 58 of the
20 laws of 2007, amending the social services law and other laws relating
21 to enacting the major components of legislation necessary to implement
22 the health and mental hygiene budget for the 2007-2008 state fiscal
23 year, as amended by section 5 of part I of chapter 57 of the laws of
24 2017, is amended to read as follows:

25 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c
26 of the public health law and section 21 of chapter 1 of the laws of
27 1999, as amended, and any other inconsistent provision of law or regu-
28 lation to the contrary, in determining rates of payments by state
29 governmental agencies effective for services provided beginning April 1,
30 2006, through March 31, 2009, and on and after April 1, 2009 through
31 March 31, 2011, and on and after April 1, 2011 through March 31, 2013,
32 and on and after April 1, 2013 through March 31, 2015, and on and after
33 April 1, 2015 through March 31, 2017, and on and after April 1, 2017
34 through March 31, 2019, and on and after April 1, 2019 through March 31,
35 2024 for inpatient and outpatient services provided by general hospitals
36 and for inpatient services and outpatient adult day health care services
37 provided by residential health care facilities pursuant to article 28 of
38 the public health law, the commissioner of health shall apply a trend
39 factor projection of two and twenty-five hundredths percent attributable
40 to the period January 1, 2006 through December 31, 2006, and on and
41 after January 1, 2007, provided, however, that on reconciliation of such
42 trend factor for the period January 1, 2006 through December 31, 2006
43 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the
44 public health law, such trend factor shall be the final US Consumer
45 Price Index (CPI) for all urban consumers, as published by the US
46 Department of Labor, Bureau of Labor Statistics less twenty-five
47 hundredths of a percentage point.

48 § 12. Subdivision 5-a of section 246 of chapter 81 of the laws of
49 1995, amending the public health law and other laws relating to medical
50 reimbursement and welfare reform, as amended by section 6 of part I of
51 chapter 57 of the laws of 2017, is amended to read as follows:

52 5-a. Section sixty-four-a of this act shall be deemed to have been in
53 full force and effect on and after April 1, 1995 through March 31, 1999
54 and on and after July 1, 1999 through March 31, 2000 and on and after
55 April 1, 2000 through March 31, 2003 and on and after April 1, 2003
56 through March 31, 2007, and on and after April 1, 2007 through March 31,

1 2009, and on and after April 1, 2009 through March 31, 2011, and on and
2 after April 1, 2011 through March 31, 2013, and on and after April 1,
3 2013 through March 31, 2015, and on and after April 1, 2015 through
4 March 31, 2017 and on and after April 1, 2017 through March 31, 2019,
5 and on and after April 1, 2019 through March 31, 2024;

6 § 13. Section 64-b of chapter 81 of the laws of 1995, amending the
7 public health law and other laws relating to medical reimbursement and
8 welfare reform, as amended by section 7 of part I of chapter 57 of the
9 laws of 2017, is amended to read as follows:

10 § 64-b. Notwithstanding any inconsistent provision of law, the
11 provisions of subdivision 7 of section 3614 of the public health law, as
12 amended, shall remain and be in full force and effect on April 1, 1995
13 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on
14 and after April 1, 2000 through March 31, 2003 and on and after April 1,
15 2003 through March 31, 2007, and on and after April 1, 2007 through
16 March 31, 2009, and on and after April 1, 2009 through March 31, 2011,
17 and on and after April 1, 2011 through March 31, 2013, and on and after
18 April 1, 2013 through March 31, 2015, and on and after April 1, 2015
19 through March 31, 2017 and on and after April 1, 2017 through March 31,
20 2019, and on and after April 1, 2019 through March 31, 2024.

21 § 14. Section 4-a of part A of chapter 56 of the laws of 2013, amend-
22 ing chapter 59 of the laws of 2011 amending the public health law and
23 other laws relating to general hospital reimbursement for annual rates,
24 as amended by section 5 of part T of chapter 57 of the laws of 2018, is
25 amended to read as follows:

26 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section
27 2807-c of the public health law, section 21 of chapter 1 of the laws of
28 1999, or any other contrary provision of law, in determining rates of
29 payments by state governmental agencies effective for services provided
30 on and after January 1, 2017 through March 31, ~~2019~~ 2024, for inpa-
31 tient and outpatient services provided by general hospitals, for inpa-
32 tient services and adult day health care outpatient services provided by
33 residential health care facilities pursuant to article 28 of the public
34 health law, except for residential health care facilities or units of
35 such facilities providing services primarily to children under twenty-
36 one years of age, for home health care services provided pursuant to
37 article 36 of the public health law by certified home health agencies,
38 long term home health care programs and AIDS home care programs, and for
39 personal care services provided pursuant to section 365-a of the social
40 services law, the commissioner of health shall apply no greater than
41 zero trend factors attributable to the 2017, 2018, ~~and~~ 2019, 2020,
42 2021, 2022, and 2023 calendar years in accordance with paragraph (c) of
43 subdivision 10 of section 2807-c of the public health law, provided,
44 however, that such no greater than zero trend factors attributable to
45 such 2017, 2018, ~~and~~ 2019, 2020, 2021, 2022, and 2023 calendar years
46 shall also be applied to rates of payment provided on and after January
47 1, 2017 through March 31, ~~2019~~ 2024 for personal care services
48 provided in those local social services districts, including New York
49 city, whose rates of payment for such services are established by such
50 local social services districts pursuant to a rate-setting exemption
51 issued by the commissioner of health to such local social services
52 districts in accordance with applicable regulations; and provided
53 further, however, that for rates of payment for assisted living program
54 services provided on and after January 1, 2017 through March 31, ~~2019~~
55 2024, such trend factors attributable to the 2017, 2018, ~~and~~ 2019,

1 2020, 2021, 2022, and 2023 calendar years shall be established at no
2 greater than zero percent.

3 § 15. Paragraph (b) of subdivision 17 of section 2808 of the public
4 health law, as amended by section 21 of part D of chapter 57 of the laws
5 of 2015, is amended to read as follows:

6 (b) Notwithstanding any inconsistent provision of law or regulation to
7 the contrary, for the state fiscal years beginning April first, two
8 thousand ten and ending March thirty-first, two thousand [~~nineteen~~]
9 twenty-four, the commissioner shall not be required to revise certified
10 rates of payment established pursuant to this article for rate periods
11 prior to April first, two thousand [~~nineteen~~] twenty-four, based on
12 consideration of rate appeals filed by residential health care facili-
13 ties or based upon adjustments to capital cost reimbursement as a result
14 of approval by the commissioner of an application for construction under
15 section twenty-eight hundred two of this article, in excess of an aggre-
16 gate annual amount of eighty million dollars for each such state fiscal
17 year provided, however, that for the period April first, two thousand
18 eleven through March thirty-first, two thousand twelve such aggregate
19 annual amount shall be fifty million dollars. In revising such rates
20 within such fiscal limit, the commissioner shall, in prioritizing such
21 rate appeals, include consideration of which facilities the commissioner
22 determines are facing significant financial hardship as well as such
23 other considerations as the commissioner deems appropriate and, further,
24 the commissioner is authorized to enter into agreements with such facil-
25 ities or any other facility to resolve multiple pending rate appeals
26 based upon a negotiated aggregate amount and may offset such negotiated
27 aggregate amounts against any amounts owed by the facility to the
28 department, including, but not limited to, amounts owed pursuant to
29 section twenty-eight hundred seven-d of this article; provided, however,
30 that the commissioner's authority to negotiate such agreements resolving
31 multiple pending rate appeals as hereinbefore described shall continue
32 on and after April first, two thousand [~~nineteen~~] twenty-four. Rate
33 adjustments made pursuant to this paragraph remain fully subject to
34 approval by the director of the budget in accordance with the provisions
35 of subdivision two of section twenty-eight hundred seven of this arti-
36 cle.

37 § 16. Paragraph (a) of subdivision 13 of section 3614 of the public
38 health law, as amended by section 22 of part D of chapter 57 of the laws
39 of 2015, is amended to read as follows:

40 (a) Notwithstanding any inconsistent provision of law or regulation
41 and subject to the availability of federal financial participation,
42 effective April first, two thousand twelve through March thirty-first,
43 two thousand [~~nineteen~~] twenty-four, payments by government agencies for
44 services provided by certified home health agencies, except for such
45 services provided to children under eighteen years of age and other
46 discreet groups as may be determined by the commissioner pursuant to
47 regulations, shall be based on episodic payments. In establishing such
48 payments, a statewide base price shall be established for each sixty day
49 episode of care and adjusted by a regional wage index factor and an
50 individual patient case mix index. Such episodic payments may be further
51 adjusted for low utilization cases and to reflect a percentage limita-
52 tion of the cost for high-utilization cases that exceed outlier thresh-
53 olds of such payments.

54 § 17. Subdivision 2 of section 246 of chapter 81 of the laws of 1995,
55 amending the public health law and other laws relating to medical

1 reimbursement and welfare reform, as amended by section 18 of part I of
2 chapter 57 of the laws of 2017, is amended to read as follows:

3 2. Sections five, seven through nine, twelve through fourteen, and
4 eighteen of this act shall be deemed to have been in full force and
5 effect on and after April 1, 1995 through March 31, 1999 and on and
6 after July 1, 1999 through March 31, 2000 and on and after April 1, 2000
7 through March 31, 2003 and on and after April 1, 2003 through March 31,
8 2006 and on and after April 1, 2006 through March 31, 2007 and on and
9 after April 1, 2007 through March 31, 2009 and on and after April 1,
10 2009 through March 31, 2011 and sections twelve, thirteen and fourteen
11 of this act shall be deemed to be in full force and effect on and after
12 April 1, 2011 through March 31, 2015 and on and after April 1, 2015
13 through March 31, 2017 and on and after April 1, 2017 through March 31,
14 2019, and on and after April 1, 2019 through March 31, 2024;

15 § 18. Section 48-a of part A of chapter 56 of the laws of 2013 amend-
16 ing chapter 59 of the laws of 2011 amending the public health law and
17 other laws relating to general hospital reimbursement for annual rates,
18 as amended by section 1 of part P of chapter 57 of the laws of 2017, is
19 amended to read as follows:

20 § 48-a. 1. Notwithstanding any contrary provision of law, the commis-
21 sioners of the office of alcoholism and substance abuse services and the
22 office of mental health are authorized, subject to the approval of the
23 director of the budget, to transfer to the commissioner of health state
24 funds to be utilized as the state share for the purpose of increasing
25 payments under the medicaid program to managed care organizations
26 licensed under article 44 of the public health law or under article 43
27 of the insurance law. Such managed care organizations shall utilize such
28 funds for the purpose of reimbursing providers licensed pursuant to
29 article 28 of the public health law or article 31 or 32 of the mental
30 hygiene law for ambulatory behavioral health services, as determined by
31 the commissioner of health, in consultation with the commissioner of
32 alcoholism and substance abuse services and the commissioner of the
33 office of mental health, provided to medicaid enrolled outpatients and
34 for all other behavioral health services except inpatient included in
35 New York state's Medicaid redesign waiver approved by the centers for
36 medicare and Medicaid services (CMS). Such reimbursement shall be in
37 the form of fees for such services which are equivalent to the payments
38 established for such services under the ambulatory patient group (APG)
39 rate-setting methodology as utilized by the department of health, the
40 office of alcoholism and substance abuse services, or the office of
41 mental health for rate-setting purposes or any such other fees pursuant
42 to the Medicaid state plan or otherwise approved by CMS in the Medicaid
43 redesign waiver; provided, however, that the increase to such fees that
44 shall result from the provisions of this section shall not, in the
45 aggregate and as determined by the commissioner of health, in consulta-
46 tion with the commissioner of alcoholism and substance abuse services
47 and the commissioner of the office of mental health, be greater than the
48 increased funds made available pursuant to this section. The increase
49 of such ambulatory behavioral health fees to providers available under
50 this section shall be for all rate periods on and after the effective
51 date of section ~~[29]~~ 1 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of
52 ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2022 for patients in the city of
53 New York, for all rate periods on and after the effective date of
54 section ~~[29]~~ 1 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~
55 2017 through ~~[March 31, 2020]~~ March 31, 2022 for patients outside the
56 city of New York, and for all rate periods on and after the effective

1 date of such chapter through [~~March 31, 2020~~] March 31, 2022 for all
2 services provided to persons under the age of twenty-one; provided,
3 however, the commissioner of health, in consultation with the commis-
4 sioner of alcoholism and substance abuse services and the commissioner
5 of mental health, may require, as a condition of approval of such ambu-
6 latory behavioral health fees, that aggregate managed care expenditures
7 to eligible providers meet the alternative payment methodology require-
8 ments as set forth in attachment I of the New York state medicaid
9 section one thousand one hundred fifteen medicaid redesign team waiver
10 as approved by the centers for medicare and medicaid services. The
11 commissioner of health shall, in consultation with the commissioner of
12 alcoholism and substance abuse services and the commissioner of mental
13 health, waive such conditions if a sufficient number of providers, as
14 determined by the commissioner, suffer a financial hardship as a conse-
15 quence of such alternative payment methodology requirements, or if he or
16 she shall determine that such alternative payment methodologies signif-
17 icantly threaten individuals access to ambulatory behavioral health
18 services. Such waiver may be applied on a provider specific or industry
19 wide basis. Further, such conditions may be waived, as the commissioner
20 determines necessary, to comply with federal rules or regulations
21 governing these payment methodologies. Nothing in this section shall
22 prohibit managed care organizations and providers from negotiating
23 different rates and methods of payment during such periods described
24 above, subject to the approval of the department of health. The depart-
25 ment of health shall consult with the office of alcoholism and substance
26 abuse services and the office of mental health in determining whether
27 such alternative rates shall be approved. The commissioner of health
28 may, in consultation with the commissioner of alcoholism and substance
29 abuse services and the commissioner of the office of mental health,
30 promulgate regulations, including emergency regulations promulgated
31 prior to October 1, 2015 to establish rates for ambulatory behavioral
32 health services, as are necessary to implement the provisions of this
33 section. Rates promulgated under this section shall be included in the
34 report required under section 45-c of part A of this chapter.

35 2. Notwithstanding any contrary provision of law, the fees paid by
36 managed care organizations licensed under article 44 of the public
37 health law or under article 43 of the insurance law, to providers
38 licensed pursuant to article 28 of the public health law or article 31
39 or 32 of the mental hygiene law, for ambulatory behavioral health
40 services provided to patients enrolled in the child health insurance
41 program pursuant to title [~~one-A~~] 1-A of article 25 of the public health
42 law, shall be in the form of fees for such services which are equivalent
43 to the payments established for such services under the ambulatory
44 patient group (APG) rate-setting methodology or any such other fees
45 established pursuant to the Medicaid state plan. The commissioner of
46 health shall consult with the commissioner of alcoholism and substance
47 abuse services and the commissioner of the office of mental health in
48 determining such services and establishing such fees. Such ambulatory
49 behavioral health fees to providers available under this section shall
50 be for all rate periods on and after the effective date of this chapter
51 through [~~March 31, 2020~~] March 31, 2022, provided, however, that managed
52 care organizations and providers may negotiate different rates and meth-
53 ods of payment during such periods described above, subject to the
54 approval of the department of health. The department of health shall
55 consult with the office of alcoholism and substance abuse services and
56 the office of mental health in determining whether such alternative

1 rates shall be approved. The report required under section 16-a of part
2 C of chapter 60 of the laws of 2014 shall also include the population of
3 patients enrolled in the child health insurance program pursuant to
4 title ~~[one-A]~~ 1-A of article 25 of the public health law in its examina-
5 tion on the transition of behavioral health services into managed care.

6 § 19. Section 1 of part H of chapter 111 of the laws of 2010 relating
7 to increasing Medicaid payments to providers through managed care organ-
8 izations and providing equivalent fees through an ambulatory patient
9 group methodology, as amended by section 2 of part P of chapter 57 of
10 the laws of 2017, is amended to read as follows:

11 Section 1. a. Notwithstanding any contrary provision of law, the
12 commissioners of mental health and alcoholism and substance abuse
13 services are authorized, subject to the approval of the director of the
14 budget, to transfer to the commissioner of health state funds to be
15 utilized as the state share for the purpose of increasing payments under
16 the medicaid program to managed care organizations licensed under arti-
17 cle 44 of the public health law or under article 43 of the insurance
18 law. Such managed care organizations shall utilize such funds for the
19 purpose of reimbursing providers licensed pursuant to article 28 of the
20 public health law, or pursuant to article 31 or article 32 of the mental
21 hygiene law for ambulatory behavioral health services, as determined by
22 the commissioner of health in consultation with the commissioner of
23 mental health and commissioner of alcoholism and substance abuse
24 services, provided to medicaid enrolled outpatients and for all other
25 behavioral health services except inpatient included in New York state's
26 Medicaid redesign waiver approved by the centers for medicare and Medi-
27 caid services (CMS). Such reimbursement shall be in the form of fees for
28 such services which are equivalent to the payments established for such
29 services under the ambulatory patient group (APG) rate-setting methodol-
30 ogy as utilized by the department of health or by the office of mental
31 health or office of alcoholism and substance abuse services for rate-
32 setting purposes or any such other fees pursuant to the Medicaid state
33 plan or otherwise approved by CMS in the Medicaid redesign waiver;
34 provided, however, that the increase to such fees that shall result from
35 the provisions of this section shall not, in the aggregate and as deter-
36 mined by the commissioner of health in consultation with the commission-
37 ers of mental health and alcoholism and substance abuse services, be
38 greater than the increased funds made available pursuant to this
39 section. The increase of such behavioral health fees to providers avail-
40 able under this section shall be for all rate periods on and after the
41 effective date of section ~~[30]~~ 2 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the
42 laws of ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2022 for patients in the
43 city of New York, for all rate periods on and after the effective date
44 of section ~~[30]~~ 2 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~
45 2017 through March 31, ~~[2020]~~ 2022 for patients outside the city of New
46 York, and for all rate periods on and after the effective date of
47 section ~~[30]~~ 2 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~
48 2017 through March 31, ~~[2020]~~ 2022 for all services provided to persons
49 under the age of twenty-one; provided, however, the commissioner of
50 health, in consultation with the commissioner of alcoholism and
51 substance abuse services and the commissioner of mental health, may
52 require, as a condition of approval of such ambulatory behavioral health
53 fees, that aggregate managed care expenditures to eligible providers
54 meet the alternative payment methodology requirements as set forth in
55 attachment I of the New York state medicaid section one thousand one
56 hundred fifteen medicaid redesign team waiver as approved by the centers

1 for medicare and medicaid services. The commissioner of health shall, in
2 consultation with the commissioner of alcoholism and substance abuse
3 services and the commissioner of mental health, waive such conditions if
4 a sufficient number of providers, as determined by the commissioner,
5 suffer a financial hardship as a consequence of such alternative payment
6 methodology requirements, or if he or she shall determine that such
7 alternative payment methodologies significantly threaten individuals
8 access to ambulatory behavioral health services. Such waiver may be
9 applied on a provider specific or industry wide basis. Further, such
10 conditions may be waived, as the commissioner determines necessary, to
11 comply with federal rules or regulations governing these payment method-
12 ologies. Nothing in this section shall prohibit managed care organiza-
13 tions and providers from negotiating different rates and methods of
14 payment during such periods described, subject to the approval of the
15 department of health. The department of health shall consult with the
16 office of alcoholism and substance abuse services and the office of
17 mental health in determining whether such alternative rates shall be
18 approved. The commissioner of health may, in consultation with the
19 commissioners of mental health and alcoholism and substance abuse
20 services, promulgate regulations, including emergency regulations
21 promulgated prior to October 1, 2013 that establish rates for behavioral
22 health services, as are necessary to implement the provisions of this
23 section. Rates promulgated under this section shall be included in the
24 report required under section 45-c of part A of chapter 56 of the laws
25 of 2013.

26 b. Notwithstanding any contrary provision of law, the fees paid by
27 managed care organizations licensed under article 44 of the public
28 health law or under article 43 of the insurance law, to providers
29 licensed pursuant to article 28 of the public health law or article 31
30 or 32 of the mental hygiene law, for ambulatory behavioral health
31 services provided to patients enrolled in the child health insurance
32 program pursuant to title ~~[one-A]~~ 1-A of article 25 of the public health
33 law, shall be in the form of fees for such services which are equivalent
34 to the payments established for such services under the ambulatory
35 patient group (APG) rate-setting methodology. The commissioner of health
36 shall consult with the commissioner of alcoholism and substance abuse
37 services and the commissioner of the office of mental health in deter-
38 mining such services and establishing such fees. Such ambulatory behav-
39 ioral health fees to providers available under this section shall be for
40 all rate periods on and after the effective date of this chapter through
41 March 31, ~~[2020]~~ 2022, provided, however, that managed care organiza-
42 tions and providers may negotiate different rates and methods of payment
43 during such periods described above, subject to the approval of the
44 department of health. The department of health shall consult with the
45 office of alcoholism and substance abuse services and the office of
46 mental health in determining whether such alternative rates shall be
47 approved. The report required under section 16-a of part C of chapter
48 60 of the laws of 2014 shall also include the population of patients
49 enrolled in the child health insurance program pursuant to title ~~[one-A]~~
50 1-A of article 25 of the public health law in its examination on the
51 transition of behavioral health services into managed care.

52 § 20. Section 2 of part H of chapter 111 of the laws of 2010, relating
53 to increasing Medicaid payments to providers through managed care organ-
54 izations and providing equivalent fees through an ambulatory patient
55 group methodology, as amended by section 16 of part C of chapter 60 of
56 the laws of 2014, is amended to read as follows:

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, and shall expire on ~~January 1, 2018~~ March 31, 2022.

§ 21. Section 10 of chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, as amended by section 2 of part D of chapter 59 of the laws of 2016, is amended to read as follows:

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed on March 31, ~~2020~~ 2025 provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

§ 22. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 1 of part D of chapter 59 of the laws of 2016, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019 and annually thereafter, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on

1 reported 1994 reconciled data as further reconciled to actual reported
2 1996 reconciled data, and for 1997 based initially on reported 1995
3 reconciled data as further reconciled to actual reported 1997 reconciled
4 data, for 1998 based initially on reported 1995 reconciled data as
5 further reconciled to actual reported 1998 reconciled data, for 1999
6 based initially on reported 1995 reconciled data as further reconciled
7 to actual reported 1999 reconciled data, for 2000 based initially on
8 reported 1995 reconciled data as further reconciled to actual reported
9 2000 data, for 2001 based initially on reported 1995 reconciled data as
10 further reconciled to actual reported 2001 data, for 2002 based initial-
11 ly on reported 2000 reconciled data as further reconciled to actual
12 reported 2002 data, and for state fiscal years beginning on April 1,
13 2005, based initially on reported 2000 reconciled data as further recon-
14 ciled to actual reported data for 2005, and for state fiscal years
15 beginning on April 1, 2006, based initially on reported 2000 reconciled
16 data as further reconciled to actual reported data for 2006, for state
17 fiscal years beginning on and after April 1, 2007 through March 31,
18 2009, based initially on reported 2000 reconciled data as further recon-
19 ciled to actual reported data for 2007 and 2008, respectively, for state
20 fiscal years beginning on and after April 1, 2009, based initially on
21 reported 2007 reconciled data, adjusted for authorized Medicaid rate
22 changes applicable to the state fiscal year, and as further reconciled
23 to actual reported data for 2009, for state fiscal years beginning on
24 and after April 1, 2010, based initially on reported reconciled data
25 from the base year two years prior to the payment year, adjusted for
26 authorized Medicaid rate changes applicable to the state fiscal year,
27 and further reconciled to actual reported data from such payment year,
28 and to actual reported data for each respective succeeding year. The
29 payments may be added to rates of payment or made as aggregate payments
30 to an eligible public general hospital.

31 § 23. This act shall take effect immediately; provided that the amend-
32 ments to section 1 of part H of chapter 111 of the laws of 2010 made by
33 section nineteen of this act shall not affect the expiration of such
34 section and shall expire therewith; and provided further that section
35 twenty of this act shall be deemed to have been in full force and effect
36 on and after January 1, 2018.

37

PART F

38 Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266
39 of the laws of 1986, amending the civil practice law and rules and other
40 laws relating to malpractice and professional medical conduct, as
41 amended by section 1 of part M of chapter 57 of the laws of 2018, is
42 amended to read as follows:

43 (a) The superintendent of financial services and the commissioner of
44 health or their designee shall, from funds available in the hospital
45 excess liability pool created pursuant to subdivision 5 of this section,
46 purchase a policy or policies for excess insurance coverage, as author-
47 ized by paragraph 1 of subsection (e) of section 5502 of the insurance
48 law; or from an insurer, other than an insurer described in section 5502
49 of the insurance law, duly authorized to write such coverage and actual-
50 ly writing medical malpractice insurance in this state; or shall
51 purchase equivalent excess coverage in a form previously approved by the
52 superintendent of financial services for purposes of providing equiv-
53 alent excess coverage in accordance with section 19 of chapter 294 of
54 the laws of 1985, for medical or dental malpractice occurrences between

1 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,
2 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June
3 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991
4 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July
5 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,
6 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June
7 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998
8 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July
9 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,
10 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June
11 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005
12 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July
13 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,
14 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June
15 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012
16 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July
17 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016,
18 between July 1, 2016 and June 30, 2017, between July 1, 2017 and June
19 30, 2018, ~~[and]~~ between July 1, 2018 and June 30, 2019, and between July
20 1, 2019 and June 30, 2020 or reimburse the hospital where the hospital
21 purchases equivalent excess coverage as defined in subparagraph (i) of
22 paragraph (a) of subdivision 1-a of this section for medical or dental
23 malpractice occurrences between July 1, 1987 and June 30, 1988, between
24 July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990,
25 between July 1, 1990 and June 30, 1991, between July 1, 1991 and June
26 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993
27 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July
28 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997,
29 between July 1, 1997 and June 30, 1998, between July 1, 1998 and June
30 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000
31 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July
32 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004,
33 between July 1, 2004 and June 30, 2005, between July 1, 2005 and June
34 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007
35 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July
36 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011,
37 between July 1, 2011 and June 30, 2012, between July 1, 2012 and June
38 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014
39 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July
40 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, ~~[and]~~
41 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and
42 June 30, 2020 for physicians or dentists certified as eligible for each
43 such period or periods pursuant to subdivision 2 of this section by a
44 general hospital licensed pursuant to article 28 of the public health
45 law; provided that no single insurer shall write more than fifty percent
46 of the total excess premium for a given policy year; and provided,
47 however, that such eligible physicians or dentists must have in force an
48 individual policy, from an insurer licensed in this state of primary
49 malpractice insurance coverage in amounts of no less than one million
50 three hundred thousand dollars for each claimant and three million nine
51 hundred thousand dollars for all claimants under that policy during the
52 period of such excess coverage for such occurrences or be endorsed as
53 additional insureds under a hospital professional liability policy which
54 is offered through a voluntary attending physician ("channeling")
55 program previously permitted by the superintendent of financial services
56 during the period of such excess coverage for such occurrences. During

1 such period, such policy for excess coverage or such equivalent excess
2 coverage shall, when combined with the physician's or dentist's primary
3 malpractice insurance coverage or coverage provided through a voluntary
4 attending physician ("channeling") program, total an aggregate level of
5 two million three hundred thousand dollars for each claimant and six
6 million nine hundred thousand dollars for all claimants from all such
7 policies with respect to occurrences in each of such years provided,
8 however, if the cost of primary malpractice insurance coverage in excess
9 of one million dollars, but below the excess medical malpractice insur-
10 ance coverage provided pursuant to this act, exceeds the rate of nine
11 percent per annum, then the required level of primary malpractice insur-
12 ance coverage in excess of one million dollars for each claimant shall
13 be in an amount of not less than the dollar amount of such coverage
14 available at nine percent per annum; the required level of such coverage
15 for all claimants under that policy shall be in an amount not less than
16 three times the dollar amount of coverage for each claimant; and excess
17 coverage, when combined with such primary malpractice insurance cover-
18 age, shall increase the aggregate level for each claimant by one million
19 dollars and three million dollars for all claimants; and provided
20 further, that, with respect to policies of primary medical malpractice
21 coverage that include occurrences between April 1, 2002 and June 30,
22 2002, such requirement that coverage be in amounts no less than one
23 million three hundred thousand dollars for each claimant and three
24 million nine hundred thousand dollars for all claimants for such occur-
25 rences shall be effective April 1, 2002.

26 § 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986,
27 amending the civil practice law and rules and other laws relating to
28 malpractice and professional medical conduct, as amended by section 2 of
29 part M of chapter 57 of the laws of 2018, is amended to read as follows:

30 (3)(a) The superintendent of financial services shall determine and
31 certify to each general hospital and to the commissioner of health the
32 cost of excess malpractice insurance for medical or dental malpractice
33 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988
34 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July
35 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,
36 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June
37 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995
38 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July
39 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,
40 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June
41 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002
42 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July
43 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,
44 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June
45 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009
46 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July
47 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and
48 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June
49 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1,
50 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, ~~and~~
51 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and
52 June 30, 2020 allocable to each general hospital for physicians or
53 dentists certified as eligible for purchase of a policy for excess
54 insurance coverage by such general hospital in accordance with subdivi-
55 sion 2 of this section, and may amend such determination and certif-
56 ication as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, ~~and~~ between July 1, 2018 and June 30, 2019, and between July 1, 2019 and June 30, 2020 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the

1 period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and
2 June 30, 2015, to the period July 1, 2015 and June 30, 2016, [~~and~~
3 ~~between~~] to the period July 1, 2016 and June 30, 2017, [~~and~~ to the
4 period July 1, 2017 to June 30, 2018, [~~and~~ to the period July 1, 2018
5 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020.

6 § 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section
7 18 of chapter 266 of the laws of 1986, amending the civil practice law
8 and rules and other laws relating to malpractice and professional
9 medical conduct, as amended by section 3 of part M of chapter 57 of the
10 laws of 2018, are amended to read as follows:

11 (a) To the extent funds available to the hospital excess liability
12 pool pursuant to subdivision 5 of this section as amended, and pursuant
13 to section 6 of part J of chapter 63 of the laws of 2001, as may from
14 time to time be amended, which amended this subdivision, are insuffi-
15 cient to meet the costs of excess insurance coverage or equivalent
16 excess coverage for coverage periods during the period July 1, 1992 to
17 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during
18 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995
19 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,
20 during the period July 1, 1997 to June 30, 1998, during the period July
21 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,
22 2000, during the period July 1, 2000 to June 30, 2001, during the period
23 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to
24 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during
25 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004
26 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,
27 during the period July 1, 2006 to June 30, 2007, during the period July
28 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,
29 2009, during the period July 1, 2009 to June 30, 2010, during the period
30 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June
31 30, 2012, during the period July 1, 2012 to June 30, 2013, during the
32 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to
33 June 30, 2015, during the period July 1, 2015 to June 30, 2016, during
34 the period July 1, 2016 to June 30, 2017, during the period July 1, 2017
35 to June 30, 2018, [~~and~~] during the period July 1, 2018 to June 30, 2019,
36 and during the period July 1, 2019 to June 30, 2020 allocated or reallo-
37 cated in accordance with paragraph (a) of subdivision 4-a of this
38 section to rates of payment applicable to state governmental agencies,
39 each physician or dentist for whom a policy for excess insurance cover-
40 age or equivalent excess coverage is purchased for such period shall be
41 responsible for payment to the provider of excess insurance coverage or
42 equivalent excess coverage of an allocable share of such insufficiency,
43 based on the ratio of the total cost of such coverage for such physician
44 to the sum of the total cost of such coverage for all physicians applied
45 to such insufficiency.

46 (b) Each provider of excess insurance coverage or equivalent excess
47 coverage covering the period July 1, 1992 to June 30, 1993, or covering
48 the period July 1, 1993 to June 30, 1994, or covering the period July 1,
49 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,
50 1996, or covering the period July 1, 1996 to June 30, 1997, or covering
51 the period July 1, 1997 to June 30, 1998, or covering the period July 1,
52 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,
53 2000, or covering the period July 1, 2000 to June 30, 2001, or covering
54 the period July 1, 2001 to October 29, 2001, or covering the period
55 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to
56 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or

1 covering the period July 1, 2004 to June 30, 2005, or covering the peri-
2 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to
3 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or
4 covering the period July 1, 2008 to June 30, 2009, or covering the peri-
5 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to
6 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or
7 covering the period July 1, 2012 to June 30, 2013, or covering the peri-
8 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to
9 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or
10 covering the period July 1, 2016 to June 30, 2017, or covering the peri-
11 od July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to
12 June 30, 2019, or covering the period July 1, 2019 to June 30, 2020
13 shall notify a covered physician or dentist by mail, mailed to the
14 address shown on the last application for excess insurance coverage or
15 equivalent excess coverage, of the amount due to such provider from such
16 physician or dentist for such coverage period determined in accordance
17 with paragraph (a) of this subdivision. Such amount shall be due from
18 such physician or dentist to such provider of excess insurance coverage
19 or equivalent excess coverage in a time and manner determined by the
20 superintendent of financial services.

21 (c) If a physician or dentist liable for payment of a portion of the
22 costs of excess insurance coverage or equivalent excess coverage cover-
23 ing the period July 1, 1992 to June 30, 1993, or covering the period
24 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to
25 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or
26 covering the period July 1, 1996 to June 30, 1997, or covering the peri-
27 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to
28 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or
29 covering the period July 1, 2000 to June 30, 2001, or covering the peri-
30 od July 1, 2001 to October 29, 2001, or covering the period April 1,
31 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,
32 2003, or covering the period July 1, 2003 to June 30, 2004, or covering
33 the period July 1, 2004 to June 30, 2005, or covering the period July 1,
34 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,
35 2007, or covering the period July 1, 2007 to June 30, 2008, or covering
36 the period July 1, 2008 to June 30, 2009, or covering the period July 1,
37 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,
38 2011, or covering the period July 1, 2011 to June 30, 2012, or covering
39 the period July 1, 2012 to June 30, 2013, or covering the period July 1,
40 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,
41 2015, or covering the period July 1, 2015 to June 30, 2016, or covering
42 the period July 1, 2016 to June 30, 2017, or covering the period July 1,
43 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,
44 2019, or covering the period July 1, 2019 to June 30, 2020 determined in
45 accordance with paragraph (a) of this subdivision fails, refuses or
46 neglects to make payment to the provider of excess insurance coverage or
47 equivalent excess coverage in such time and manner as determined by the
48 superintendent of financial services pursuant to paragraph (b) of this
49 subdivision, excess insurance coverage or equivalent excess coverage
50 purchased for such physician or dentist in accordance with this section
51 for such coverage period shall be cancelled and shall be null and void
52 as of the first day on or after the commencement of a policy period
53 where the liability for payment pursuant to this subdivision has not
54 been met.

55 (d) Each provider of excess insurance coverage or equivalent excess
56 coverage shall notify the superintendent of financial services and the

1 commissioner of health or their designee of each physician and dentist
2 eligible for purchase of a policy for excess insurance coverage or
3 equivalent excess coverage covering the period July 1, 1992 to June 30,
4 1993, or covering the period July 1, 1993 to June 30, 1994, or covering
5 the period July 1, 1994 to June 30, 1995, or covering the period July 1,
6 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,
7 1997, or covering the period July 1, 1997 to June 30, 1998, or covering
8 the period July 1, 1998 to June 30, 1999, or covering the period July 1,
9 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,
10 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-
11 ing the period April 1, 2002 to June 30, 2002, or covering the period
12 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to
13 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or
14 covering the period July 1, 2005 to June 30, 2006, or covering the peri-
15 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to
16 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or
17 covering the period July 1, 2009 to June 30, 2010, or covering the peri-
18 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to
19 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or
20 covering the period July 1, 2013 to June 30, 2014, or covering the peri-
21 od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to
22 June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or
23 covering the period July 1, 2017 to June 30, 2018, or covering the peri-
24 od July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to
25 June 30, 2020 that has made payment to such provider of excess insurance
26 coverage or equivalent excess coverage in accordance with paragraph (b)
27 of this subdivision and of each physician and dentist who has failed,
28 refused or neglected to make such payment.

29 (e) A provider of excess insurance coverage or equivalent excess
30 coverage shall refund to the hospital excess liability pool any amount
31 allocable to the period July 1, 1992 to June 30, 1993, and to the period
32 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June
33 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the
34 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to
35 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to
36 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000
37 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,
38 and to the period April 1, 2002 to June 30, 2002, and to the period July
39 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,
40 2004, and to the period July 1, 2004 to June 30, 2005, and to the period
41 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June
42 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the
43 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to
44 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to
45 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012
46 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and
47 to the period July 1, 2014 to June 30, 2015, and to the period July 1,
48 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and
49 to the period July 1, 2017 to June 30, 2018, and to the period July 1,
50 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020
51 received from the hospital excess liability pool for purchase of excess
52 insurance coverage or equivalent excess coverage covering the period
53 July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to
54 June 30, 1994, and covering the period July 1, 1994 to June 30, 1995,
55 and covering the period July 1, 1995 to June 30, 1996, and covering the
56 period July 1, 1996 to June 30, 1997, and covering the period July 1,

1 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30,
2 1999, and covering the period July 1, 1999 to June 30, 2000, and cover-
3 ing the period July 1, 2000 to June 30, 2001, and covering the period
4 July 1, 2001 to October 29, 2001, and covering the period April 1, 2002
5 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003,
6 and covering the period July 1, 2003 to June 30, 2004, and covering the
7 period July 1, 2004 to June 30, 2005, and covering the period July 1,
8 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30,
9 2007, and covering the period July 1, 2007 to June 30, 2008, and cover-
10 ing the period July 1, 2008 to June 30, 2009, and covering the period
11 July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to
12 June 30, 2011, and covering the period July 1, 2011 to June 30, 2012,
13 and covering the period July 1, 2012 to June 30, 2013, and covering the
14 period July 1, 2013 to June 30, 2014, and covering the period July 1,
15 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,
16 2016, and covering the period July 1, 2016 to June 30, 2017, and cover-
17 ing the period July 1, 2017 to June 30, 2018, and covering the period
18 July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to
19 June 30, 2020 for a physician or dentist where such excess insurance
20 coverage or equivalent excess coverage is cancelled in accordance with
21 paragraph (c) of this subdivision.

22 § 4. Section 40 of chapter 266 of the laws of 1986, amending the civil
23 practice law and rules and other laws relating to malpractice and
24 professional medical conduct, as amended by section 4 of part M of chap-
25 ter 57 of the laws of 2018, is amended to read as follows:

26 § 40. The superintendent of financial services shall establish rates
27 for policies providing coverage for physicians and surgeons medical
28 malpractice for the periods commencing July 1, 1985 and ending June 30,
29 ~~[2019;]~~ 2020; provided, however, that notwithstanding any other
30 provision of law, the superintendent shall not establish or approve any
31 increase in rates for the period commencing July 1, 2009 and ending June
32 30, 2010. The superintendent shall direct insurers to establish segre-
33 gated accounts for premiums, payments, reserves and investment income
34 attributable to such premium periods and shall require periodic reports
35 by the insurers regarding claims and expenses attributable to such peri-
36 ods to monitor whether such accounts will be sufficient to meet incurred
37 claims and expenses. On or after July 1, 1989, the superintendent shall
38 impose a surcharge on premiums to satisfy a projected deficiency that is
39 attributable to the premium levels established pursuant to this section
40 for such periods; provided, however, that such annual surcharge shall
41 not exceed eight percent of the established rate until July 1, ~~[2019;]~~
42 2020, at which time and thereafter such surcharge shall not exceed twen-
43 ty-five percent of the approved adequate rate, and that such annual
44 surcharges shall continue for such period of time as shall be sufficient
45 to satisfy such deficiency. The superintendent shall not impose such
46 surcharge during the period commencing July 1, 2009 and ending June 30,
47 2010. On and after July 1, 1989, the surcharge prescribed by this
48 section shall be retained by insurers to the extent that they insured
49 physicians and surgeons during the July 1, 1985 through June 30, ~~[2019]~~
50 2020 policy periods; in the event and to the extent physicians and
51 surgeons were insured by another insurer during such periods, all or a
52 pro rata share of the surcharge, as the case may be, shall be remitted
53 to such other insurer in accordance with rules and regulations to be
54 promulgated by the superintendent. Surcharges collected from physicians
55 and surgeons who were not insured during such policy periods shall be
56 apportioned among all insurers in proportion to the premium written by

1 each insurer during such policy periods; if a physician or surgeon was
2 insured by an insurer subject to rates established by the superintendent
3 during such policy periods, and at any time thereafter a hospital,
4 health maintenance organization, employer or institution is responsible
5 for responding in damages for liability arising out of such physician's
6 or surgeon's practice of medicine, such responsible entity shall also
7 remit to such prior insurer the equivalent amount that would then be
8 collected as a surcharge if the physician or surgeon had continued to
9 remain insured by such prior insurer. In the event any insurer that
10 provided coverage during such policy periods is in liquidation, the
11 property/casualty insurance security fund shall receive the portion of
12 surcharges to which the insurer in liquidation would have been entitled.
13 The surcharges authorized herein shall be deemed to be income earned for
14 the purposes of section 2303 of the insurance law. The superintendent,
15 in establishing adequate rates and in determining any projected defi-
16 ciency pursuant to the requirements of this section and the insurance
17 law, shall give substantial weight, determined in his discretion and
18 judgment, to the prospective anticipated effect of any regulations
19 promulgated and laws enacted and the public benefit of stabilizing
20 malpractice rates and minimizing rate level fluctuation during the peri-
21 od of time necessary for the development of more reliable statistical
22 experience as to the efficacy of such laws and regulations affecting
23 medical, dental or podiatric malpractice enacted or promulgated in 1985,
24 1986, by this act and at any other time. Notwithstanding any provision
25 of the insurance law, rates already established and to be established by
26 the superintendent pursuant to this section are deemed adequate if such
27 rates would be adequate when taken together with the maximum authorized
28 annual surcharges to be imposed for a reasonable period of time whether
29 or not any such annual surcharge has been actually imposed as of the
30 establishment of such rates.

31 § 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of
32 chapter 63 of the laws of 2001, amending chapter 266 of the laws of
33 1986, amending the civil practice law and rules and other laws relating
34 to malpractice and professional medical conduct, relating to the effec-
35 tiveness of certain provisions of such chapter, as amended by section 5
36 of part M of chapter 57 of the laws of 2018, are amended to read as
37 follows:

38 § 5. The superintendent of financial services and the commissioner of
39 health shall determine, no later than June 15, 2002, June 15, 2003, June
40 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,
41 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,
42 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June
43 15, 2018, ~~and~~ June 15, 2019, and June 15, 2020 the amount of funds
44 available in the hospital excess liability pool, created pursuant to
45 section 18 of chapter 266 of the laws of 1986, and whether such funds
46 are sufficient for purposes of purchasing excess insurance coverage for
47 eligible participating physicians and dentists during the period July 1,
48 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003
49 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to
50 June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June
51 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30,
52 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30,
53 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
54 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
55 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,

1 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
2 as applicable.

3 (a) This section shall be effective only upon a determination, pursu-
4 ant to section five of this act, by the superintendent of financial
5 services and the commissioner of health, and a certification of such
6 determination to the state director of the budget, the chair of the
7 senate committee on finance and the chair of the assembly committee on
8 ways and means, that the amount of funds in the hospital excess liabil-
9 ity pool, created pursuant to section 18 of chapter 266 of the laws of
10 1986, is insufficient for purposes of purchasing excess insurance cover-
11 age for eligible participating physicians and dentists during the period
12 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July
13 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,
14 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007
15 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to
16 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June
17 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
18 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
19 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,
20 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
21 as applicable.

22 (e) The commissioner of health shall transfer for deposit to the
23 hospital excess liability pool created pursuant to section 18 of chapter
24 266 of the laws of 1986 such amounts as directed by the superintendent
25 of financial services for the purchase of excess liability insurance
26 coverage for eligible participating physicians and dentists for the
27 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,
28 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,
29 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,
30 2007, as applicable, and the cost of administering the hospital excess
31 liability pool for such applicable policy year, pursuant to the program
32 established in chapter 266 of the laws of 1986, as amended, no later
33 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June
34 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,
35 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,
36 2015, June 15, 2016, June 15, 2017, June 15, 2018, ~~[and]~~ June 15, 2019,
37 and June 15, 2020 as applicable.

38 § 6. Section 20 of part H of chapter 57 of the laws of 2017, amending
39 the New York Health Care Reform Act of 1996 and other laws relating to
40 extending certain provisions thereto, as amended by section 6 of part M
41 of chapter 57 of the laws of 2018, is amended to read as follows:

42 § 20. Notwithstanding any law, rule or regulation to the contrary,
43 only physicians or dentists who were eligible, and for whom the super-
44 intendent of financial services and the commissioner of health, or their
45 designee, purchased, with funds available in the hospital excess liabil-
46 ity pool, a full or partial policy for excess coverage or equivalent
47 excess coverage for the coverage period ending the thirtieth of June,
48 two thousand ~~[eighteen,]~~ nineteen, shall be eligible to apply for such
49 coverage for the coverage period beginning the first of July, two thou-
50 sand ~~[eighteen,]~~ nineteen; provided, however, if the total number of
51 physicians or dentists for whom such excess coverage or equivalent
52 excess coverage was purchased for the policy year ending the thirtieth
53 of June, two thousand ~~[eighteen]~~ nineteen exceeds the total number of
54 physicians or dentists certified as eligible for the coverage period
55 beginning the first of July, two thousand ~~[eighteen,]~~ nineteen, then the
56 general hospitals may certify additional eligible physicians or dentists

1 in a number equal to such general hospital's proportional share of the
2 total number of physicians or dentists for whom excess coverage or
3 equivalent excess coverage was purchased with funds available in the
4 hospital excess liability pool as of the thirtieth of June, two thousand
5 [~~eighteen,~~ nineteen], as applied to the difference between the number of
6 eligible physicians or dentists for whom a policy for excess coverage or
7 equivalent excess coverage was purchased for the coverage period ending
8 the thirtieth of June, two thousand [~~eighteen~~ nineteen] and the number
9 of such eligible physicians or dentists who have applied for excess
10 coverage or equivalent excess coverage for the coverage period beginning
11 the first of July, two thousand [~~eighteen~~ nineteen].

12 § 7. This act shall take effect immediately and shall be deemed to
13 have been in full force and effect on and after April 1, 2019.

14 PART G

15 Section 1. Paragraph (a) of subdivision 3 of section 366 of the social
16 services law is REPEALED and a new paragraph (a) is added to read as
17 follows:

18 (a) Medical assistance shall be furnished without consideration of the
19 income and resources of an applicant's legally responsible relative if
20 the applicant's eligibility would normally be determined by comparing
21 the amount of available income and/or resources of the applicant,
22 including amounts deemed available to the applicant from legally respon-
23 sible relatives, to an applicable eligibility standard, and:

24 (1) (i) the legally responsible relative is a community spouse, as
25 defined in section three hundred sixty-six-c of this title;

26 (ii) such relative is refusing to make his or her income and/or
27 resources available to meet the cost of necessary medical care,
28 services, and supplies; and

29 (iii) the applicant executes an assignment of support from the commu-
30 nity spouse in favor of the social services district and the department,
31 unless the applicant is unable to execute such assignment due to phys-
32 ical or mental impairment or to deny assistance would create an undue
33 hardship, as defined by the commissioner; or

34 (2) the legally responsible relative is absent from the applicant's
35 household, and fails or refuses to make his or her income and/or
36 resources available to meet the cost of necessary medical care,
37 services, and supplies.

38 In such cases, however, the furnishing of such assistance shall create
39 an implied contract with such relative, and the cost thereof may be
40 recovered from such relative in accordance with title six of article
41 three of this chapter and other applicable provisions of law.

42 § 2. Paragraphs (c), (d), (e), (f), (g), and (h) of subdivision 4-a
43 and subdivision 4-c of section 365-f of the social services law are
44 REPEALED, and paragraph (i) of subdivision 4-a is relettered paragraph
45 (c).

46 Section 3. Subdivision 4-a of section 365-f of the social services law
47 is redesignated as subdivision 5, and subparagraph (i) of paragraph (a)
48 of such subdivision is amended as follows:

49 [~~4-a~~ 5]. Fiscal intermediary services. (a) For the purposes of this
50 section:

51 (i) "Fiscal intermediary" means an entity that provides fiscal inter-
52 mediary services and has a contract for providing such services with[+]

53 ~~(A) a local department of social services;~~

~~(B) an organization licensed under article forty four of the public health law; or~~

~~(C) an accountable care organization certified under article twenty-nine-E of the public health law or an integrated delivery system composed primarily of health care providers recognized by the department as a performing provider system under the delivery system reform incentive payment program]~~

the department of health and is selected through the procurement process described in paragraph (b) of this subdivision, or by authorization upon application in accordance with such criteria as the department may develop together with such other forms and information prescribed by, or acceptable to, the commissioner. Eligible applicants for authorization under this paragraph are limited to entities that:

(A) are a service center for independent living under section one thousand one hundred twenty-one of the education law; or

(B) have a history of providing fiscal intermediary services for persons with disabilities, as demonstrated by having a continuous history of arrangements with local departments of social services beginning no later than January first, two thousand twelve.

§ 4. Paragraph (b) of subdivision 4-a, redesignated as subdivision 5 pursuant to section 3 of this Part, of section 365-f of the social services law is amended as follows:

~~(b) [No entity shall provide, directly or through contract, fiscal intermediary services without an authorization as a fiscal intermediary issued by the commissioner in accordance with this subdivision]~~ Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under this subdivision with an entity or entities without a competitive bid or request for proposal process, provided, however, that:

(i) the department shall post on its website, for a period of no less than thirty days:

(A) a description of the proposed services to be provided pursuant to the contract or contracts;

(B) the criteria for selection of a contractor or contractors;

(C) the period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(D) the manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) all reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner; and

(iii) the commissioner shall select such contractor or contractors that, in the commissioner's discretion, are best suited to serve the purposes of this section.

§ 5. Subdivision 4-b of section 365-f of the social services law is REPEALED and current subdivisions 5, 6, 7, 8 and 9 are redesignated as subdivisions 6, 7, 8, 9, and 10.

§ 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided however, that sections three, four, and five of this act shall take effect January 1, 2020.

1 Section 1. Subparagraph (v) of paragraph (b) of subdivision 5-b of
2 section 2807-k of the public health law is REPEALED.

3 § 2. Section 2807 of the public health law is amended by adding a new
4 subdivision 20-a to read as follows:

5 20-a. Notwithstanding any provision of law to the contrary, the
6 commissioners of the department of health, the office of mental health,
7 the office of people with developmental disabilities, and the office of
8 alcoholism and substance abuse services are authorized to waive any
9 regulatory requirements as are necessary, consistent with applicable
10 law, to allow providers that are involved in DSRIP projects or repli-
11 cation and scaling activities, as approved by the authorizing commis-
12 sioner, to avoid duplication of requirements and to allow the efficient
13 scaling and replication of DSRIP promising practices, as determined by
14 the authorizing commissioner; provided however, that regulations
15 pertaining to patient safety may not be waived, nor shall any regu-
16 lations be waived if such waiver would risk patient safety.

17 § 3. Subparagraph (i) of paragraph (e-1) of subdivision 4 of section
18 2807-c of the public health law, as amended by section 29 of part C of
19 chapter 60 of the laws of 2014, is amended to read as follows:

20 (i) For rate periods on and after April first, two thousand ten, the
21 commissioner, in consultation with the commissioner of the office of
22 mental health, shall promulgate regulations, and may promulgate emergen-
23 cy regulations, establishing methodologies for determining the operating
24 cost components of rates of payments for services described in this
25 paragraph. Such regulations shall utilize two thousand five operating
26 costs as submitted to the department prior to July first, two thousand
27 nine and ~~shall~~ may provide for methodologies establishing per diem
28 inpatient rates that utilize case mix adjustment mechanisms. Such regu-
29 lations ~~shall~~ may contain criteria for adjustments based on length of
30 stay and may also provide for a base year update, provided, however,
31 that such base year update shall take effect no earlier than April
32 first, two thousand fifteen, and provided further, however, that the
33 commissioner may make such adjustments to such utilization and to the
34 methodology for computing such rates as is necessary to achieve no
35 aggregate, net growth in overall Medicaid expenditures related to such
36 rates, as compared to such aggregate expenditures from the prior year.
37 In determining the updated base year to be utilized pursuant to this
38 subparagraph, the commissioner shall take into account the base year
39 determined in accordance with paragraph (c) of subdivision thirty-five
40 of this section.

41 § 4. Subdivision 35 of section 2807-c of the public health law is
42 amended by adding a new paragraph (k) to read as follows:

43 (k) Notwithstanding any contrary provision of law, the commissioner
44 may make such adjustments to general hospital inpatient rates and to the
45 methodology for computing such rates as is necessary to reduce payments
46 to facilities with a higher percentage of potentially avoidable inpa-
47 tient services by instituting lower inpatient payment rates for both
48 fee-for-service and managed care to incentivize the provision of preven-
49 tative care to reduce preventable events and overall inpatient costs. A
50 portion of such savings derived from the implementation of such payment
51 methodologies shall be reinvested in initiatives to incentivize the
52 provision of preventative care, maternity services, and other ambulatory
53 care services to reduce preventable health care costs.

54 § 5. Social Services Law section 367-u, as amended by chapter 6 of the
55 laws of 2015, is amended to read as follows:

§ 367-u. Payment for home telehealth services. 1. Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

2. Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law; provided, however, for telehealth services provided to individuals dually enrolled in Medicaid and Medicare, the commissioner is authorized to promulgate regulations governing Medicaid coverage and reimbursement of such services, including development of a covered services list which may be limited to higher priority services and procedures. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.

§ 6. Subdivision 5-d of section 2807-k of the public health law, as amended by chapter 57 of the laws of 28, is amended to read as follows.

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand thirteen, through March thirty-first, two thousand ~~twenty~~ twenty-one, all funds available for distribution pursuant to this section, except for funds distributed pursuant to subparagraph (v) of paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand thirteen through two thousand ~~nineteen~~ twenty calendar years shall be in accord with the following:

(A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and

(B) ~~nine hundred ninety-four~~ seven hundred nineteen million ~~nine~~ four hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals; and

(C) provided, however, that notwithstanding any inconsistent provision of this section, for all calendar years beginning on January first, two

thousand twenty, general hospitals located in a city with a population of more than one million persons and/or in the counties of Westchester, Suffolk and Nassau, that have, or that that are part of a system of co-established general hospitals that collectively has, and average operating margin greater than 2.98 where average operating margin is calculated by subtracting total operating expenses from total operating revenue and dividing the result by the total operating revenue, and that also have, or that that are part of a system of co-established general hospitals that collectively has, a net operating income of more than sixty-eight million dollars, both as determined by the department pursuant to the hospital institutional cost reports for year two thousand seventeen, shall only be eligible for indigent care pool payments of a maximum of ten thousand dollars.

(iii)(A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph (ii) of this paragraph such that no facility experiences a reduction in indigent care pool payments pursuant to this subdivision that is greater than the percentages, as specified in clause (C) of this subparagraph as compared to the average distribution that each such facility received for the three calendar years prior to two thousand thirteen pursuant to this section and section twenty-eight hundred seven-w of this article.

(B) Such regulations shall also establish adjustments limiting the increases in indigent care pool payments experienced by facilities pursuant to this subdivision by an amount that will be, as determined by the commissioner and in conjunction with such other funding as may be available for this purpose, sufficient to ensure full funding for the transition adjustment payments authorized by clause (A) of this subparagraph.

(C) No facility shall experience a reduction in indigent care pool payments pursuant to this subdivision that: for the calendar year beginning January first, two thousand thirteen, is greater than two and one-half percent; for the calendar year beginning January first, two thousand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen, is greater than seven and one-half percent, and for the calendar year beginning on January first, two thousand sixteen, is greater than ten percent; and for the calendar year beginning on January first, two thousand seventeen, is greater than twelve and one-half percent; and for the calendar year beginning on January first, two thousand eighteen, is greater than fifteen percent; and for the calendar year beginning on January first, two thousand nineteen, is greater than seventeen and one-half percent.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and
(iii) the extent to which access to care has been enhanced.
§ 7. This act shall take effect immediately.

PART I

Section 1. The insurance law is amended by adding a new article 29 to read as follows:

ARTICLE 29
PHARMACY BENEFIT MANAGERS

Section 2901. Definitions.

2902. Acting without a registration.

2903. Registration requirements for pharmacy benefit managers.

2904. Reporting requirements for pharmacy benefit managers.

2905. Acting without a license.

2906. Licensing of a pharmacy benefit manager.

2907. Revocation or suspension of a registration or license of a pharmacy benefit manager.

2908. Penalties for violations.

2909. Stay or suspension of superintendent's determination.

2910. Revoked registration or licenses.

2911. Change of address.

2912. Applicability of other laws.

2913. Assessments.

§ 2901. Definitions. For purposes of this article:

(a) "Controlling person" is any person or other entity who or which directly or indirectly has the power to direct or cause to be directed the management, control or activities of a pharmacy benefit manager.

(b) "Health insurer" means an insurance company authorized in this state to write accident and health insurance, a company organized pursuant to article forty-three of this chapter, a municipal cooperative health benefit plan established pursuant to article forty-seven of this chapter, an organization certified pursuant to article forty-four of the public health law, an institution of higher education certified pursuant to section one thousand one hundred twenty-four of this chapter, or the New York state health insurance plan established under article eleven of the civil service law.

(c) "Pharmacy benefit management services" means directly or through an intermediary, managing the prescription drug coverage provided by a health insurer under a contract or policy delivered or issued for delivery in this state or a plan subject to section three hundred sixty-four-j of the social services law, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, negotiation of rebates, and controlling the cost of covered prescription drugs.

(d) "Pharmacy benefit manager" means a person, firm, association, corporation or other entity that, pursuant to a contract with a health insurer provides pharmacy benefit management services, except that term shall not include:

(1) an officer or employee of a registered or licensed pharmacy benefit manager; or

(2) a health insurer, or any manager thereof, individual or corporate, or any officer, director or regular salaried employee thereof, providing

1 pharmacy benefit management services under a policy or contract issued
2 by the health insurer.

3 § 2902. Acting without a registration. (a) No person, firm, associ-
4 ation, corporation or other entity may act as a pharmacy benefits manag-
5 er prior to January first, two thousand twenty without having a valid
6 registration as a pharmacy benefit manager filed with the superintendent
7 in accordance with this article and any regulations promulgated there-
8 under.

9 (b) Prior to January first, two thousand twenty, no health insurer may
10 pay any fee or other compensation to any person, firm, association,
11 corporation or other entity for performing pharmacy benefit management
12 services unless the person, firm, association, corporation or other
13 entity is registered as a pharmacy benefit manager in accordance with
14 this article.

15 (c) Any person, firm, association, corporation or other entity that
16 violates this section shall, in addition to any other penalty provided
17 by law, be liable for restitution to any insurer or insured harmed by
18 the violation and shall also be subject to a penalty of the greater of
19 (1) one thousand dollars for the first violation and two thousand five
20 hundred dollars for each subsequent violation or (2) the aggregate
21 economic gross receipts attributable to all violations.

22 § 2903. Registration requirements for pharmacy benefit managers. (a)
23 Every pharmacy benefit manager that performs pharmacy benefit management
24 services prior to January first, two thousand twenty-one shall register
25 with the superintendent in a manner acceptable to the superintendent,
26 and shall pay a fee of one thousand dollars for each year or fraction of
27 a year in which the registration shall be valid. The superintendent, in
28 consultation with the commissioner of health, may establish, by regu-
29 lation, minimum registration standards required for a pharmacy benefit
30 manager. The superintendent can reject a registration application filed
31 by a pharmacy benefit manager that fails to comply with the minimum
32 registration standards.

33 (b) For each business entity, the officer or officers and director or
34 directors named in the application shall be designated responsible for
35 the business entity's compliance with the financial services and insur-
36 ance laws, rules and regulations of this state.

37 (c) Every registration will expire on December thirty-first, two thou-
38 sand twenty regardless of when registration was first made.

39 (d) Every pharmacy benefit manager that performs pharmacy benefit
40 management services at any time between January first, two thousand
41 nineteen and June first, two thousand nineteen, shall make the registra-
42 tion and fee payment required by subsection (a) of this section on or
43 before June first, two thousand nineteen. Any other pharmacy benefit
44 manager shall make the registration and fee payment required by
45 subsection (a) of this section prior to performing pharmacy benefit
46 management services.

47 (e) Registrants under this section shall be subject to examination by
48 the superintendent as often as the superintendent may deem it necessary.
49 The superintendent may promulgate regulations establishing methods and
50 procedures for facilitating and verifying compliance with the require-
51 ments of this article and such other regulations as necessary to enforce
52 the provisions of this article.

53 § 2904. Reporting requirements for pharmacy benefit managers. (a)(1)
54 On or before July first of each year, beginning in two thousand twenty,
55 every pharmacy benefit manager shall report to the superintendent, in a
56 statement subscribed and affirmed as true under penalties of perjury,

1 the information requested by the superintendent including, without limi-
2 tation, disclosure of any financial incentive or benefit for promoting
3 the use of certain drugs and other financial arrangements affecting
4 health insurers or their policyholders or insureds and any information
5 relating to the business, financial condition, or market conduct of the
6 pharmacy benefit manager. The superintendent also may require the filing
7 of quarterly or other statements, which shall be in such form and shall
8 contain such matters as the superintendent shall prescribe.

9 (2) The superintendent also may address to any pharmacy benefit manag-
10 er or its officers any inquiry in relation to its provision of pharmacy
11 benefit management services or any matter connected therewith. Every
12 pharmacy benefit manager or person so addressed shall reply in writing
13 to such inquiry promptly and truthfully, and such reply shall be, if
14 required by the superintendent, subscribed by such individual, or by
15 such officer or officers of the pharmacy benefit manager, as the super-
16 intendent shall designate, and affirmed by them as true under the penal-
17 ties of perjury.

18 (b) In the event any pharmacy benefit manager or person does not
19 submit the report required by paragraph one of subsection (a) of this
20 section or does not provide a good faith response to an inquiry from the
21 superintendent pursuant to paragraph two of subsection (a) of this
22 section within a time period specified by the superintendent of not less
23 than fifteen business days, the superintendent is authorized to levy a
24 civil penalty, after notice and hearing, against such pharmacy benefit
25 manager or person not to exceed five hundred dollars per day for each
26 day beyond the date the report is due or the date specified by the
27 superintendent for response to the inquiry.

28 (c) All information disclosed by a pharmacy benefit manager shall be
29 deemed confidential and not subject to disclosure unless the superinten-
30 dent determines that such disclosure is in the public interest, or is
31 necessary to carry out this article or to allow the department to
32 perform examinations or investigations authorized by law.

33 § 2905. Acting without a license. (a) No person, firm, association,
34 corporation or other entity may act as a pharmacy benefit manager on or
35 after January first, two thousand twenty-one without having authority to
36 do so by virtue of a license issued in force pursuant to the provisions
37 of this article.

38 (b) No health insurer may pay any fee or other compensation to any
39 person, firm, association, corporation or other entity for performing
40 pharmacy benefit management services on or after January first, two
41 thousand twenty-one unless the person, firm, association, corporation or
42 other entity is licensed as a pharmacy benefit manager in accordance
43 with this article.

44 (c) Any person, firm, association, corporation or other entity that
45 violates this section shall, in addition to any other penalty provided
46 by law, be subject to a penalty of the greater of (1) one thousand
47 dollars for the first violation and two thousand five hundred dollars
48 for each subsequent violation or (2) the aggregate gross receipts
49 attributable to all violations.

50 § 2906. Licensing of a pharmacy benefit manager. (a) The superinten-
51 dent may issue a pharmacy benefit manager's license to any person, firm,
52 association or corporation who or that has complied with the require-
53 ments of this article, including regulations promulgated by the super-
54 intendent. The superintendent, in consultation with the commissioner of
55 health, may establish, by regulation, minimum standards for the issuance
56 of a license to a pharmacy benefit manager.

1 (b) The minimum standards established under this subsection may
2 address, without limitation:

3 (1) conflicts of interest between pharmacy benefit managers and health
4 insurers;

5 (2) deceptive practices in connection with the performance of pharmacy
6 benefit management services;

7 (3) anti-competitive practices in connection with the performance of
8 pharmacy benefit management services;

9 (4) unfair claims practices in connection with the performance of
10 pharmacy benefit management services; and

11 (5) protection of consumers.

12 (c)(1) Any such license issued to a firm or association shall author-
13 ize all of the members of the firm or association and any designated
14 employees to act as pharmacy benefit managers under the license, and all
15 such persons shall be named in the application and supplements thereto.

16 (2) Any such license issued to a corporation shall authorize all of
17 the officers and any designated employees and directors thereof to act
18 as pharmacy benefit managers on behalf of such corporation, and all such
19 persons shall be named in the application and supplements thereto.

20 (3) For each business entity, the officer or officers and director or
21 directors named in the application shall be designated responsible for
22 the business entity's compliance with the insurance laws, rules and
23 regulations of this state.

24 (d)(1) Before a pharmacy benefit manager's license shall be issued or
25 renewed, the prospective licensee shall properly file in the office of
26 the superintendent a written application therefor in such form or forms
27 and supplements thereto as the superintendent prescribes, and pay a fee
28 of one thousand dollars for each year or fraction of a year in which a
29 license shall be valid.

30 (2) Every pharmacy benefit manager's license issued to a business
31 entity pursuant to this section shall expire on the thirtieth day of
32 November of even-numbered years. Every license issued pursuant to this
33 section to an individual pharmacy benefit manager who was born in an
34 odd-numbered year, shall expire on the individual's birthday in each
35 odd-numbered year. Every license issued pursuant to this section to an
36 individual pharmacy benefit manager who was born in an even-numbered
37 year, shall expire on the individual's birthday in each even-numbered
38 year. Every license issued pursuant to this section may be renewed for
39 the ensuing period of twenty-four months upon the filing of an applica-
40 tion in conformity with this subsection.

41 (e)(1) If an application for a renewal license shall have been filed
42 with the superintendent before October first of the year of expiration,
43 then the license sought to be renewed shall continue in full force and
44 effect either until the issuance by the superintendent of the renewal
45 license applied for or until five days after the superintendent shall
46 have refused to issue such renewal license and given notice of such
47 refusal to the applicant.

48 (2) Before refusing to renew any license pursuant to this section for
49 which a renewal application has been filed pursuant to paragraph one of
50 this subsection, the superintendent shall notify the applicant of the
51 superintendent's intention to do so and shall give such applicant a
52 hearing.

53 (f) The superintendent may refuse to issue a pharmacy benefit manag-
54 er's license if, in the superintendent's judgment, the applicant or any
55 member, principal, officer or director of the applicant, is not trust-
56 worthy and competent to act as or in connection with a pharmacy benefit

1 manager, or that any of the foregoing has given cause for revocation or
2 suspension of such license, or has failed to comply with any prerequi-
3 site for the issuance of such license.

4 (g) Licensees and applicants for a license under this section shall be
5 subject to examination by the superintendent as often as the superinten-
6 dent may deem it expedient. The superintendent may promulgate regu-
7 lations establishing methods and procedures for facilitating and verify-
8 ing compliance with the requirements of this section and such other
9 regulations as necessary.

10 (h) The superintendent may issue a replacement for a currently
11 in-force license that has been lost or destroyed. Before the replacement
12 license shall be issued, there shall be on file in the office of the
13 superintendent a written application for the replacement license,
14 affirming under penalty of perjury that the original license has been
15 lost or destroyed, together with a fee of one hundred dollars.

16 § 2907. Revocation or suspension of a registration or license of a
17 pharmacy benefit manager. (a) The superintendent may refuse to renew,
18 may revoke, or may suspend for a period the superintendent determines
19 the registration or license of any pharmacy benefit manager if, after
20 notice and hearing, the superintendent determines that the registrant or
21 licensee or any member, principal, officer, director, or controlling
22 person of the registrant or licensee, has:

23 (1) violated any insurance laws, or violated any regulation, subpoena
24 or order of the superintendent or of another state's insurance commis-
25 sioner, or has violated any law in the course of his or her dealings in
26 such capacity;

27 (2) provided materially incorrect, materially misleading, materially
28 incomplete or materially untrue information in the registration or
29 license application;

30 (3) obtained or attempted to obtain a registration or license through
31 misrepresentation or fraud;

32 (4)(A) used fraudulent, coercive or dishonest practices;

33 (B) demonstrated incompetence;

34 (C) demonstrated untrustworthiness; or

35 (D) demonstrated financial irresponsibility in the conduct of business
36 in this state or elsewhere;

37 (5) improperly withheld, misappropriated or converted any monies or
38 properties received in the course of business in this state or else-
39 where;

40 (6) intentionally misrepresented the terms of an actual or proposed
41 insurance contract;

42 (7) been convicted of a felony;

43 (8) admitted or been found to have committed any insurance unfair
44 trade practice or fraud;

45 (9) had a pharmacy benefit manager registration or license, or its
46 equivalent, denied, suspended or revoked in any other state, province,
47 district or territory;

48 (10) failed to pay state income tax or comply with any administrative
49 or court order directing payment of state income tax; or

50 (11) ceased to meet the requirements for registration or licensure
51 under this article.

52 (b) Before revoking or suspending the registration or license of any
53 pharmacy benefit manager pursuant to the provisions of this article, the
54 superintendent shall give notice to the registrant or licensee and to
55 every sub-licensee and shall hold, or cause to be held, a hearing not
56 less than ten days after the giving of such notice.

1 (c) If a registration or license pursuant to the provisions of this
2 article is revoked or suspended by the superintendent, then the super-
3 intendent shall forthwith give notice to the registrant or licensee.

4 (d) The revocation or suspension of any registration or license pursu-
5 ant to the provisions of this article shall terminate forthwith such
6 registration or license and the authority conferred thereby upon all
7 sub-licensees. For good cause shown, the superintendent may delay the
8 effective date of a revocation or suspension to permit the registrant or
9 licensee to satisfy some or all of its contractual obligations to
10 perform pharmacy benefit management services in the state.

11 (e)(1) No individual, corporation, firm or association whose registra-
12 tion or license as a pharmacy benefit manager has been revoked pursuant
13 to subsection (a) of this section, and no firm or association of which
14 such individual is a member, and no corporation of which such individual
15 is an officer or director, and no controlling person of the registrant
16 or licensee shall be entitled to obtain any registration or license
17 under the provisions of this article for a period of one year after such
18 revocation, or, if such revocation be judicially reviewed, for one year
19 after the final determination thereof affirming the action of the super-
20 intendent in revoking such license.

21 (2) If any such registration or license held by a firm, association or
22 corporation be revoked, no member of such firm or association and no
23 officer or director of such corporation or any controlling person of the
24 registrant or licensee shall be entitled to obtain any registration or
25 license, or to be named as a sub-licensee in any such license, under
26 this article for the same period of time, unless the superintendent
27 determines, after notice and hearing, that such member, officer or
28 director was not personally at fault in the matter on account of which
29 such registration or license was revoked.

30 (f) If any registered or licensed pharmacy benefit manager or any
31 person aggrieved shall file with the superintendent a verified complaint
32 setting forth facts tending to show sufficient ground for the revocation
33 or suspension of any pharmacy benefit manager's registration or license,
34 then the superintendent shall, after notice and a hearing, determine
35 whether such registration or license shall be suspended or revoked.

36 (g) The superintendent shall retain the authority to enforce the
37 provisions of and impose any penalty or remedy authorized by this chap-
38 ter against any person or entity who is under investigation for or
39 charged with a violation of this chapter, even if the person's or enti-
40 ty's registration or license has been surrendered, or has expired or has
41 lapsed by operation of law.

42 (h) A registrant or licensee subject to this article shall report to
43 the superintendent any administrative action taken against the regis-
44 trant or licensee in another jurisdiction or by another governmental
45 agency in this state within thirty days of the final disposition of the
46 matter. This report shall include a copy of the order, consent to order
47 or other relevant legal documents.

48 (i) Within thirty days of the initial pretrial hearing date, a regis-
49 trant or licensee subject to this article shall report to the super-
50 intendent any criminal prosecution of the registrant or licensee taken
51 in any jurisdiction. The report shall include a copy of the initial
52 complaint filed, the order resulting from the hearing and any other
53 relevant legal documents.

54 § 2908. Penalties for violations. (a) The superintendent, in lieu of
55 revoking or suspending the registration or license of a registrant or
56 licensee in accordance with the provisions of this article, may in any

1 one proceeding by order, require the registrant or licensee to pay to
2 the people of this state a penalty in a sum not exceeding the greater of
3 (1) one thousand dollars for each offense and two thousand five hundred
4 dollars for each subsequent violation or (2) the aggregate gross
5 receipts attributable to all offenses.

6 (b) Upon the failure of such a registrant or licensee to pay the
7 penalty ordered pursuant to subsection (a) of this section within twenty
8 days after the mailing of the order, postage prepaid, registered, and
9 addressed to the last known place of business of the licensee, unless
10 the order is stayed by an order of a court of competent jurisdiction,
11 the superintendent may revoke the registration or license of the regis-
12 trant or licensee or may suspend the same for such period as the super-
13 intendent determines.

14 § 2909. Stay or suspension of superintendent's determination. The
15 commencement of a proceeding under article seventy-eight of the civil
16 practice law and rules, to review the action of the superintendent in
17 suspending or revoking or refusing to renew any certificate under this
18 article, shall stay such action of the superintendent for a period of
19 thirty days. Such stay shall not be extended for a longer period unless
20 the court shall determine, after a preliminary hearing of which the
21 superintendent is notified forty-eight hours in advance, that a stay of
22 the superintendent's action pending the final determination or further
23 order of the court will not unduly injure the interests of the people of
24 the state.

25 § 2910. Revoked registrations or licenses. (a)(1) No person, firm,
26 association, corporation or other entity subject to the provisions of
27 this article whose registration or license under this article has been
28 revoked, or whose registration or license to engage in the business of
29 pharmacy benefit management in any capacity has been revoked by any
30 other state or territory of the United States shall become employed or
31 appointed by a pharmacy benefit manager as an officer, director, manag-
32 er, controlling person or for other services, without the prior written
33 approval of the superintendent, unless such services are for maintenance
34 or are clerical or ministerial in nature.

35 (2) No person, firm, association, corporation or other entity subject
36 to the provisions of this article shall knowingly employ or appoint any
37 person or entity whose registration or license issued under this article
38 has been revoked, or whose registration or license to engage in the
39 business of pharmacy benefit management in any capacity has been revoked
40 by any other state or territory of the United States, as an officer,
41 director, manager, controlling person or for other services, without the
42 prior written approval of the superintendent, unless such services are
43 for maintenance or are clerical or ministerial in nature.

44 (3) No corporation or partnership subject to the provisions of this
45 article shall knowingly permit any person whose registration or license
46 issued under this article has been revoked, or whose registration or
47 license to engage in the business of pharmacy benefit management in any
48 capacity has been revoked by any other state, or territory of the United
49 States, to be a shareholder or have an interest in such corporation or
50 partnership, nor shall any such person become a shareholder or partner
51 in such corporation or partnership, without the prior written approval
52 of the superintendent.

53 (b) The superintendent may approve the employment, appointment or
54 participation of any such person whose registration or license has been
55 revoked:

1 (1) if the superintendent determines that the duties and responsibil-
2 ities of such person are subject to appropriate supervision and that
3 such duties and responsibilities will not have an adverse effect upon
4 the public, other registrants or licensees, or the registrant or licen-
5 see proposing employment or appointment of such person; or

6 (2) if such person has filed an application for reregistration or
7 relicensing pursuant to this article and the application for reregistra-
8 tion or relicensing has not been approved or denied within one hundred
9 twenty days following the filing thereof, unless the superintendent
10 determines within the said time that employment or appointment of such
11 person by a registrant or licensee in the conduct of a pharmacy benefit
12 management business would not be in the public interest.

13 (c) The provisions of this section shall not apply to the ownership of
14 shares of any corporation registered or licensed pursuant to this arti-
15 cle if the shares of such corporation are publicly held and traded in
16 the over-the-counter market or upon any national or regional securities
17 exchange.

18 § 2911. Change of address. A registrant or licensee under this article
19 shall inform the superintendent by a means acceptable to the superinten-
20 dent of a change of address within thirty days of the change.

21 § 2912. Applicability of other laws. Nothing in this article shall be
22 construed to exempt a pharmacy benefit manager from complying with the
23 provisions of articles twenty-one and forty-nine of this chapter and
24 article forty-nine of the public health law or any other provision of
25 this chapter or the financial services law.

26 § 2913. Assessments. Pharmacy benefit managers that file a registra-
27 tion with the department or are licensed by the department shall be
28 assessed by the superintendent for the operating expenses of the depart-
29 ment that are solely attributable to regulating such pharmacy benefit
30 managers in such proportions as the superintendent shall deem just and
31 reasonable.

32 § 2. Subsection (b) of section 2402 of the insurance law, as amended
33 by section 71 of part A of chapter 62 of the laws of 2011, is amended to
34 read as follows:

35 (b) "Defined violation" means the commission by a person of an act
36 prohibited by: subsection (a) of section one thousand one hundred two,
37 section one thousand two hundred fourteen, one thousand two hundred
38 seventeen, one thousand two hundred twenty, one thousand three hundred
39 thirteen, subparagraph (B) of paragraph two of subsection (i) of section
40 one thousand three hundred twenty-two, subparagraph (B) of paragraph two
41 of subsection (i) of section one thousand three hundred twenty-four, two
42 thousand one hundred two, two thousand one hundred seventeen, two thou-
43 sand one hundred twenty-two, two thousand one hundred twenty-three,
44 subsection (p) of section two thousand three hundred thirteen, section
45 two thousand three hundred twenty-four, two thousand five hundred two,
46 two thousand five hundred three, two thousand five hundred four, two
47 thousand six hundred one, two thousand six hundred two, two thousand six
48 hundred three, two thousand six hundred four, two thousand six hundred
49 six, two thousand seven hundred three, two thousand nine hundred two,
50 two thousand nine hundred five, three thousand one hundred nine, three
51 thousand two hundred twenty-four-a, three thousand four hundred twenty-
52 nine, three thousand four hundred thirty-three, paragraph seven of
53 subsection (e) of section three thousand four hundred twenty-six, four
54 thousand two hundred twenty-four, four thousand two hundred twenty-five,
55 four thousand two hundred twenty-six, seven thousand eight hundred nine,
56 seven thousand eight hundred ten, seven thousand eight hundred eleven,

1 seven thousand eight hundred thirteen, seven thousand eight hundred
2 fourteen and seven thousand eight hundred fifteen of this chapter; or
3 section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one
4 hundred five of the penal law.

5 § 3. This act shall take effect immediately and shall be deemed to
6 have been in full force and effect on and after April 1, 2019.

7 PART J

8 Section 1. This Part enacts into law major components of legislation
9 which are necessary to protect health care consumers; increase access to
10 more affordable quality health insurance coverage; and preserve and
11 foster New York's health insurance markets. Each component is wholly
12 contained within a Subpart identified as Subparts A through F. The
13 effective date for each particular provision contained within such
14 Subpart is set forth in the last section of such Subpart. Any provision
15 in any section contained within a Subpart, including the effective date
16 of the Subpart, which makes a reference to a section "of this act," when
17 used in connection with that particular component, shall be deemed to
18 mean and refer to the corresponding section of the Subpart in which it
19 is found. Section five of this Part sets forth the general effective
20 date of this Part.

21 SUBPART A

22 Section 1. Section 3221 of the insurance law is amended by adding a
23 new subsection (t) to read as follows:

24 (t) (1) Any insurer that delivers or issues for delivery in this state
25 hospital, surgical or medical expense group policies in the small group
26 or large group market shall offer to any employer in this state all such
27 policies in the applicable market, and shall accept at all times
28 throughout the year any employer that applies for any of those policies.

29 (2) The requirements of paragraph one of this subsection shall apply
30 with respect to an employer that applies for coverage either directly
31 from the insurer or through an association or trust to which the insurer
32 has issued coverage and in which the employer participates.

33 § 2. Paragraph 1 of subsection (g) of section 3231 of the insurance
34 law, as amended by section 70 of part D of chapter 56 of the laws of
35 2013, is amended to read as follows:

36 (1) This section shall also apply to policies issued to a group
37 defined in subsection (c) of section four thousand two hundred thirty-
38 five, including but not limited to an association or trust of employers,
39 if the group includes one or more member employers or other member
40 groups which have [~~fifty~~] one hundred or fewer employees or members
41 exclusive of spouses and dependents. For policies issued or renewed on
42 or after January first, two thousand fourteen, if the group includes one
43 or more member small group employers eligible for coverage subject to
44 this section, then such member employers shall be classified as small
45 groups for rating purposes and the remaining members shall be rated
46 consistent with the rating rules applicable to such remaining members
47 pursuant to paragraph two of this subsection.

48 § 3. Subsections (h) and (i) of section 3232 of the insurance law are
49 REPEALED.

50 § 4. Subsections (f) and (g) of section 3232 of the insurance law, as
51 added by chapter 219 of the laws of 2011, are amended to read as
52 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~~ An insurer ~~[may]~~ shall 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].~~

§ 5. Subparagraph (A) of paragraph 1 of subsection (c) of section 4235 of the insurance law, as amended by chapter 515 of the laws of 2010, is amended to read as follows:

(A) A policy issued to an employer or to a trustee or trustees of a fund established by an employer, which employer or trustee or trustees shall be deemed the policyholder, insuring with or without evidence of insurability satisfactory to the insurer, employees of such employer, and insuring, except as hereinafter provided, all of such employees or all of any class or classes thereof determined by conditions pertaining to the employment or a combination of such conditions and conditions pertaining to the family status of the employee, for insurance coverage on each person insured based upon some plan ~~[which]~~ that will preclude individual selection. However, such a plan may permit a limited number of selections by employees if the selections offered utilize consistent plans of coverage for individual group members so that the resulting plans of coverage are reasonable. The premium for the policy shall be paid by the policyholder, either from the employer's funds, or from funds contributed by the insured employees, or from funds contributed jointly by the employer and employees. If all or part of the premium is to be derived from funds contributed by the insured employees, then ~~[such]~~ the insurer issuing the policy ~~[must insure not less than fifty percent of such eligible employees or, if less, fifty or more]~~ shall not require a minimum number or minimum percentage of such employees be insured when ~~[such]~~ the policy is providing coverage for group hospital, medical, major medical or similar comprehensive types of expense reimbursed insurance and, for all other types of group accident and health insurance, ~~[must]~~ the policy shall insure a minimum of fifty percent or five of such eligible employees, whichever is fewer.

§ 6. Section 4305 of the insurance law is amended by adding a new subsection (n) to read as follows:

(n) (1) Any corporation subject to the provisions of this article that issues hospital, surgical or medical expense contracts in the small group or large group market in this state shall offer to any employer in this state all such contracts in the applicable market, and shall accept at all times throughout the year any employer that applies for any of those contracts.

(2) The requirements of paragraph one of this subsection shall apply with respect to an employer that applies for coverage either directly from the corporation or through an association or trust to which the corporation has issued coverage and in which the employer participates.

§ 7. Paragraph 1 of subsection (d) of section 4317 of the insurance law, as amended by section 72 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) This section shall also apply to a contract issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have ~~[fifty]~~ one hundred or fewer employees or members exclusive of spouses and dependents. For contracts issued or renewed on or after January first, two thousand fourteen, if the group includes one or more member small group employers eligible for coverage subject to this section, then such member employers shall be classified as small groups for rating purposes and the remaining members shall be rated consistent with the rating rules applicable to such remaining members pursuant to paragraph two of this subsection.

§ 8. Subsections (h) and (i) of section 4318 of the insurance law are REPEALED.

§ 9. Subsections (f) and (g) of section 4318 of the insurance law, as added by chapter 219 of the laws of 2011, are amended 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, 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, a~~ A corporation ~~[may]~~ shall 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].~~

§ 10. Section 4413 of the insurance law is amended by adding a new subsection (h) to read as follows:

(h) (1) On or after June first, two thousand nineteen, an employee welfare fund registered with the superintendent shall not provide medical, surgical or hospital care or benefits in the event of sickness or injury for employees or their families or dependents, or for both, unless provided under a group comprehensive-type health insurance policy or contract in accordance with the requirements of this chapter and delivered or issued for delivery in this state by an authorized insurer or a health maintenance organization issued a certificate of authority under article forty-four of the public health law.

(2) Notwithstanding paragraph one of this subsection, an employee welfare fund registered with the superintendent prior to June first, two thousand nineteen, which, as of February first, two thousand nineteen directly provided medical, surgical or hospital care or benefits in the event of sickness or injury for employees or their families or dependents, or for both, may continue to provide those benefits directly rather than under a group comprehensive-type health insurance policy or contract delivered or issued for delivery in this state by an authorized insurer or a health maintenance organization issued a certificate of authority under article forty-four of the public health law; provided,

1 however, that, if the employee welfare fund ceases offering the benefits
2 directly, it may not resume providing the benefits directly.

3 § 11. Subdivision 1 of section 4406 of the public health law, as
4 amended by section 46-a of part D of chapter 56 of the laws of 2013, is
5 amended to read as follows:

6 1. The contract between a health maintenance organization and an
7 enrollee shall be subject to regulation by the superintendent as if it
8 were a health insurance subscriber contract, and shall include, but not
9 be limited to, all mandated benefits required by article forty-three of
10 the insurance law. Such contract shall fully and clearly state the bene-
11 fits and limitations therein provided or imposed, so as to facilitate
12 understanding and comparisons, and to exclude provisions which may be
13 misleading or unreasonably confusing. Such contract shall be issued to
14 any individual and dependents of such individual and any group of
15 [~~fifty~~] one hundred or fewer employees or members, exclusive of spouses
16 and dependents, or to any employee or member of the group, including
17 dependents, applying for such contract at any time throughout the year[~~,
18 and may include a pre-existing condition provision as provided for in
19 section four thousand three hundred eighteen of the insurance law,
20 provided, however, that, the~~]. An individual direct payment contract
21 shall be issued only in accordance with section four thousand three
22 hundred twenty-eight of the insurance law. The superintendent may, after
23 giving consideration to the public interest, exempt a health maintenance
24 organization from the requirements of this section provided that another
25 health insurer or health maintenance organization within the health
26 maintenance organization's same holding company system, as defined in
27 article fifteen of the insurance law, including a health maintenance
28 organization operated as a line of business of a health service corpo-
29 ration licensed under article forty-three of the insurance law, offers
30 coverage that, at a minimum, complies with this section and provides all
31 of the consumer protections required to be provided by a health mainte-
32 nance organization pursuant to this chapter and regulations, including
33 those consumer protections contained in sections four thousand four
34 hundred three and four thousand four hundred eight-a of this chapter.

35 The requirements shall not apply to a health maintenance organization
36 exclusively serving individuals enrolled pursuant to title eleven of
37 article five of the social services law, title eleven-D of article five
38 of the social services law, title one-A of article twenty-five of [~~the
39 public health law~~] this chapter or title eighteen of the federal Social
40 Security Act, and, further provided, that such health maintenance organ-
41 ization shall not discontinue a contract for an individual receiving
42 comprehensive-type coverage in effect prior to January first, two thou-
43 sand four who is ineligible to purchase policies offered after such date
44 pursuant to this section or section four thousand three hundred [~~twen-
45 ty-two of this article~~] twenty-eight of the insurance law due to the
46 provision of 42 U.S.C. 1395ss in effect prior to January first, two
47 thousand four. [~~Subject to the creditable coverage requirements of
48 subsection (a) of section four thousand three hundred eighteen of the
49 insurance law, the organization may, as an alternative to the use of a
50 pre-existing condition provision, elect to offer contracts without a
51 pre-existing condition provision to such groups but may require that
52 coverage shall not become effective until after a specified affiliation
53 period of not more than sixty days after the application for coverage is
54 submitted. The organization is not required to provide health care
55 services or benefits during such period and no premium shall be charged
56 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. § 300gg-41(b), impose any pre-existing condition exclusion.]~~

§ 12. This act shall take effect immediately, provided that:

(1) sections one, three, four, five, six, eight and nine of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after January 1, 2020; and

(2) sections two and seven of this act shall take effect on the same date as the reversion of paragraph 1 of subsection (g) of section 3231 and paragraph 1 of subsection (d) of section 4317 of the insurance law, as provided in section 5 of chapter 588 of the laws of 2015, as amended.

SUBPART B

Section 1. Subparagraph (A) of paragraph 5 of subsection (c) of section 3216 of the insurance law, as amended by chapter 388 of the laws of 2014, is amended to read as follows:

(A) Any family policy providing hospital or surgical expense insurance (but not including such insurance against accidental injury only) shall provide that, in the event such insurance on any person, other than the policyholder, is terminated because the person is no longer within the definition of the family as set forth in the policy but before such person has attained the limiting age, if any, for coverage of adults specified in the policy, such person shall be entitled to have issued to that person by the insurer, without evidence of insurability, upon application therefor and payment of the first premium, within sixty days after such insurance shall have terminated, an individual conversion policy that contains the essential health benefits package described in paragraph ~~[one]~~ three of subsection ~~[(b)]~~ (f) of section ~~[four thousand three hundred twenty eight of this chapter. The insurer shall offer one policy at each level of coverage as defined in section 1302(d) of the affordable care act, 42 U.S.C. § 18022(d).]~~ three thousand two hundred seventeen-i of this article. The insurer shall offer one policy at each level of coverage as defined in subsection (c) of section three thousand two hundred seventeen-i of this article. The individual may choose any such policy offered by the insurer. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of this subparagraph through the offering of policies that comply with this subparagraph by another insurer, corporation or health maintenance organization within the insurer's holding company system, as defined in article fifteen of this chapter. The conversion privilege afforded herein shall also be available upon the divorce or annulment of the marriage of the policyholder to the former spouse of such policyholder.

§ 2. Subparagraph (E) of paragraph 2 of subsection (g) of section 3216 of the insurance law, as added by chapter 388 of the laws of 2014, is amended to read as follows:

(E) The superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of subparagraph (C) of this paragraph through the offering of policies at each level of coverage as defined in subsection (c) of section ~~[1302(d) of the affordable care act, 42 U.S.C. § 18022(d).]~~ three thousand two hundred seventeen-i of this article that

1 contains the essential health benefits package described in paragraph
2 ~~[one] three~~ of subsection ~~[(b)] (f)~~ of section ~~[four thousand three~~
3 ~~hundred twenty-eight of this chapter]~~ three thousand two hundred seven-
4 teen-i of this article by another insurer, corporation or health mainte-
5 nance organization within the insurer's same holding company system, as
6 defined in article fifteen of this chapter.

7 § 3. Items (i) and (ii) of subparagraph (D) of paragraph 11 of
8 subsection (i) of section 3216 of the insurance law, as added by chapter
9 219 of the laws of 2011, are amended, and a new item (iii) is added to
10 read as follows:

11 (i) evidence-based items or services for mammography that have in
12 effect a rating of 'A' or 'B' in the current recommendations of the
13 United States preventive services task force; ~~[and]~~

14 (ii) with respect to women, such additional preventive care and
15 screenings for mammography not described in item (i) of this subpara-
16 graph and as provided for in comprehensive guidelines supported by the
17 health resources and services administration~~[-]; and~~

18 (iii) any other preventive care and screenings designated by the
19 superintendent in a regulation that are consistent with current or
20 previous recommendations or guidelines identified in items (i) and (ii)
21 of this subparagraph.

22 § 4. Items (i) and (ii) of subparagraph (D) of paragraph 15 of
23 subsection (i) of section 3216 of the insurance law, as added by chapter
24 219 of the laws of 2011, are amended, and a new item (iii) is added to
25 read as follows:

26 (i) evidence-based items or services for cervical cytology that have
27 in effect a rating of 'A' or 'B' in the current recommendations of the
28 United States preventive services task force; ~~[and]~~

29 (ii) with respect to women, such additional preventive care and
30 screenings for cervical cytology not described in item (i) of this
31 subparagraph and as provided for in comprehensive guidelines supported
32 by the health resources and services administration~~[-]; and~~

33 (iii) any other preventive care and screenings designated by the
34 superintendent in a regulation that are consistent with current or
35 previous recommendations or guidelines identified in items (i) and (ii)
36 of this subparagraph.

37 § 5. Items (iii) and (iv) of subparagraph (E) of paragraph 17 of
38 subsection (i) of section 3216 of the insurance law, as added by chapter
39 219 of the laws of 2011, are amended and a new item (v) is added to read
40 as follows:

41 (iii) with respect to children, including infants and adolescents,
42 evidence-informed preventive care and screenings provided for in compre-
43 hensive guidelines supported by the health resources and services admin-
44 istration; ~~[and]~~

45 (iv) with respect to women, such additional preventive care and
46 screenings not described in item (i) of this subparagraph and as
47 provided for in comprehensive guidelines supported by the health
48 resources and services administration~~[-]; and~~

49 (v) any other preventive care and screenings designated by the super-
50 intendent in a regulation that are consistent with current or previous
51 recommendations or guidelines identified in items (i) through (iv) of
52 this subparagraph.

53 § 6. Paragraph 21 of subsection (i) of section 3216 of the insurance
54 law, as amended by chapter 469 of the laws of 2018, is amended to read
55 as follows:

(21) Every policy ~~[which]~~ that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas ~~[which]~~ that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein ~~[or which]~~, contain modified protein, or are amino acid based ~~[which]~~ that are medically necessary~~[, and such coverage for such modified solid food products for any calendar year or for any continuous period of twelve months for any insured individual shall not exceed two thousand five hundred dollars]~~.

§ 7. Paragraph 30 of subsection (i) of section 3216 of the insurance law, as amended by chapter 377 of the laws of 2014, is amended to read as follows:

(30) Every policy ~~[which]~~ that provides medical coverage that includes coverage for physician services in a physician's office and every policy ~~[which]~~ that 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]~~ defined in subsection (a) of section [2707 (a) of the public health services act 42 U.S.C. 300 gg-6(a)] three thousand two hundred seventeen-i of this article.

§ 8. Subsection (1) of section 3216 of the insurance law, as added by section 42 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) ~~[On and after October first, two thousand thirteen, an]~~ An insurer shall not offer individual hospital, medical or surgical expense insurance policies unless the policies meet the requirements of subsection (b) of section four thousand three hundred twenty-eight of this chapter. Such policies that are offered within the health benefit exchange established ~~[pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, or any regulations promulgated thereunder,]~~ by this state also shall meet any requirements established by the health benefit exchange.

§ 9. Subsection (m) of section 3216 of the insurance law, as added by section 53 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(m) An insurer shall not be required to offer the policyholder any benefits that must be made available pursuant to this section if the benefits must be covered as essential health benefits. For any policy issued within the health benefit exchange established [~~pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031~~] by this state, an insurer shall not be required to offer the policyholder any benefits that must be made available pursuant to this section. For purposes of this subsection, "essential health benefits" shall have the meaning set forth in subsection (a) of section [1302(b) of the affordable care act, 42 U.S.C. § 18022(b)] three thousand two hundred seven-teen-i of this article.

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

§ 3217-i. Essential health benefits package and limit on cost-sharing.
(a) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

(1) ambulatory patient services;
(2) emergency services;
(3) hospitalization;
(4) maternity and newborn care;
(5) mental health and substance use disorder services, including behavioral health treatment;
(6) prescription drugs;
(7) rehabilitative and habilitative services and devices;
(8) laboratory services;
(9) preventive and wellness services and chronic disease management;
and
(10) pediatric services, including oral and vision care.

(b) The superintendent, in consultation with the commissioner of health, may select as a benchmark, a plan or combination of plans that together contain essential health benefits, in accordance with this section and any applicable federal regulation.

(c) (1) Every individual and small group accident and health insurance policy that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan shall provide coverage that meets the actuarial requirements of one of the following levels of coverage:

(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; or

(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) The superintendent may provide for a variation in the actuarial values used in determining the level of coverage of a plan to account for the differences in actuarial estimates.

(3) Every student accident and health insurance policy shall provide coverage that meets at least sixty percent of the full actuarial value of the benefits provided under the policy. The policy's schedule of benefits shall include the level as described in paragraph one of this subsection nearest to, but below the actual actuarial value.

(d) Every individual or group accident and health insurance policy that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan, and every student accident and health insurance policy shall limit the insured's cost-sharing for in-network services in a policy year to not more than the maximum out-of-pocket amount determined by the superintendent for all policies subject to this section. Such amount shall not exceed any annual out-of-pocket limit on cost-sharing set by the United States secretary of health and human services, if available.

(e) The superintendent may require the use of model language describing the coverage requirements for any accident and health insurance policy form that is subject to the superintendent's approval pursuant to section three thousand two hundred one of this article.

(f) For purposes of this section:

(1) "actuarial value" means the percentage of the total expected payments by the insurer for benefits provided to a standard population, without regard to the population to whom the insurer actually provides benefits;

(2) "cost-sharing" means annual deductibles, coinsurance, copayments, or similar charges, for covered services;

(3) "essential health benefits package" means coverage that:

(A) provides for essential health benefits;

(B) limits cost-sharing for such coverage in accordance with subsection (d) of this section; and

(C) provides one of the levels of coverage described in subsection (c) of this section;

(4) "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);

(5) "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

(6) "student accident and health insurance" shall have the meaning set forth in subsection (a) of section three thousand two hundred forty of this article.

§ 11. Subsection (g) of section 3221 of the insurance law, as amended by chapter 388 of the laws of 2014, is amended to read as follows:

(g) For conversion purposes, an insurer shall offer to the employee or member a policy at each level of coverage as defined in subsection (c) of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)] three thousand two hundred seventeen-i of this article that contains the essential health benefits package described in paragraph [one] three of subsection [(b)] (f) of section [four thousand three hundred twenty-eight of this chapter] three thousand two hundred seventeen-i of this article. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of this subsection

1 and subsections (e) and (f) of this section through the offering of
2 policies that comply with this subsection by another insurer, corpo-
3 ration or health maintenance organization within the insurer's holding
4 company system, as defined in article fifteen of this chapter.

5 § 12. Subsection (h) of section 3221 of the insurance law, as added by
6 section 54 of part D of chapter 56 of the laws of 2013, is amended to
7 read as follows:

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

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

18 (2) "grandfathered health plan" means coverage provided by an insurer
19 in which an individual was enrolled on March twenty-third, two thousand
20 ten for as long as the coverage maintains grandfathered status in
21 accordance with section 1251(e) of the affordable care act, 42 U.S.C. §
22 18011(e);

23 (3) "small group" means a group of ~~[fifty or fewer employees or~~
24 ~~members exclusive of spouses and dependents; provided, however, that~~
25 ~~beginning January first, two thousand sixteen, "small group" means a~~
26 ~~group of]~~ one hundred or fewer employees or members exclusive of spouses
27 and dependents; and

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

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

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

34 § 13. Subsection (i) of section 3221 of the insurance law, as added by
35 section 54 of part D of chapter 56 of the laws of 2013, is amended to
36 read as follows:

37 (i) An insurer shall not be required to offer the policyholder any
38 benefits that must be made available pursuant to this section if the
39 benefits must be covered pursuant to subsection (h) of this section. For
40 any policy issued within the health benefit exchange established ~~[pursu-~~
41 ~~ant to section 1311 of the affordable care act, 42 U.S.C. § 18031]~~ by
42 this state, an insurer shall not be required to offer the policyholder
43 any benefits that must be made available pursuant to this section.

44 § 14. Paragraph 11 of subsection (k) of section 3221 of the insurance
45 law, as amended by chapter 469 of the laws of 2018, is amended to read
46 as follows:

47 (11) Every policy ~~[which]~~ that provides coverage for prescription
48 drugs shall include coverage for the cost of enteral formulas for home
49 use, whether administered orally or via tube feeding, for which a physi-
50 cian or other licensed health care provider legally authorized to
51 prescribe under title eight of the education law has issued a written
52 order. Such written order shall state that the enteral formula is clear-
53 ly medically necessary and has been proven effective as a disease-spe-
54 cific treatment regimen. Specific diseases and disorders for which
55 enteral formulas have been proven effective shall include, but are not
56 limited to, inherited diseases of amino-acid or organic acid metabolism;

1 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
2 motility such as chronic intestinal pseudo-obstruction; and multiple,
3 severe food allergies including, but not limited to immunoglobulin E and
4 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
5 food protein induced enterocolitis syndrome; eosinophilic disorders and
6 impaired absorption of nutrients caused by disorders affecting the
7 absorptive surface, function, length, and motility of the gastrointesti-
8 nal tract. Enteral formulas ~~[which]~~ that are medically necessary and
9 taken under written order from a physician for the treatment of specific
10 diseases shall be distinguished from nutritional supplements taken elec-
11 tively. Coverage for certain inherited diseases of amino acid and organ-
12 ic acid metabolism as well as severe protein allergic conditions shall
13 include modified solid food products that are low protein ~~[or which]~~,
14 contain modified protein, or are amino acid based ~~[which]~~ that are
15 medically necessary~~[, and such coverage for such modified solid food~~
16 ~~products for any calendar year or for any continuous period of twelve~~
17 ~~months for any insured individual shall not exceed two thousand five~~
18 ~~hundred dollars]~~.

19 § 15. Items (i) and (ii) of subparagraph (D) of paragraph 13 of
20 subsection (k) of section 3221 of the insurance law, as added by chapter
21 219 of the laws of 2011, are amended and a new item (iii) is added to
22 read as follows:

23 (i) evidence-based items or services for bone mineral density that
24 have in effect a rating of 'A' or 'B' in the current recommendations of
25 the United States preventive services task force; ~~[and]~~

26 (ii) with respect to women, such additional preventive care and
27 screenings for bone mineral density not described in item (i) of this
28 subparagraph and as provided for in comprehensive guidelines supported
29 by the health resources and services administration~~[-]; and~~

30 (iii) any other preventive care and screenings designated by the
31 superintendent in a regulation that are consistent with current or
32 previous recommendations or guidelines identified in items (i) and (ii)
33 of this subparagraph.

34 § 16. Paragraph 19 of subsection (k) of section 3221 of the insurance
35 law, as amended by chapter 377 of the laws of 2014, is amended to read
36 as follows:

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

52 § 17. Items (iii) and (iv) of subparagraph (E) of paragraph 8 of
53 subsection (l) of section 3221 of the insurance law, as added by chapter
54 219 of the laws of 2011, are amended and a new item (v) is added to read
55 as follows:

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; ~~and~~

(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration~~[-]; and~~

(v) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in items (i) through (iv) of this subparagraph.

§ 18. Items (i) and (ii) of subparagraph (D) of paragraph 11 of subsection (l) of section 3221 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new item (iii) is added to read as follows:

(i) evidence-based items or services for mammography that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; ~~and~~

(ii) with respect to women, such additional preventive care and screenings for mammography not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration~~[-]; and~~

(iii) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in items (i) and (ii) of this subparagraph.

§ 19. Items (i) and (ii) of subparagraph (D) of paragraph 14 of subsection (l) of section 3221 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new item (iii) is added to read as follows:

(i) evidence-based items or services for cervical cytology that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; ~~and~~

(ii) with respect to women, such additional preventive care and screenings for cervical cytology not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration~~[-]; and~~

(iii) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in items (i) and (ii) of this subparagraph.

§ 20. Paragraph 4 of subsection (a) of section 3231 of the insurance law, as amended by section 69 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy form is the same based on the experience of the entire pool of risks of all individuals or small groups covered by the insurer without regard to age, sex, health status, tobacco usage or occupation, excluding those individuals or small groups covered by medicare supplemental insurance. For medicare supplemental insurance coverage, "community rated" means a rating methodology in which the premiums for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, tobacco usage or occupation.

~~[Catastrophic health insurance policies issued pursuant to section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e), shall be classified in a distinct community rating pool.]~~

§ 21. 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 subsection (a) of section [1302(b) of the affordable care act, 42 U.S.C. § 18022(b)] three thousand two hundred seventeen-i or subsection (a) of section four thousand three hundred six-h of this chapter, as applicable.

§ 22. Subparagraph (A) of paragraph 3 of subsection (d) of section 4235 of the insurance law, as added by section 60 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(A) "employee" shall have the meaning set forth in ~~[section 2701 of the public health service act, 42 U.S.C. § 300gg-01(d)(5) or any regulations promulgated thereunder]~~ the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(6); and

§ 23. Subparagraphs (C) and (D) of paragraph 3 of subsection (j) of section 4303 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new subparagraph (E) is added to read as follows:

(C) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; ~~[and]~~

(D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration~~[-]; and~~

(E) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in subparagraphs (A) through (D) of this paragraph.

§ 24. Subparagraphs (A) and (B) of paragraph 3 of subsection (p) of section 4303 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new subparagraph (C) is added to read as follows:

(A) evidence-based items or services for mammography that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; ~~[and]~~

(B) with respect to women, such additional preventive care and screenings for mammography not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration~~[-]; and~~

(C) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in subparagraphs (A) and (B) of this paragraph.

§ 25. Subparagraphs (A) and (B) of paragraph 3 of subsection (t) of section 4303 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new subparagraph (C) is added to read as follows:

1 (A) evidence-based items or services for cervical cytology that have
2 in effect a rating of 'A' or 'B' in the current recommendations of the
3 United States preventive services task force; ~~and~~

4 (B) with respect to women, such additional preventive care and screen-
5 ings for cervical cytology not described in subparagraph (A) of this
6 paragraph and as provided for in comprehensive guidelines supported by
7 the health resources and services administration~~[-]~~; ~~and~~

8 (C) any other preventive care and screenings designated by the super-
9 intendent in a regulation that are consistent with current or previous
10 recommendations or guidelines identified in subparagraphs (A) and (B) of
11 this paragraph.

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

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

29 § 27. Subsection (y) of section 4303 of the insurance law, as amended
30 by chapter 469 of the laws of 2018, is amended to read as follows:

31 (y) Every contract ~~[which]~~ that provides coverage for prescription
32 drugs shall include coverage for the cost of enteral formulas for home
33 use, whether administered orally or via tube feeding, for which a physi-
34 cian or other licensed health care provider legally authorized to
35 prescribe under title eight of the education law has issued a written
36 order. Such written order shall state that the enteral formula is clear-
37 ly medically necessary and has been proven effective as a disease-spe-
38 cific treatment regimen. Specific diseases and disorders for which
39 enteral formulas have been proven effective shall include, but are not
40 limited to, inherited diseases of amino-acid or organic acid metabolism;
41 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
42 motility such as chronic intestinal pseudo-obstruction; and multiple,
43 severe food allergies including, but not limited to immunoglobulin E and
44 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
45 food protein induced enterocolitis syndrome; eosinophilic disorders; and
46 impaired absorption of nutrients caused by disorders affecting the
47 absorptive surface, function, length, and motility of the gastrointesti-
48 nal tract. Enteral formulas ~~[which]~~ that are medically necessary and
49 taken under written order from a physician for the treatment of specific
50 diseases shall be distinguished from nutritional supplements taken elec-
51 tively. Coverage for certain inherited diseases of amino acid and organ-
52 ic acid metabolism as well as severe protein allergic conditions shall
53 include modified solid food products that are low protein, ~~[or which]~~
54 contain modified protein, or are amino acid based ~~[which]~~ that are
55 medically necessary~~[-, and such coverage for such modified solid food~~
56 ~~products for any calendar year or for any continuous period of twelve~~

~~months for any insured individual shall not exceed two thousand five hundred dollars~~].

§ 28. Subparagraphs (A) and (B) of paragraph 4 of subsection (bb) of section 4303 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new subparagraph (C) is added to read as follows:

(A) evidence-based items or services for bone mineral density that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force; ~~and~~

(B) with respect to women, such additional preventive care and screenings for bone mineral density not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration~~[-]~~; and

(C) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in subparagraphs (A) and (B) of this paragraph.

§ 29. Subsection (ll) of section 4303 of the insurance law, as added by section 55 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(ll) Every small group contract or association group contract ~~[delivered or issued for delivery in this state]~~ issued by a corporation subject to the provisions of this article 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]~~ benefits package ~~[as required in section 2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)]~~. For purposes of this subsection:

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

(2) "grandfathered health plan" means coverage provided by a corporation 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); and

(3) "small group" means a group of ~~[fifty or fewer employees or members exclusive of spouses and dependents. 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.

§ 30. Subsection (mm) of section 4303 of the insurance law, as added by section 55 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(mm) A corporation shall not be required to offer the contract holder any benefits that must be made available pursuant to this section if such benefits must be covered pursuant to subsection (kk) of this section. For any contract issued within the health benefit exchange established ~~[pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031]~~ by this state, a corporation shall not be required to

1 offer the contract holder any benefits that must be made available
2 pursuant to this section.

3 § 31. Item (i) of subparagraph (C) of paragraph 2 of subsection (c) of
4 section 4304 of the insurance law, as amended by chapter 317 of the laws
5 of 2017, is amended to read as follows:

6 (i) Discontinuance of a class of contract upon not less than ninety
7 days' prior written notice. In exercising the option to discontinue
8 coverage pursuant to this item, the corporation must act uniformly with-
9 out regard to any health status-related factor of enrolled individuals
10 or individuals who may become eligible for such coverage and must offer
11 to subscribers or group remitting agents, as may be appropriate, the
12 option to purchase all other individual health insurance coverage
13 currently being offered by the corporation to applicants in that market.
14 Provided, however, the superintendent may, after giving due consider-
15 ation to the public interest, approve a request made by a corporation
16 for the corporation to satisfy the requirements of this item through the
17 offering of contracts at each level of coverage as defined in subsection
18 (c) of section [1302(d) of the affordable care act, 42 U.S.C. §
19 18022(d)] four thousand three hundred six-h of this article that
20 contains the essential health benefits package described in paragraph
21 [one] three of subsection [(b)] (f) of section four thousand three
22 hundred [twenty-eight] six-h of this [chapter] article by another corpo-
23 ration, insurer or health maintenance organization within the corpo-
24 ration's same holding company system, as defined in article fifteen of
25 this chapter.

26 § 32. Paragraph 1 of subsection (e) of section 4304 of the insurance
27 law, as amended by chapter 388 of the laws of 2014, is amended to read
28 as follows:

29 (1) (A) If any such contract is terminated in accordance with the
30 provisions of paragraph one of subsection (c) of this section, or any
31 such contract is terminated because of a default by the remitting agent
32 in the payment of premiums not cured within the grace period and the
33 remitting agent has not replaced the contract with similar and contin-
34 uous coverage for the same group whether insured or self-insured, or any
35 such contract is terminated in accordance with the provisions of subpar-
36 agraph (E) of paragraph two of subsection (c) of this section, or if an
37 individual other than the contract holder is no longer covered under a
38 "family contract" because the individual is no longer within the defi-
39 nition set forth in the contract, or a spouse is no longer covered under
40 the contract because of divorce from the contract holder or annulment of
41 the marriage, or any such contract is terminated because of the death of
42 the contract holder, then such individual, former spouse, or in the case
43 of the death of the contract holder the surviving spouse or other depen-
44 dents of the deceased contract holder covered under the contract, as the
45 case may be, shall be entitled to convert, without evidence of insura-
46 bility, upon application therefor and the making of the first payment
47 thereunder within sixty days after the date of termination of such
48 contract, to a contract that contains the essential health benefits
49 package described in paragraph [one] three of subsection [(b)] (f) of
50 section four thousand three hundred [twenty-eight] six-h of this [chap-
51 ter] article.

52 (B) The corporation shall offer one contract at each level of coverage
53 as defined in subsection (c) of section [1302(d) of the affordable care
54 act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this
55 article. The individual may choose any such contract offered by the
56 corporation. Provided, however, the superintendent may, after giving due

1 consideration to the public interest, approve a request made by a corpo-
2 ration for the corporation to satisfy the requirements of this paragraph
3 through the offering of contracts that comply with this paragraph by
4 another corporation, insurer or health maintenance organization within
5 the corporation's same holding company system, as defined in article
6 fifteen of this chapter.

7 (C) The effective date of the coverage provided by the converted
8 direct payment contract shall be the date of the termination of coverage
9 under the contract from which conversion was made.

10 § 33. Subsection (l) of section 4304 of the insurance law, as added by
11 section 43 of part D of chapter 56 of the laws of 2013, is amended to
12 read as follows:

13 (l) ~~[On and after October first, two thousand thirteen, a]~~ A corpo-
14 ration shall not offer individual hospital, medical, or surgical expense
15 insurance contracts unless the contracts meet the requirements of
16 subsection (b) of section four thousand three hundred twenty-eight of
17 this article. Such contracts that are offered within the health benefit
18 exchange established ~~[pursuant to section 1311 of the affordable care~~
19 ~~act, 42 U.S.C. § 18031, or any regulations promulgated thereunder,]~~ by
20 this state also shall meet any requirements established by the health
21 benefit exchange. To the extent that a holder of a special purpose
22 certificate of authority issued pursuant to section four thousand four
23 hundred three-a of the public health law offers individual hospital,
24 medical, or surgical expense insurance contracts, the contracts shall
25 meet the requirements of subsection (b) of section four thousand three
26 hundred twenty-eight of this article.

27 § 34. Subparagraph (A) of paragraph 1 of subsection (d) of section
28 4305 of the insurance law, as amended by chapter 388 of the laws of
29 2014, is amended to read as follows:

30 (A) A group contract issued pursuant to this section shall contain a
31 provision to the effect that in case of a termination of coverage under
32 such contract of any member of the group because of (i) termination for
33 any reason whatsoever of the member's employment or membership, or (ii)
34 termination for any reason whatsoever of the group contract itself
35 unless the group contract holder has replaced the group contract with
36 similar and continuous coverage for the same group whether insured or
37 self-insured, the member shall be entitled to have issued to the member
38 by the corporation, without evidence of insurability, upon application
39 therefor and payment of the first premium made to the corporation within
40 sixty days after termination of the coverage, an individual direct
41 payment contract, covering such member and the member's eligible depen-
42 dents who were covered by the group contract, which provides coverage
43 that contains the essential health benefits package described in para-
44 graph ~~[one]~~ three of subsection ~~[(b)]~~ (f) of section four thousand three
45 hundred ~~[twenty-eight]~~ six-h of this ~~[chapter]~~ article. The corporation
46 shall offer one contract at each level of coverage as defined in
47 subsection (c) of section ~~[1302(d) of the affordable care act, 42 U.S.C.~~
48 ~~§ 18022(d)]~~ four thousand three hundred six-h of this article. The
49 member may choose any such contract offered by the corporation.
50 Provided, however, the superintendent may, after giving due consider-
51 ation to the public interest, approve a request made by a corporation
52 for the corporation to satisfy the requirements of this subparagraph
53 through the offering of contracts that comply with this subparagraph by
54 another corporation, insurer or health maintenance organization within
55 the corporation's same holding company system, as defined in article
56 fifteen of this chapter.

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

3 § 4306-h. Essential health benefits package and limit on cost-sharing.

4 (a) For purposes of this article, "essential health benefits" shall mean
5 the following categories of benefits:

6 (1) ambulatory patient services;

7 (2) emergency services;

8 (3) hospitalization;

9 (4) maternity and newborn care;

10 (5) mental health and substance use disorder services, including
11 behavioral health treatment;

12 (6) prescription drugs;

13 (7) rehabilitative and habilitative services and devices;

14 (8) laboratory services;

15 (9) preventive and wellness services and chronic disease management;
16 and

17 (10) pediatric services, including oral and vision care.

18 (b) The superintendent, in consultation with the commissioner of
19 health, may select as a benchmark, a plan or combination of plans that
20 together contain essential health benefits, in accordance with this
21 section and any applicable federal regulation.

22 (c) (1) Every individual and small group contract that provides hospi-
23 tal, surgical, or medical expense coverage and is not a grandfathered
24 health plan shall provide coverage that meets the actuarial requirements
25 of one of the following levels of coverage:

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

30 (B) Silver Level. A plan in the silver level shall provide a level of
31 coverage that is designed to provide benefits that are actuarially
32 equivalent to seventy percent of the full actuarial value of the bene-
33 fits provided under the plan;

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

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

42 (2) The superintendent may provide for a variation in the actuarial
43 values used in determining the level of coverage of a plan to account
44 for the differences in actuarial estimates.

45 (3) Every student accident and health insurance contract shall provide
46 coverage that meets at least sixty percent of the full actuarial value
47 of the benefits provided under the contract. The contract's schedule of
48 benefits shall include the level as described in paragraph one of this
49 subsection nearest to, but below the actual actuarial value.

50 (d) Every individual or group contract that provides hospital, surgi-
51 cal, or medical expense coverage and is not a grandfathered health plan,
52 and every student accident and health insurance contract shall limit the
53 insured's cost-sharing for in-network services in a contract year to not
54 more than the maximum out-of-pocket amount determined by the superinten-
55 dent for all contracts subject to this section. Such amount shall not

1 exceed any annual out-of-pocket limit on cost-sharing set by the United
2 States secretary of health and human services, if available.

3 (e) The superintendent may require the use of model language describ-
4 ing the coverage requirements for any form that is subject to the
5 approval of the superintendent pursuant to section four thousand three
6 hundred eight of this article.

7 (f) For purposes of this section:

8 (1) "actuarial value" means the percentage of the total expected
9 payments by the corporation for benefits provided to a standard popu-
10 lation, without regard to the population to whom the corporation actual-
11 ly provides benefits;

12 (2) "cost-sharing" means annual deductibles, coinsurance, copayments,
13 or similar charges, for covered services;

14 (3) "essential health benefits package" means coverage that:

15 (A) provides for essential health benefits;

16 (B) limits cost-sharing for such coverage in accordance with
17 subsection (d) of this section; and

18 (C) provides one of the levels of coverage described in subsection (c)
19 of this section;

20 (4) "grandfathered health plan" means coverage provided by a corpo-
21 ration in which an individual was enrolled on March twenty-third, two
22 thousand ten for as long as the coverage maintains grandfathered status
23 in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C.
24 § 18011(e);

25 (5) "small group" means a group of one hundred or fewer employees or
26 members exclusive of spouses and dependents; and

27 (6) "student accident and health insurance" shall have the meaning set
28 forth in subsection (a) of section three thousand two hundred forty of
29 this chapter.

30 § 36. Paragraph 4 of subsection (a) of section 4317 of the insurance
31 law, as amended by section 72 of part D of chapter 56 of the laws of
32 2013, is amended to read as follows:

33 (4) For the purposes of this section, "community rated" means a rating
34 methodology in which the premium for all persons covered by a policy or
35 contract form is the same, based on the experience of the entire pool of
36 risks of all individuals or small groups covered by the corporation
37 without regard to age, sex, health status, tobacco usage or occupation
38 excluding those individuals of small groups covered by Medicare supple-
39 mental insurance. For medicare supplemental insurance coverage, "commu-
40 nity rated" means a rating methodology in which the premiums for all
41 persons covered by a policy or contract form is the same based on the
42 experience of the entire pool of risks covered by that policy or
43 contract form without regard to age, sex, health status, tobacco usage
44 or occupation. [~~Catastrophic health insurance contracts issued pursuant~~
45 ~~to section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e),~~
46 ~~shall be classified in a distinct community rating pool.~~]

47 § 37. Subsections (d), (e) and (j) of section 4326 of the insurance
48 law, as amended by section 56 of part D of chapter 56 of the laws of
49 2013, are amended to read as follows:

50 (d) A qualifying group health insurance contract shall provide cover-
51 age for the essential health [~~benefit~~] benefits package as [~~required in~~]
52 defined in paragraph three of subsection (f) of section [2707(a) of the
53 public health service act, 42 U.S.C. § 300gg-6(a). For purposes of this
54 subsection "essential health benefits package" shall have the meaning
55 set forth in section 1302(a) of the affordable care act, 42 U.S.C. §
56 18022(a)] 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), 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)~~] 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[~~; 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).~~]. 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~~] by this state.

(j) [~~Beginning January first, two thousand fourteen, pursuant to section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3, a~~] A corporation shall not impose any pre-existing condition limitation in a qualifying group health insurance contract.

§ 38. Subsection (m-1) of section 4327 of the insurance law, as amended by section 58 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(m-1) In the event that the superintendent suspends the enrollment of new individuals for qualifying group health insurance contracts, the superintendent shall ensure that small employers seeking to enroll in a qualified group health insurance contract pursuant to section forty-three hundred twenty-six of this article are provided information on and directed to coverage options available through the health benefit exchange established [~~pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031~~] by this state.

§ 39. Paragraphs 1, 2 and 3 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, are 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~~] benefits package as [~~required in~~] defined in paragraph three of subsection (f) of section [~~2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a). 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)~~] four thousand three hundred six-h of this article.

(2) A health maintenance organization shall offer at least one individual enrollee direct payment contract at each level of coverage as defined in subsection (c) of section [~~1302(d) of the affordable care act, 42 U.S.C. § 18022(d)~~] four thousand three hundred six-h of this article. A health maintenance organization also shall offer one child-only plan, as required by section 1302(f) of the affordable care act, 42 U.S.C. § 18022(f), at each level of coverage [~~as required in section 2707(c) of the public health service act, 42 U.S.C. § 300gg-6(c)~~].

(3) Within the health benefit exchange established [~~pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031~~] by this

1 state, a health maintenance organization may offer an individual enrollee direct payment contract that is a catastrophic health plan as defined in section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e), or any regulations promulgated thereunder.

5 § 40. Subparagraph (A) of paragraph 4 of subsection (b) of section 4328 of the insurance law, as added by chapter 11 of the laws of 2016, is amended to read as follows:

8 (A) The individual enrollee direct payment contract offered pursuant to this section shall have the same enrollment periods, including special enrollment periods, as required for an individual direct payment contract offered within the health benefit exchange established ~~[pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, or any regulations promulgated thereunder]~~ by this state.

14 § 41. Subsection (c) 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:

17 (c) In addition to or in lieu of the individual enrollee direct payment contracts required under this section, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article may offer individual enrollee direct payment contracts within the health benefit exchange established ~~[pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, or any regulations promulgated thereunder]~~ by this state, subject to any requirements established by the health benefit exchange. If a health maintenance organization satisfies the requirements of subsection (a) of this section by offering individual enrollee direct payment contracts, only within the health benefit exchange, the health maintenance organization, not including a holder of a special purpose certificate of authority issued pursuant to section four thousand four hundred three-a of the public health law, shall also offer at least one individual enrollee direct payment contract at each level of coverage as defined in subsection (c) section [1302 (d) of the affordable care act, 42 U.S.C. § 18022 (d)] four thousand three hundred six-h of this article, outside the health benefit exchange.

35 § 42. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

SUBPART C

40 Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 35 to read as follows:

42 (35) No policy delivered or issued for delivery in this state that provides hospital, surgical, or medical expense coverage shall limit or exclude coverage for abortions that are medically necessary. Coverage for abortions that are medically necessary shall not be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan as defined in section 223(c)(2) of the internal revenue code of 1986; in which case coverage for medically necessary abortions may be subject to the plan's annual deductible.

50 § 2. Subsection (1) of section 3221 of the insurance law is amended by adding a new paragraph 21 to read as follows:

52 (21) (A) No policy delivered or issued for delivery in this state that provides hospital, surgical, or medical expense coverage shall limit or exclude coverage for abortions that are medically necessary. Coverage

1 for abortions that are medically necessary shall not be subject to annu-
2 al deductibles or coinsurance, including co-payments, unless the policy
3 is a high deductible health plan as defined in section 223(c)(2) of the
4 internal revenue code of 1986; in which case coverage for medically
5 necessary abortions may be subject to the plan's annual deductible.

6 (B) Notwithstanding any other provision, a group policy that provides
7 hospital, surgical, or medical expense coverage delivered or issued for
8 delivery in this state to a religious employer, as defined in paragraph
9 sixteen of this subsection, may exclude coverage for medically necessary
10 abortions only if the insurer:

11 (i) obtains an annual certification from the group policyholder that
12 the policyholder is a religious employer and that the religious employer
13 requests a policy without coverage for medically necessary abortions;

14 (ii) issues a rider to each certificateholder at no premium to be
15 charged to the certificateholder or religious employer for the rider,
16 that provides coverage for medically necessary abortions subject to the
17 same rules as would have been applied to the same category of treatment
18 in the policy issued to the religious employer. The rider shall clearly
19 and conspicuously specify that the religious employer does not adminis-
20 ter medically necessary abortion benefits, but that the insurer is issu-
21 ing a rider for coverage of medically necessary abortions, and shall
22 provide the insurer's contact information for questions; and

23 (iii) provides notice of the issuance of the policy and rider to the
24 superintendent in a form and manner acceptable to the superintendent.

25 § 3. Section 4303 of the insurance law is amended by adding a new
26 subsection (ss) to read as follows:

27 (ss) (1) No contract issued by a corporation subject to the provisions
28 of this article that provides hospital, surgical, or medical expense
29 coverage shall limit or exclude coverage for abortions that are
30 medically necessary. Coverage for abortions that are medically necessary
31 shall not be subject to annual deductibles or coinsurance, including
32 co-payments, unless the contract is a high deductible health plan as
33 defined in section 223(c)(2) of the internal revenue code of 1986 in
34 which case coverage for medically necessary abortions may be subject to
35 the contract's annual deductible.

36 (2) Notwithstanding any other provision, a group contract that
37 provides hospital, surgical, or medical expense coverage delivered or
38 issued for delivery in this state to a religious employer as defined in
39 subsection (cc) of this section may exclude coverage for medically
40 necessary abortions only if the corporation:

41 (A) obtains an annual certification from the group contractholder that
42 the contractholder is a religious employer and that the religious
43 employer requests a contract without coverage for medically necessary
44 abortions;

45 (B) issues a rider to each certificateholder at no premium to be
46 charged to the certificateholder or religious employer for the rider,
47 that provides coverage for medically necessary abortions subject to the
48 same rules as would have been applied to the same category of treatment
49 in the contract issued to the religious employer. The rider must clearly
50 and conspicuously specify that the religious employer does not adminis-
51 ter medically necessary abortion benefits, but that the corporation is
52 issuing a rider for coverage of medically necessary abortions, and shall
53 provide the corporation's contact information for questions; and

54 (C) provides notice of the issuance of the contract and rider to the
55 superintendent in a form and manner acceptable to the superintendent.

§ 4. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

SUBPART D

Section 1. The insurance law is amended by adding a new section 3242 to read as follows:

§ 3242. Prescription drug coverage. (a) Every insurer that delivers or issues for delivery in this state a policy that provides coverage for prescription drugs shall, with respect to the prescription drug coverage, publish an up-to-date, accurate, and complete list of all covered prescription drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a manner that is easily accessible to insureds and prospective insureds. The formulary drug list shall clearly identify the preventive prescription drugs that are available without annual deductibles or coinsurance, including co-payments.

(b) (1) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, an insurer shall follow the process and procedures specified in article forty-nine of this chapter and article forty-nine of the public health law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

(2) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request a standard review that is not based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on a standard exception request that is not based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than seventy-two hours following receipt of the request.

(C) An insurer that grants a standard exception request that is not based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills.

(D) For the purpose of this subsection, "exigent circumstances" means when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary prescription drug.

(3) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request an expedited review based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on an expedited review request based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than twenty-four hours following receipt of the request.

1 (C) An insurer that grants an exception based on exigent circumstances
2 shall provide coverage of the non-formulary prescription drug for the
3 duration of the exigent circumstances.

4 (4) An insurer that denies an exception request under paragraph two or
5 three of this subsection shall provide written notice of its determi-
6 nation to the insured or the insured's designee and the insured's
7 prescribing health care provider within three business days of receipt
8 of the exception request. The written notice shall be considered a final
9 adverse determination under section four thousand nine hundred four of
10 this chapter or section four thousand nine hundred four of the public
11 health law. Written notice shall also include the name or names of clin-
12 ically appropriate prescription drugs covered by the insurer to treat
13 the insured.

14 (5) (A) If an insurer denies a request for an exception under para-
15 graph two or three of this subsection, the insured, the insured's desig-
16 nee, or the insured's prescribing health care provider shall have the
17 right to request that such denial be reviewed by an external appeal
18 agent certified by the superintendent pursuant to section four thousand
19 nine hundred eleven of this chapter in accordance with article forty-
20 nine of this chapter or article forty-nine of the public health law.

21 (B) An external appeal agent shall make a determination on the
22 external appeal and notify the insurer, the insured or the insured's
23 designee, and the insured's prescribing health care provider by tele-
24 phone of its determination no later than seventy-two hours following the
25 external appeal agent's receipt of the request, if the original request
26 was a standard exception request under paragraph two of this subsection.
27 The external appeal agent shall notify the insurer, the insured or the
28 insured's designee, and the insured's prescribing health care provider
29 in writing of the external appeal determination within two business days
30 of rendering such determination.

31 (C) An external appeal agent shall make a determination on the
32 external appeal and notify the insurer, the insured or the insured's
33 designee, and the insured's prescribing health care provider by tele-
34 phone of its determination no later than twenty-four hours following the
35 external appeal agent's receipt of the request, if the original request
36 was an expedited exception request under paragraph three of this
37 subsection and the insured's prescribing health care provider attests
38 that exigent circumstances exist. The external appeal agent shall notify
39 the insurer, the insured or the insured's designee, and the insured's
40 prescribing health care provider in writing of the external appeal
41 determination within seventy-two hours of the external appeal agent's
42 receipt of the external appeal.

43 (D) An external appeal agent shall make a determination in accordance
44 with subparagraph (A) of paragraph four of subsection (b) of section
45 four thousand nine hundred fourteen of this chapter or subparagraph (A)
46 of paragraph (d) of subdivision two of section four thousand nine
47 hundred fourteen of the public health law. When making a determination,
48 the external appeal agent shall consider whether the formulary
49 prescription drug covered by the insurer will be or has been ineffec-
50 tive, would not be as effective as the non-formulary prescription drug,
51 or would have adverse effects.

52 (E) If an external appeal agent overturns the insurer's denial of a
53 standard exception request under paragraph two of this subsection, then
54 the insurer shall provide coverage of the non-formulary prescription
55 drug for the duration of the prescription, including refills. If an
56 external appeal agent overturns the insurer's denial of an expedited

1 exception request under paragraph three of this subsection, then the
2 insurer shall provide coverage of the non-formulary prescription drug
3 for the duration of the exigent circumstances.

4 § 2. The insurance law is amended by adding a new section 4329 to read
5 as follows:

6 § 4329. Prescription drug coverage. (a) Every corporation subject to
7 the provisions of this article that issues a contract that provides
8 coverage for prescription drugs shall, with respect to the prescription
9 drug coverage, publish an up-to-date, accurate, and complete list of all
10 covered prescription drugs on its formulary drug list, including any
11 tiering structure that it has adopted and any restrictions on the manner
12 in which a prescription drug may be obtained, in a manner that is easily
13 accessible to insureds and prospective insureds. The formulary drug list
14 shall clearly identify the preventive prescription drugs that are avail-
15 able without annual deductibles or coinsurance, including co-payments.

16 (b) (1) Every contract issued by a corporation subject to the
17 provisions of this article that provides coverage for prescription drugs
18 shall include in the contract a process that allows an insured, the
19 insured's designee, or the insured's prescribing health care provider to
20 request a formulary exception. With respect to the process for such a
21 formulary exception, a corporation shall follow the process and proce-
22 dures specified in article forty-nine of this chapter and article
23 forty-nine of the public health law, except as otherwise provided in
24 paragraphs two, three, four and five of this subsection.

25 (2) (A) A corporation shall have a process for an insured, the
26 insured's designee, or the insured's prescribing health care provider to
27 request a standard review that is not based on exigent circumstances of
28 a formulary exception for a prescription drug that is not covered by the
29 contract.

30 (B) A corporation shall make a determination on a standard exception
31 request that is not based on exigent circumstances and notify the
32 insured or the insured's designee and the insured's prescribing health
33 care provider by telephone of its coverage determination no later than
34 seventy-two hours following receipt of the request.

35 (C) A corporation that grants a standard exception request that is not
36 based on exigent circumstances shall provide coverage of the non-formu-
37 lary prescription drug for the duration of the prescription, including
38 refills.

39 (D) For the purpose of this subsection, "exigent circumstances" means
40 when an insured is suffering from a health condition that may seriously
41 jeopardize the insured's life, health, or ability to regain maximum
42 function or when an insured is undergoing a current course of treatment
43 using a non-formulary prescription drug.

44 (3) (A) A corporation shall have a process for an insured, the
45 insured's designee, or the insured's prescribing health care provider to
46 request an expedited review based on exigent circumstances of a formu-
47 lary exception for a prescription drug is not covered by the contract.

48 (B) A corporation shall make a determination on an expedited review
49 request based on exigent circumstances and notify the insured or the
50 insured's designee and the insured's prescribing health care provider by
51 telephone of its coverage determination no later than twenty-four hours
52 following receipt of the request.

53 (C) A corporation that grants an exception based on exigent circum-
54 stances shall provide coverage of the non-formulary prescription drug
55 for the duration of the exigent circumstances.

1 (4) A corporation that denies an exception request under paragraph two
2 or three of this subsection shall provide written notice of its determi-
3 nation to the insured or the insured's designee and the insured's
4 prescribing health care provider within three business days of receipt
5 of the exception request. The written notice shall be considered a final
6 adverse determination under section four thousand nine hundred four of
7 this chapter or section four thousand nine hundred four of the public
8 health law. Written notice shall also include the name or names of clin-
9 ically appropriate prescription drugs covered by the corporation to
10 treat the insured.

11 (5) (A) If a corporation denies a request for an exception under para-
12 graph two or three of this subsection, the insured, the insured's desig-
13 nee, or the insured's prescribing health care provider shall have the
14 right to request that such denial be reviewed by an external appeal
15 agent certified by the superintendent pursuant to section four thousand
16 nine hundred eleven of this chapter in accordance with article forty-
17 nine of this chapter and article forty-nine of the public health law.

18 (B) An external appeal agent shall make a determination on the
19 external appeal and notify the corporation, the insured or the insured's
20 designee, and the insured's prescribing health care provider by tele-
21 phone of its determination no later than seventy-two hours following the
22 external appeal agent's receipt of the request, if the original request
23 was a standard exception request under paragraph two of this subsection.
24 The external appeal agent shall notify the corporation, the insured or
25 the insured's designee and the insured's prescribing health care provid-
26 er in writing of the external appeal determination within two business
27 days of rendering such determination.

28 (C) An external appeal agent shall make a determination on the
29 external appeal and notify the corporation, the insured or the insured's
30 designee, and the insured's prescribing health care provider by tele-
31 phone of its determination no later than twenty-four hours following the
32 external appeal agent's receipt of the request, if the original request
33 was an expedited exception request under paragraph three of this
34 subsection and the insured's prescribing health care provider attests
35 that exigent circumstances exist. The external appeal agent shall notify
36 the corporation, the insured or the insured's designee and the insured's
37 prescribing health care provider in writing of the external appeal
38 determination within seventy-two hours of the external appeal agent's
39 receipt of the external appeal.

40 (D) An external appeal agent shall make a determination in accordance
41 with subparagraph (A) of paragraph four of subsection (b) of section
42 four thousand nine hundred fourteen of this chapter and subparagraph (A)
43 of paragraph (d) of subdivision two of section four thousand nine
44 hundred fourteen of the public health law. When making a determination,
45 the external appeal agent shall consider whether the formulary
46 prescription drug covered by the corporation will be or has been inef-
47 fective, would not be as effective as the non-formulary prescription
48 drug, or would have adverse effects.

49 (E) If an external appeal agent overturns the corporation's denial of
50 a standard exception request under paragraph two of this subsection,
51 then the corporation shall provide coverage of the non-formulary
52 prescription drug for the duration of the prescription, including
53 refills. If an external appeal agent overturns the corporation's denial
54 of an expedited exception request under paragraph three of this
55 subsection, then the corporation shall provide coverage of the non-for-
56 mulary prescription drug for the duration of the exigent circumstances.

1 § 3. This act shall take effect on the first of January next succeed-
2 ing the date on which it shall have become a law and shall apply to all
3 policies and contracts issued, renewed, modified, altered or amended on
4 or after such date.

5 SUBPART E

6 Section 1. Section 2607 of the insurance law is amended to read as
7 follows:

8 § 2607. Discrimination because of sex or marital status. (a) No indi-
9 vidual or entity shall refuse to issue any policy of insurance, or
10 cancel or decline to renew [such] the policy because of the sex or mari-
11 tal status of the applicant or policyholder or engage in sexual stere-
12 otyping.

13 (b) For the purposes of this section, "sex" shall include sexual
14 orientation, gender identity or expression, and transgender status.

15 § 2. The insurance law is amended by adding a new section 3243 to read
16 as follows:

17 § 3243. Discrimination because of sex or marital status in hospital,
18 surgical or medical expense insurance. (a) With regard to an accident
19 and health insurance policy that provides hospital, surgical, or medical
20 expense coverage or a policy of student accident and health insurance,
21 as defined in subsection (a) of section three thousand two hundred forty
22 of this article, delivered or issued for delivery in this state, no
23 insurer shall because of sex, marital status or based on pregnancy,
24 false pregnancy, termination of pregnancy, or recovery therefrom, child-
25 birth or related medical conditions:

26 (1) make any distinction or discrimination between persons as to the
27 premiums or rates charged for the policy or in any other manner whatev-
28 er;

29 (2) demand or require a greater premium from any person than it
30 requires at that time from others in similar cases;

31 (3) make or require any rebate, discrimination or discount upon the
32 amount to be paid or the service to be rendered on any policy;

33 (4) insert in the policy any condition, or make any stipulation,
34 whereby the insured binds his or herself, or his or her heirs, execu-
35 tors, administrators or assigns, to accept any sum or service less than
36 the full value or amount of such policy in case of a claim thereon
37 except such conditions and stipulations as are imposed upon others in
38 similar cases; and any such stipulation or condition so made or inserted
39 shall be void;

40 (5) reject any application for a policy issued or sold by it;

41 (6) cancel or refuse to issue, renew or sell such policy after appro-
42 priate application therefor;

43 (7) fix any lower rate or discriminate in the fees or commissions of
44 insurance agents or insurance brokers for writing or renewing such a
45 policy; or

46 (8) engage in sexual stereotyping.

47 (b) For the purposes of this section, "sex" shall include sexual
48 orientation, gender identity or expression, and transgender status.

49 § 3. The insurance law is amended by adding a new section 4330 to read
50 as follows:

51 § 4330. Discrimination because of sex or marital status in hospital,
52 surgical or medical expense insurance. (a) With regard to a contract
53 issued by a corporation subject to the provisions of this article that
54 provides hospital, surgical, or medical expense coverage or a contract

1 of student accident and health insurance, as defined in subsection (a)
2 of section three thousand two hundred forty of this chapter, no corpo-
3 ration shall because of sex, marital status or based on pregnancy, false
4 pregnancy, termination of pregnancy, or recovery therefrom, childbirth
5 or related medical conditions:

6 (1) make any distinction or discrimination between persons as to the
7 premiums or rates charged for the contract or in any other manner what-
8 ever;

9 (2) demand or require a greater premium from any person than it
10 requires at that time from others in similar cases;

11 (3) make or require any rebate, discrimination or discount upon the
12 amount to be paid or the service to be rendered on any contract;

13 (4) insert in the contract any condition, or make any stipulation,
14 whereby the insured binds his or herself, or his or her heirs, execu-
15 tors, administrators or assigns, to accept any sum or service less than
16 the full value or amount of such contract in case of a claim thereon
17 except such conditions and stipulations as are imposed upon others in
18 similar cases; and any such stipulation or condition so made or inserted
19 shall be void;

20 (5) reject any application for a contract issued or sold by it;

21 (6) cancel or refuse to issue, renew or sell such contract after
22 appropriate application therefor;

23 (7) fix any lower rate or discriminate in the fees or commissions of
24 insurance agents or insurance brokers for writing or renewing such a
25 contract; or

26 (8) engage in sexual stereotyping.

27 (b) For purposes of this section, "sex" shall include sexual orien-
28 tation, gender identity or expression, and transgender status.

29 § 4. This act shall take effect on the first of January next succeed-
30 ing the date on which it shall have become a law and shall apply to all
31 policies and contracts issued, renewed, modified, altered or amended on
32 or after such date.

33 SUBPART F

34 Section 1. Subparagraph (B) of paragraph 2 of subsection (b) of
35 section 1101 of the insurance law, as amended by chapter 369 of the laws
36 of 1985, is amended to read as follows:

37 (B) transactions with respect to group life, group annuity, group
38 accident and health or blanket accident and health insurance (other than
39 any transaction with respect to a group annuity contract funding indi-
40 vidual retirement accounts or individual retirement annuities, as
41 defined in section four hundred eight of the Internal Revenue Code,
42 funding annuities in accordance with subdivision (b) of section four
43 hundred three of such code or providing a plan of retirement annuities
44 under which the payments are derived wholly from funds contributed by
45 the persons covered):

46 (i) where such groups conform to the definitions of eligibility
47 contained in[+]:

48 (I) the following paragraphs of subsection (b) of section four thou-
49 sand two hundred sixteen of this chapter:

50 (aa) paragraph (1) or (2);

51 (bb) paragraph (3), if, with respect to those credit transactions
52 entered into in this state, the policy fully conforms with the require-
53 ments of sections three thousand two hundred one, three thousand two
54 hundred twenty and four thousand two hundred sixteen of this chapter; or

(cc) paragraphs (4), (5), (6), (7), (8), (9) [~~and~~ or (10)[~~-~~];
(II) the following subparagraphs of paragraph (1) of subsection (c) of section four thousand two hundred thirty-five of this chapter:

(aa) subparagraph (A), (B), (C) or (D), (except that with regard to subparagraphs (A), (B), and (D), transactions with respect to an employer that has established or participates in a fund to insure employees of an employer or an employer to whom the policy is issued, where: (aaa) the employer has its principal place of business in this state; or (bbb) the lesser of twenty-five percent of employees work in this state or twenty-five or more employers work in this state);

(bb) subparagraph (E), if, with respect to those credit transactions entered into in this state, the policy fully conforms with the requirements of sections three thousand two hundred one, three thousand two hundred twenty-one and four thousand two hundred thirty-five of this chapter;

(cc) subparagraphs (F)[~~-~~] and (G) [~~and (H)-~~];

(III) section four thousand two hundred thirty-seven (except subparagraph (B) for transactions with respect to an employer to whom the policy is issued where the employer has its principal place of business in this state or the lesser of twenty-five percent of employees work in this state or twenty-five or more employees work in this state, (C), (E), or (F) of paragraph three of subsection (a) thereof) or four thousand two hundred thirty-eight (except paragraphs six and seven of subsection (b) thereof) of this chapter; and

(ii) where the master policies or contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business;

§ 2. Items (ii) and (iii) of subparagraph (A) of paragraph 8 of subsection (b) of section 1101 of the insurance law, as added by chapter 449 of the laws of 2014, are amended to read as follows:

(ii) subparagraph (A), (B), (C), or (D) [~~(with respect to a policy issued to a trustee or trustees of a fund established or participated in by two or more employers, one or more labor unions, or by one or more employers or labor unions, provided that all such employers or labor unions are in the same industry)~~] of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter (except that with regard to subparagraphs (A), (B), and (D), transactions with respect to an employer that has established or participates in a fund to insure employees of an employer or an employer to whom the policy is issued, where: (I) the employer has its principal place of business in this state; or (II) the lesser of twenty-five percent of employees work in this state or twenty-five or more employees work in this state); or

(iii) paragraphs one, two, three or four of subsection (b) of section four thousand two hundred thirty-eight of this chapter, but not including a group annuity contract: (I) funding individual retirement accounts or individual retirement annuities, as defined in section four hundred eight of the Internal Revenue Code; (II) funding annuities in accordance with subdivision (b) of section four hundred three of such code; or (III) providing a plan of retirement annuities under which the payments are derived wholly from funds contributed by the persons covered[~~-~~];

§ 3. Subsection (b) of section 1101 of the insurance law is amended by adding a new paragraph 9 to read as follows:

(9) For purposes of this subsection, "principal place of business" shall mean the place where an employer maintains its headquarters or where the employer's high-level officers direct, control, and coordinate the business activities.

§ 4. Paragraph 1 of subsection (b) of section 3201 of the insurance law, as amended by chapter 369 of the laws of 1985, is amended to read as follows:

(1) (A) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law.

(B) A group life, group accident, group health, group accident and health, blanket accident, blanket health, or blanket accident and health insurance certificate evidencing insurance coverage on a resident of this state shall be deemed to have been delivered in this state, regardless of the place of actual delivery[~~, unless the insured group~~] or the type of group to which the group or blanket policy or contract is issued.

(C) Notwithstanding subparagraph (B) of this paragraph, a certificate shall not be deemed to have been delivered in this state when: (i) the certificate is not actually delivered in this state; (ii) the insured group is of the type described in[~~+(A)~~] section four thousand two hundred sixteen of this chapter, except paragraph four where the group policy is issued to a trustee or trustees of a fund established or participated in by two or more employers not in the same industry with respect to an employer principally located within the state, paragraph twelve, thirteen or fourteen of subsection (b) thereof; and (iii) the master policy or contract is lawfully issued without this state in a jurisdiction where the insurer is authorized to do an insurance business.

(D) Notwithstanding subparagraph (B) of this paragraph, where the master policy or contract is lawfully issued without this state in a jurisdiction where the insurer is authorized to do an insurance business, a certificate shall not be deemed to have been delivered in this state even if it is actually delivered in this state when the insured group is of the type described in:

[~~(B)~~] (i) section four thousand two hundred thirty-five of this chapter, except [~~subparagraph~~]: (I) subparagraphs (A), (B) and (D) [where the group policy is issued to a trustee or trustees of a fund established or participated in by two or more employers not in the same industry with respect to an employer principally located within the state, subparagraph] of paragraph one of subsection (c) thereof, with respect to an employer that has established or participates in a fund to insure employees of an employer or an employer to whom the policy is issued, where the employer has its principal place of business in this state or the lesser of twenty-five percent of employees work in this state or twenty-five or more employees work in this state; or (II) subparagraphs (H), (K), (L) or (M) of paragraph one of subsection (c) thereof; or

[~~(C)~~] (ii) section four thousand two hundred thirty-seven [~~+~~] of this chapter, except subparagraph (B) with respect to an employer to whom the policy is issued where the employer has its principal place of business in this state or the lesser of twenty-five percent of employees work in this state or twenty-five or more employees work in this state, (C), (E) or (F) of paragraph three of subsection (a) thereof[~~; of this chapter; and where the master policies or contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business~~].

(E)(i) With regard to any group life insurance certificate deemed to have been delivered in this state by virtue of subparagraph (B) or (C)

1 of this paragraph, the superintendent shall ~~[(i)]: (I)~~ require that the
2 premiums charged be reasonable in relation to the benefits provided,
3 except in cases where the policyholder pays the entire premium; ~~[(ii)]~~
4 (II) have power to issue regulations prescribing the required, optional
5 and prohibited provisions in such certificates; ~~[(iii)]~~ and (III) estab-
6 lish an accelerated certificate form approval procedure available to an
7 insurer ~~[which]~~ that includes a statement in its policy form submission
8 letter that it is the company's opinion that the certificate form or
9 forms comply with applicable New York law and regulations. The super-
10 intendent, upon receipt of such a filing letter, shall grant conditional
11 approval of such certificate form or forms in reliance on the aforemen-
12 tioned statement by the company upon the condition that the company will
13 retroactively modify such certificate form or forms, to the extent
14 necessary, if it is found by the superintendent that the certificate
15 form fails to comply with applicable New York laws and regulations~~[-];~~;

16 (ii) The superintendent may, with regard to the approval of any group
17 life insurance certificate deemed to have been delivered in this state
18 by virtue of subparagraph (B) or (C) of this paragraph, approve such
19 certificate if the superintendent finds that the certificate affords
20 insureds protections substantially similar to those ~~[which]~~ that have
21 been provided by certificates delivered in this state~~[-];~~ and

22 (iii) Any regulations issued by the superintendent pursuant to this
23 ~~[paragraph]~~ subparagraph may not impose stricter requirements than those
24 applicable to similar policies and certificates actually delivered in
25 this state.

26 (F)(i) A group accident, group health, group accident and health,
27 blanket accident, blanket health, or blanket accident and health insur-
28 ance certificate deemed to have been delivered in this state pursuant to
29 subparagraph (B) or (D) of this paragraph, shall be subject to the same
30 provisions of this chapter as a certificate actually delivered or issued
31 for delivery in this state.

32 (ii) An insurer shall issue to the group or person in whose name the
33 policy or contract is issued, for delivery to each member of the insured
34 group, a certificate setting forth in summary form a statement of the
35 essential features of the insurance coverage.

36 (G) For purposes of this paragraph:

37 (i) "institution of higher education" shall have the meaning set forth
38 in paragraph two of subsection (a) of section three thousand two hundred
39 forty of this article;

40 (ii) "principal place of business" shall mean the place where an
41 employer maintains its headquarters or where the employer's high-level
42 officers direct, control, and coordinate the business activities; and

43 (iii) "resident of this state" shall include a student who is enrolled
44 in an institution of higher education in this state that offers coverage
45 to the student through a group or blanket policy or contract.

46 § 5. Subparagraph (E) of paragraph 3 of subsection (a) of section 4237
47 of the insurance law is amended to read as follows:

48 (E) Under a policy or contract issued to ~~[and in the name of]~~ an
49 ~~[incorporated or unincorporated]~~ association ~~[of persons having a common~~
50 ~~interest or calling, which association shall be deemed the policyholder,~~
51 ~~having not less than fifty members, covering all the members of such~~
52 ~~association or if part or all of]~~ or the trustee or trustees of a trust
53 established, or participated in, by one or more associations, to insure
54 association members, subject to the following:

55 (i) Each association shall have:

1 (I) a minimum of two hundred insured individuals at the policy or
2 contract's date of issue;

3 (II) been organized and maintained in good faith for purposes princi-
4 pally other than that of obtaining insurance;

5 (III) been in active existence for at least two years; and

6 (IV) a constitution and by-laws that provide that:

7 (aa) the association hold regular meetings not less than annually to
8 further the purposes of the association;

9 (bb) the association collect dues or solicit contributions from
10 members; and

11 (cc) the members have voting privileges and representation on the
12 governing board and committees;

13 (ii) the premium ~~[is to be derived]~~ for the policy or contract shall
14 be paid by the association or the trustees either wholly from funds
15 contributed by the association or by the insured ~~[members and if the~~
16 ~~opportunity to take such insurance is offered to all eligible]~~ individ-
17 uals, or from funds contributed jointly by the association and insured
18 ~~[members, then such]~~ individuals. A policy ~~[must cover not less than~~
19 ~~seventy-five percent of any class or classes of members determined by~~
20 ~~conditions pertaining to membership in the association]~~ or contract on
21 which no part of the premium is to be derived from funds contributed by
22 the insured individuals specifically for their insurance shall insure
23 all eligible individuals, excluding any as to whom evidence of individ-
24 ual insurability is not satisfactory to the insurer to the extent
25 permitted by law;

26 (iii) The amount of insurance under the policy or contract shall be
27 based upon some plan precluding individual selection either by the
28 insured individuals or by the association. However, with respect to an
29 association, such a plan may permit a number of selections by the asso-
30 ciation if the selections offered utilize consistent plans of insurance
31 so that the resulting plans of coverage are reasonable. Furthermore,
32 such a plan may permit a limited number of selections by insured indi-
33 viduals if the selections offered utilize consistent plans of insurance
34 for insured individuals so that the resulting plans of coverage are
35 reasonable.

36 (iv) Except as provided in subsection (b) of this section, such policy
37 or contract shall provide for the payment of benefits to the person
38 insured or to some beneficiary or beneficiaries other than the associ-
39 ation or any officials, representatives, trustees or agents thereof and
40 shall provide for the issuance of a certificate to the association for
41 delivery to the insured individual or such beneficiary, as evidence of
42 such insurance.

43 (v) The premiums charged shall be reasonable in relation to the bene-
44 fits provided.

45 § 6. Subsection (d) of section 4237-a of the insurance law, as amended
46 by chapter 599 of the laws of 2003, is amended to read as follows:

47 (d) No stop-loss insurance contract shall be delivered or issued ~~[or~~
48 ~~renewed]~~ for delivery in or outside this state by an insurer or health
49 service corporation:

50 (1) to a New York employer with one hundred or fewer employees,
51 provided that "New York employer" shall mean an employer who has at
52 least one employee that works in this state; or

53 (2) if issuance of the policy would be prohibited by section two thou-
54 sand six hundred thirteen, three thousand two hundred thirty-one, four
55 thousand three hundred seventeen or four thousand three hundred twenty
56 of this chapter.

§ 7. This act shall take effect on the one hundred eightieth day after it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date. Effective immediately:

(1) the superintendent of financial services may promulgate any rules or regulations necessary for the implementation of the provisions of this act on its effective date; and

(2) insurers may submit to the superintendent and the superintendent may approve filings necessary to comply with the provisions of this act on its effective date.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or subpart of this act shall 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, paragraph, subdivision, section or subpart thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 3. Interpretations by the superintendent. The superintendent of financial services has special expertise and experience in the regulation of insurance in this state. As such his or her interpretations of the insurance law shall be afforded the highest level of deference.

§ 4. Legislative intent. It is hereby declared to be the intent of the legislature in enacting this act, that the laws of this state provide consumer and market protections at least as robust as those under the federal Patient Protection and Affordable Care Act, public law 111-148, as that law existed and was interpreted on January 19, 2017. In addition to any other power conferred by law, the superintendent of financial services is hereby specifically empowered to promulgate regulations under, and issue interpretations of, this act as necessary to ensure that the intent of the legislature as expressed in this section is realized.

§ 5. This act shall take effect immediately provided, however, that the applicable effective date of Subparts A through F of this act shall be as specifically set forth in the last section of such Subparts.

PART K

Section 1. Subdivisions 4 and 5 of section 2999-h of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, are amended to read as follows:

4. "Qualified plaintiff" means every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefor; and (iii) has been ordered to be enrolled in the fund by a court in New York state.

~~[5. Any reference to the "department of financial services" and the "superintendent of financial services" in this title shall mean, prior to October third, two thousand eleven, respectively, the "department of insurance" and "superintendent of insurance."]~~

§ 2. Section 2999-i of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, subdivision 1 as amended by

1 section 29 of part D of chapter 56 of the laws of 2012, is amended to
2 read as follows:

3 § 2999-i. Custody and administration of the fund. 1. (a) The commis-
4 sioner of taxation and finance shall be the custodian of the fund and
5 the special account established pursuant to section ninety-nine-t of the
6 state finance law. All payments from the fund shall be made by the
7 commissioner of taxation and finance upon certificates signed by the
8 ~~[superintendent of financial services]~~ commissioner, or his or her
9 designee, as hereinafter provided. The fund shall be separate and apart
10 from any other fund and from all other state monies; provided, however,
11 that monies of the fund may be invested as set forth in paragraph (b) of
12 this subdivision. No monies from the fund shall be transferred to any
13 other fund, nor shall any such monies be applied to the making of any
14 payment for any purpose other than the purpose set forth in this title.

15 (b) Any monies of the fund not required for immediate use may, at the
16 discretion of the commissioner ~~[of financial services]~~ in consultation
17 with ~~[the commissioner of health and]~~ the director of the budget, be
18 invested by the commissioner of taxation and finance in obligations of
19 the United States or the state or obligations the principal and interest
20 of which are guaranteed by the United States or the state. The proceeds
21 of any such investment shall be retained by the fund as assets to be
22 used for the purposes of the fund.

23 2. (a) The fund shall be administered by the ~~[superintendent of finan-~~
24 ~~cial services]~~ commissioner or his or her designee in accordance with
25 the provisions of this article.

26 (b) The ~~[superintendent of financial services]~~ commissioner shall have
27 all powers necessary and proper to carry out the purposes of the fund.

28 (c) Notwithstanding any contrary provision of this section, sections
29 one hundred twelve and one hundred sixty-three of the state finance law
30 or any other contrary provision of law, the superintendent of financial
31 services is authorized to ~~[enter into a contract or contracts without a~~
32 ~~competitive bid or request for proposal process for purposes of adminis-~~
33 ~~tering the fund for the first year of its operation and in preparation~~
34 ~~therefor]~~ assign and the commissioner is authorized to receive assign-
35 ment of any and all contracts entered into by the superintendent of
36 financial services to administer the fund for periods prior to October
37 first, two thousand nineteen.

38 (d) The department ~~[of financial services and the department]~~ shall
39 post on ~~[their websites]~~ its website information about the fund~~[, eligi-~~
40 ~~bility for enrollment in the fund,]~~ and the process for enrollment in
41 the fund.

42 3. The expense of administering the fund~~[, including the expenses~~
43 ~~incurred by the department,]~~ shall be paid from the fund.

44 4. Monies for the fund will be provided pursuant to this chapter.

45 5. For the state fiscal year beginning April first, two thousand elev-
46 en and ending March thirty-first, two thousand twelve, the state fiscal
47 year beginning April first, two thousand twelve and ending March thir-
48 ty-first, two thousand thirteen, and the state fiscal year beginning
49 April first, two thousand thirteen and ending March thirty-first, two
50 thousand fourteen, the superintendent of financial services shall cause
51 to be deposited into the fund for each such fiscal year the amount
52 appropriated for such purpose. Beginning April first, two thousand four-
53 teen and annually thereafter, the superintendent of financial services
54 or the commissioner, whoever is administering the fund for the applica-
55 ble period shall cause to be deposited into the fund, subject to avail-
56 able appropriations, an amount equal to the difference between the

1 amount appropriated to the fund in the preceding fiscal year, as
2 increased by the adjustment factor defined in subdivision seven of this
3 section, and the assets of the fund at the conclusion of that fiscal
4 year.

5 6. (a) Following the deposit referenced in subdivision five of this
6 section, the [~~superintendent of financial services~~] commissioner shall
7 conduct an actuarial calculation of the estimated liabilities of the
8 fund for the coming year resulting from the qualified plaintiffs
9 enrolled in the fund. The administrator shall from time to time adjust
10 such calculation in accordance with subdivision seven of this section.
11 If the total of all estimates of current liabilities equals or exceeds
12 eighty percent of the fund's assets, then the fund shall not accept any
13 new enrollments until a new deposit has been made pursuant to subdivi-
14 sion five of this section. When, as a result of such new deposit, the
15 fund's liabilities no longer exceed eighty percent of the fund's assets,
16 the fund administrator shall enroll new qualified plaintiffs in the
17 order that an application for enrollment has been submitted in accord-
18 ance with subdivision seven of section twenty-nine hundred ninety-nine-j
19 of this title.

20 (b) Whenever enrollment is suspended pursuant to paragraph (a) of this
21 subdivision and until such time as enrollment resumes pursuant to such
22 paragraph: (i) notice of such suspension shall be promptly posted on the
23 department's website [~~and on the website of the department of financial~~
24 ~~services~~]; (ii) the fund administrator shall deny each application for
25 enrollment that had been received but not accepted prior to the date of
26 suspension and each application for enrollment received after the date
27 of such suspension; and (iii) notification of each such denial shall be
28 made to the plaintiff or claimant or persons authorized to act on behalf
29 of such plaintiff or claimant and all defendants in regard to such
30 plaintiff or claimant, to the extent they are known to the fund adminis-
31 trator. Judgments and settlements for plaintiffs or claimants for whom
32 applications are denied under this paragraph or who are not eligible for
33 enrollment due to suspension pursuant to paragraph (a) of this subdivi-
34 sion shall be satisfied as if this title had not been enacted.

35 (c) Following a suspension, whenever enrollment resumes pursuant to
36 paragraph (a) of this subdivision, notice that enrollment has resumed
37 shall be promptly posted on the department's website [~~and on the website~~
38 ~~of the department of financial services~~].

39 (d) The suspension of enrollment pursuant to paragraph (a) of this
40 subdivision shall not impact payment under the fund for any qualified
41 plaintiffs already enrolled in the fund.

42 7. For purposes of this section, the adjustment factor referenced in
43 this section shall be the ten year rolling average medical component of
44 the consumer price index as published by the United States department of
45 labor, bureau of labor statistics, for the preceding ten years.

46 § 3. Subdivisions 2, 5, 6, 7, 9, 11, 12, 15 and 16 of section 2999-j
47 of the public health law, subdivision 2 as amended by chapter 517 of the
48 laws of 2016, paragraph (c) of subdivision 2 as amended by chapter 4 of
49 the laws of 2017, and subdivisions 5, 6, 7, 9, 11, 12, 15 and 16 as
50 added by section 52 of part H of chapter 59 of the laws of 2011, are
51 amended to read as follows:

52 2. The provision of qualifying health care costs to qualified plain-
53 tiffs shall not be subject to prior authorization, except as described
54 by the commissioner in regulation; provided, however:

1 (a) such regulation shall not prevent qualified plaintiffs from
2 receiving care or assistance that would, at a minimum, be authorized
3 under the medicaid program;

4 (b) if any prior authorization is required by such regulation, the
5 regulation shall require that requests for prior authorization be proc-
6 essed within a reasonably prompt period of time and~~[, subject to the~~
7 ~~provisions of subdivision two-a of this section,~~] shall identify a proc-
8 ess for prompt administrative review of any denial of a request for
9 prior authorization; and

10 (c) such regulations shall not prohibit qualifying health care costs
11 on the grounds that the qualifying health care cost may incidentally
12 benefit other members of the household, provided that whether the quali-
13 fying health care cost primarily benefits the patient may be considered.

14 5. Claims for the payment or reimbursement from the fund of qualifying
15 health care costs shall be made upon forms prescribed and furnished by
16 the fund administrator ~~[in consultation with the commissioner and]~~ in
17 conjunction with regulations establishing a mechanism for submission of
18 claims by health care providers directly to the fund, where practicable.

19 6. (a) Every settlement agreement for claims arising out of a
20 plaintiff's or claimant's birth related neurological injury subject to
21 this title, and that provides for the payment of future medical expenses
22 for the plaintiff or claimant, shall provide that ~~[in the event the~~
23 ~~administrator of the fund determines that the plaintiff or claimant is a~~
24 ~~qualified plaintiff,~~] all payments for future medical expenses shall be
25 paid in accordance with this title~~[,]~~ in lieu of that portion of the
26 settlement agreement that provides for payment of such expenses. The
27 plaintiff's or claimant's future medical expenses shall be paid in
28 accordance with this title. When such a settlement agreement does not so
29 provide, the court shall direct the modification of the agreement to
30 include such term as a condition of court approval.

31 (b) In any case where the jury or court has made an award for future
32 medical expenses arising out of a birth related neurological injury, any
33 party to such action or person authorized to act on behalf of such party
34 may make application to the court that the judgment reflect that, in
35 lieu of that portion of the award that provides for payment of such
36 expenses, ~~[and upon a determination by the fund administrator that the~~
37 ~~plaintiff is a qualified plaintiff,~~] the future medical expenses of the
38 plaintiff shall be paid out of the fund in accordance with this title.
39 Upon a finding by the court that the applicant has made a prima facie
40 showing that the plaintiff is a qualified plaintiff, the court shall
41 ensure that the judgment so provides.

42 7. A qualified plaintiff shall be enrolled when (a) such plaintiff or
43 person authorized to act on behalf of such person, upon notice to all
44 defendants, or any of the defendants in regard to the plaintiff's claim,
45 upon notice to such plaintiff, makes an application for enrollment by
46 providing the fund administrator with a certified copy of the judgment
47 or of the court approved settlement agreement; and (b) the fund adminis-
48 trator determines ~~[upon the basis of such judgment or settlement agree-~~
49 ~~ment and any additional information the fund administrator shall~~
50 ~~request]~~ that the relevant provisions of subdivision six of this section
51 have been met ~~[and that the plaintiff is a qualified plaintiff];~~
52 provided that no enrollment shall occur when the fund is closed to
53 enrollment pursuant to subdivision six of section twenty-nine hundred
54 ninety-nine-i of this title.

55 9. Payments from the fund shall be made by the commissioner of taxa-
56 tion and finance on the said certificate of the ~~[superintendent of~~

1 ~~financial services]~~ commissioner. No payment shall be made by the
2 commissioner of taxation and finance in excess of the amount certified.
3 Promptly upon receipt of the said certificate of the ~~[superintendent of~~
4 ~~financial services]~~ commissioner, the commissioner of taxation and
5 finance shall pay the qualified plaintiff's health care provider or
6 reimburse the qualified plaintiff the amount so certified for payment.

7 11. All health care providers shall accept from qualified plaintiff's
8 or persons authorized to act on behalf of such plaintiff's assignments
9 of the right to receive payments from the fund for qualifying health
10 care costs. Such payments shall constitute payment in full for any
11 services provided to a qualified plaintiff in accordance with this arti-
12 cle.

13 12. Health insurers (other than medicare and Medicaid) shall be the
14 primary payers of qualifying health care costs of qualified plaintiffs.
15 Such costs shall be paid from the fund only to the extent that health
16 insurers or other collateral sources or other persons are not otherwise
17 obligated to make payments therefor. Health insurers that make payments
18 for qualifying health care costs to or on behalf of qualified plaintiffs
19 shall have no right of recovery against and shall have no lien upon the
20 fund or any person or entity nor shall the fund constitute an additional
21 payment source to offset the payments otherwise contractually required
22 to be made by such health insurers. The superintendent of financial
23 services shall have the authority to enforce the provisions of this
24 subdivision upon the referral of the commissioner.

25 15. The commissioner~~[, in consultation with the superintendent of~~
26 ~~financial services,]~~ shall promulgate, amend and enforce all rules and
27 regulations necessary for the proper administration of the fund in
28 accordance with the provisions of this section, including, but not
29 limited to, those concerning the payment of claims and concerning the
30 actuarial calculations necessary to determine, annually, the total
31 amount to be paid into the fund as provided herein, and as otherwise
32 needed to implement this title.

33 ~~[16. The commissioner shall convene a consumer advisory committee for~~
34 ~~the purpose of providing information, as requested by the commissioner,~~
35 ~~in the development of the regulations authorized by subdivision fifteen~~
36 ~~of this section.]~~

37 § 4. Section 5 of chapter 517 of the laws of 2016, amending the public
38 health law relating to payments from the New York state medical indem-
39 nity fund, as amended by chapter 4 of the laws of 2017, is amended to
40 read as follows:

41 § 5. This act shall take effect on the forty-fifth day after it shall
42 have become a law, provided that the amendments to subdivision 4 of
43 section 2999-j of the public health law made by section two of this act
44 shall take effect on June 30, 2017 and shall expire and be deemed
45 repealed December 31, ~~[2019]~~ 2020.

46 § 5. Section 99-t of the state finance law, as added by section 52-e
47 of part H of chapter 59 of the laws of 2011, is amended to read as
48 follows:

49 § 99-t. New York state medical indemnity fund account. 1. There is
50 hereby established in the custody of the commissioner of taxation and
51 finance a special account to be known as the "New York state medical
52 indemnity fund account".

53 2. All moneys received by the New York state medical indemnity fund
54 pursuant to title four of article twenty-nine-D of the public health law
55 from whatever source derived shall be deposited to the exclusive credit
56 of such fund account. Said moneys shall be kept separate and shall not

1 be commingled with any other moneys in the custody of the commissioner
2 of taxation and finance.

3 3. The moneys in said account shall be retained by the fund and shall
4 be released by the commissioner of taxation and finance only upon
5 certificates signed by the [~~superintendent of financial services or the~~
6 ~~head of any successor agency to the department of insurance~~] commission-
7 er of health or his or her designee and only for the purposes set forth
8 in title four of article twenty-nine-D of the public health law.

9 § 6. This act shall take effect October 1, 2019; provided however, on
10 and after April 1, 2019, the commissioner of health may take any steps
11 necessary to implement this act on its effective date; and notwithstand-
12 ing any inconsistent provision of the state administrative procedure act
13 or any other provision of law, rule or regulation, the commissioner of
14 health is authorized to adopt or amend or promulgate on an emergency
15 basis any regulation he or she determines necessary to implement any
16 provision of this act on its effective date.

17 PART L

18 Section 1. Subparagraph (C) of paragraph 6 of subsection (k) of
19 section 3221 of the insurance law, as amended by section 1 of part K of
20 chapter 82 of the laws of 2002, is amended to read as follows:

21 (C) Coverage of diagnostic and treatment procedures, including
22 prescription drugs, used in the diagnosis and treatment of infertility
23 as required by subparagraphs (A) and (B) of this paragraph shall be
24 provided in accordance with the provisions of this subparagraph.

25 (i) [~~Coverage~~] Except as provided in items (vi) and (vii) of this
26 subparagraph, coverage shall be provided for persons whose ages range
27 from twenty-one through forty-four years, provided that nothing herein
28 shall preclude the provision of coverage to persons whose age is below
29 or above such range.

30 (ii) Diagnosis and treatment of infertility shall be prescribed as
31 part of a physician's overall plan of care and consistent with the
32 guidelines for coverage as referenced in this subparagraph.

33 (iii) Coverage may be subject to co-payments, coinsurance and deduct-
34 ibles as may be deemed appropriate by the superintendent and as are
35 consistent with those established for other benefits within a given
36 policy.

37 (iv) [~~Coverage shall be limited to those individuals who have been~~
38 ~~previously covered under the policy for a period of not less than twelve~~
39 ~~months, provided that for the purposes of this subparagraph "period of~~
40 ~~not less than twelve months" shall be determined by calculating such~~
41 ~~time from either the date the insured was first covered under the exist-~~
42 ~~ing policy or from the date the insured was first covered by a previous-~~
43 ~~ly in force converted policy, whichever is earlier.~~

44 (v) Coverage] Except as provided in items (vi) and (vii) of this
45 subparagraph, coverage shall not be required to include the diagnosis
46 and treatment of infertility in connection with: (I) in vitro fertiliza-
47 tion, gamete intrafallopian tube transfers or zygote intrafallopian tube
48 transfers; (II) the reversal of elective sterilizations; (III) sex
49 change procedures; (IV) cloning; or (V) medical or surgical services or
50 procedures that are deemed to be experimental in accordance with clin-
51 ical guidelines referenced in [~~clause (vi)~~] item (v) of this subpara-
52 graph.

53 [~~(vi)~~] (v) The superintendent, in consultation with the commissioner
54 of health, shall promulgate regulations which shall stipulate the guide-

1 lines and standards which shall be used in carrying out the provisions
2 of this subparagraph, which shall include:

3 (I) The determination of "infertility" in accordance with the stand-
4 ards and guidelines established and adopted by the American College of
5 Obstetricians and Gynecologists and the American Society for Reproduc-
6 tive Medicine including "iatrogenic infertility", which means an impair-
7 ment of fertility by surgery, radiation, chemotherapy or other medical
8 treatment affecting reproductive organs or processes;

9 (II) The identification of experimental procedures and treatments not
10 covered for the diagnosis and treatment of infertility determined in
11 accordance with the standards and guidelines established and adopted by
12 the American College of Obstetricians and Gynecologists and the American
13 Society for Reproductive Medicine;

14 (III) The identification of the required training, experience and
15 other standards for health care providers for the provision of proce-
16 dures and treatments for the diagnosis and treatment of infertility
17 determined in accordance with the standards and guidelines established
18 and adopted by the American College of Obstetricians and Gynecologists
19 and the American Society for Reproductive Medicine; and

20 (IV) The determination of appropriate medical candidates by the treat-
21 ing physician in accordance with the standards and guidelines estab-
22 lished and adopted by the American College of Obstetricians and Gynecol-
23 ogists and/or the American Society for Reproductive Medicine.

24 (vi) Coverage shall also include standard fertility preservation
25 services when a medical treatment may directly or indirectly cause
26 iatrogenic infertility to an insured. Coverage may be subject to annual
27 deductibles and coinsurance, including copayments, as may be deemed
28 appropriate by the superintendent and as are consistent with those
29 established for other benefits within a given policy.

30 (vii) Every large group policy delivered or issued for delivery in
31 this state that provides medical, major medical or similar comprehen-
32 sive-type coverage shall provide coverage for three cycles of in-vitro
33 fertilization used in the treatment of infertility as defined in clause
34 (I) of item (v) of this subparagraph. Coverage may be subject to annual
35 deductibles and coinsurance, including copayments, as may be deemed
36 appropriate by the superintendent and as are consistent with those
37 established for other benefits within a given policy. For purposes of
38 this item, a "cycle" is defined as either all treatment that starts
39 when: preparatory medications are administered for ovarian stimulation
40 for oocyte retrieval with the intent of undergoing in-vitro fertiliza-
41 tion using a fresh embryo transfer; or medications are administered for
42 endometrial preparation with the intent of undergoing in-vitro fertili-
43 zation using a frozen embryo transfer. No insurer providing coverage
44 under this item or item (vi) of this subparagraph shall discriminate
45 based on an insured's expected length of life, present or predicted
46 disability, degree of medical dependency, perceived quality of life, or
47 other health conditions, nor based on personal characteristics, includ-
48 ing age, sex, sexual orientation, marital status or gender identity.

49 § 2. Paragraph 3 of subsection (s) of section 4303 of the insurance
50 law, as amended by section 2 of part K of chapter 82 of the laws of
51 2002, is amended to read as follows:

52 (3) Coverage of diagnostic and treatment procedures, including
53 prescription drugs used in the diagnosis and treatment of infertility as
54 required by paragraphs one and two of this subsection shall be provided
55 in accordance with this paragraph.

(A) ~~Coverage~~ Except as provided in subparagraphs (F) and (G) of this paragraph, coverage shall be provided for persons whose ages range from twenty-one through forty-four years, provided that nothing herein shall preclude the provision of coverage to persons whose age is below or above such range.

(B) Diagnosis and treatment of infertility shall be prescribed as part of a physician's overall plan of care and consistent with the guidelines for coverage as referenced in this paragraph.

(C) Coverage may be subject to co-payments, coinsurance and deductibles as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given policy.

~~(D) [Coverage shall be limited to those individuals who have been previously covered under the policy for a period of not less than twelve months, provided that for the purposes of this paragraph "period of not less than twelve months" shall be determined by calculating such time from either the date the insured was first covered under the existing policy or from the date the insured was first covered by a previously in-force converted policy, whichever is earlier.~~

~~(E)~~ Coverage Except as provided in subparagraphs (F) and (G) of this paragraph, coverage shall not be required to include the diagnosis and treatment of infertility in connection with: (i) in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (ii) the reversal of elective sterilizations; (iii) sex change procedures; (iv) cloning; or (v) medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in subparagraph ~~(F)~~ (E) of this paragraph.

~~(F)~~ (E) The superintendent, in consultation with the commissioner of health, shall promulgate regulations which shall stipulate the guidelines and standards which shall be used in carrying out the provisions of this paragraph, which shall include:

(i) The determination of "infertility" in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine;

(ii) The identification of experimental procedures and treatments not covered for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine including "iatrogenic infertility", which means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes;

(iii) The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine; and

(iv) The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.

(F) Coverage shall also include standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility to an insured. Coverage may be subject to annual

1 deductibles and coinsurance, including copayments, as may be deemed
2 appropriate by the superintendent and as are consistent with those
3 established for other benefits within a given contract.

4 (G) Every large group contract that provides medical, major medical or
5 similar comprehensive-type coverage shall provide coverage for three
6 cycles of in-vitro fertilization used in the treatment of infertility as
7 defined in item (i) of subparagraph (E) of this paragraph. Coverage may
8 be subject to annual deductibles and coinsurance, including copayments,
9 as may be deemed appropriate by the superintendent and as are consistent
10 with those established for other benefits within a given contract. For
11 purposes of this subparagraph, a "cycle" is defined as either all treat-
12 ment that starts when: preparatory medications are administered for
13 ovarian stimulation for oocyte retrieval with the intent of undergoing
14 in-vitro fertilization using a fresh embryo transfer; or medications are
15 administered for endometrial preparation with the intent of undergoing
16 in-vitro fertilization using a frozen embryo transfer. No corporation
17 providing coverage under subparagraphs (F) or (G) of this paragraph
18 shall discriminate based on an insured's expected length of life, pres-
19 ent or predicted disability, degree of medical dependency, perceived
20 quality of life, or other health conditions, nor based on personal char-
21 acteristics, including age, sex, sexual orientation, marital status or
22 gender identity.

23 § 3. Paragraph 13 of subsection (i) of section 3216 of the insurance
24 law is amended by adding a new subparagraph (C) to read as follows:

25 (C) Every policy that provides medical, major medical or similar
26 comprehensive-type coverage shall provide coverage for standard fertili-
27 ty preservation services when a medical treatment may directly or indi-
28 rectly cause iatrogenic infertility to an insured. Coverage may be
29 subject to annual deductibles and coinsurance, including copayments, as
30 may be deemed appropriate by the superintendent and as are consistent
31 with those established for other benefits within a given policy.

32 (i) For purposes of this subparagraph, "iatrogenic infertility" means
33 an impairment of fertility by surgery, radiation, chemotherapy or other
34 medical treatment affecting reproductive organs or processes.

35 (ii) No insurer providing coverage under this paragraph shall discrim-
36 inate based on an insured's expected length of life, present or
37 predicted disability, degree of medical dependency, perceived quality of
38 life, or other health conditions, nor based on personal characteristics,
39 including age, sex, sexual orientation, marital status or gender identi-
40 ty.

41 § 4. This act shall take effect January 1, 2020 and shall apply to
42 policies and contracts issued, renewed, modified, altered or amended on
43 or after such date.

44 PART M

45 Section 1. This act shall be known and may be cited as the "comprehen-
46 sive contraception coverage act".

47 § 2. Paragraph 16 of subsection (1) of section 3221 of the insurance
48 law, as added by chapter 554 of the laws of 2002, is amended to read as
49 follows:

50 ~~(16) (A) Every group or blanket policy which [provides coverage for~~
51 ~~prescription drugs shall include coverage for the cost of contraceptive~~
52 ~~drugs or devices approved by the federal food and drug administration or~~
53 ~~generic equivalents approved as substitutes by such food and drug admin-~~
54 ~~istration under the prescription of a health care provider legally~~

~~authorized to prescribe under title eight of the education law. The coverage required by this section shall be included in policies and certificates only through the addition of a rider.~~

(A)] provides medical, major medical or similar comprehensive-type coverage shall provide coverage for all of the following services and contraceptive methods:

(i) All FDA-approved contraceptive drugs, devices, and other products. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law. Notwithstanding this paragraph, an insurer shall not be required to provide coverage of male condoms. The following applies to this coverage:

(I) where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, an insurer is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this paragraph;

(II) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, the insurer shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing upon the recommendation of the insured's attending health care provider. An insurer shall defer to the attending health care provider's determination of medical necessity. The superintendent may develop a standard exception form with instructions that an attending health care provider may use to recommend a particular contraceptive drug, device, or product based upon a determination of medical necessity for an insured. The insurer shall accept the standard exception form submitted by the insured's attending health care provider;

(III) this coverage shall include emergency contraception without cost-sharing when provided pursuant to prescription, order under section sixty-eight hundred thirty-one of the education law, over-the-counter, or when otherwise lawfully provided other than pursuant to a prescription; and

(IV) this coverage shall allow for the dispensing of twelve months-worth of a contraceptive at one time;

(ii) Voluntary sterilization procedures for women;

(iii) Patient education and counseling on contraception; and

(iv) Follow-up services related to the drugs, devices, products, and procedures covered under this paragraph, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(B) An insurer subject to this paragraph shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant to this paragraph.

(C) Except as otherwise authorized under this paragraph, an insurer shall not impose any restrictions or delays on the coverage required under this paragraph.

(D) Notwithstanding any other provision of this subsection, a religious employer may request a contract without coverage for federal food and drug administration approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, such contract shall be provided without coverage for contraceptive methods.

1 This paragraph shall not be construed to deny an enrollee coverage of,
2 and timely access to, contraceptive methods.

3 (1) For purposes of this subsection, a "religious employer" is an
4 entity for which each of the following is true:

5 (a) The inculcation of religious values is the purpose of the entity.

6 (b) The entity primarily employs persons who share the religious
7 tenets of the entity.

8 (c) The entity serves primarily persons who share the religious tenets
9 of the entity.

10 (d) The entity is a nonprofit organization as described in Section
11 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

12 (2) Every religious employer that invokes the exemption provided under
13 this paragraph shall provide written notice to prospective enrollees
14 prior to enrollment with the plan, listing the contraceptive health care
15 services the employer refuses to cover for religious reasons.

16 ~~[(B)-(i)]~~ (E) (1) Where a group policyholder makes an election not to
17 purchase coverage for contraceptive drugs or devices in accordance with
18 subparagraph ~~[(A)]~~ (D) of this paragraph each certificateholder covered
19 under the policy issued to that group policyholder shall have the right
20 to directly purchase the rider required by this paragraph from the
21 insurer which issued the group policy at the prevailing small group
22 community rate for such rider whether or not the employee is part of a
23 small group.

24 ~~[(ii)]~~ (2) Where a group policyholder makes an election not to
25 purchase coverage for contraceptive drugs or devices in accordance with
26 subparagraph ~~[(A)]~~ (D) of this paragraph, the insurer that provides such
27 coverage shall provide written notice to certificateholders upon enroll-
28 ment with the insurer of their right to directly purchase a rider for
29 coverage for the cost of contraceptive drugs or devices. The notice
30 shall also advise the certificateholders of the additional premium for
31 such coverage.

32 ~~[(C)]~~ (F) Nothing in this paragraph shall be construed as authorizing
33 a group or blanket policy which provides coverage for prescription drugs
34 to exclude coverage for prescription drugs prescribed for reasons other
35 than contraceptive purposes.

36 ~~[(D) Such coverage may be subject to reasonable annual deductibles and~~
37 ~~coinsurance as may be deemed appropriate by the superintendent and as~~
38 ~~are consistent with those established for other drugs or devices covered~~
39 ~~under the policy.]~~

40 § 3. Subsection (cc) of section 4303 of the insurance law, as added by
41 chapter 554 of the laws of 2002, is amended to read as follows:

42 (cc) (1) Every contract ~~[which provides coverage for prescription~~
43 ~~drugs shall include coverage for the cost of contraceptive drugs or~~
44 ~~devices approved by the federal food and drug administration or generic~~
45 ~~equivalents approved as substitutes by such food and drug administration~~
46 ~~under the prescription of a health care provider legally authorized to~~
47 ~~prescribe under title eight of the education law. The coverage required~~
48 ~~by this section shall be included in contracts and certificates only~~
49 ~~through the addition of a rider.~~

50 (1) which provides medical, major medical, or similar comprehensive-
51 type coverage shall provide coverage for all of the following services
52 and contraceptive methods:

53 (A) All FDA-approved contraceptive drugs, devices, and other products.
54 This includes all FDA-approved over-the-counter contraceptive drugs,
55 devices, and products as prescribed or as otherwise authorized under
56 state or federal law. Notwithstanding this paragraph, a corporation

1 shall not be required to provide coverage of male condoms. The follow-
2 ing applies to this coverage:

3 (i) where the FDA has approved one or more therapeutic and pharmaceu-
4 tical equivalent, as defined by the FDA, versions of a contraceptive
5 drug, device, or product, a corporation is not required to include all
6 such therapeutic and pharmaceutical equivalent versions in its formu-
7 lary, so long as at least one is included and covered without cost-shar-
8 ing and in accordance with this subsection;

9 (ii) if the covered therapeutic and pharmaceutical equivalent versions
10 of a drug, device, or product are not available or are deemed medically
11 inadvisable, a corporation shall provide coverage for an alternate ther-
12 apeutic and pharmaceutical equivalent version of the contraceptive drug,
13 device, or product without cost-sharing upon the recommendation of the
14 insured's attending health care provider. A corporation shall defer to
15 the attending health care provider's determination of medical necessity.
16 The superintendent may develop a standard exception form with
17 instructions that an attending health care provider may use to recommend
18 a particular contraceptive drug, device, or product based upon a deter-
19 mination of medical necessity for an insured. The insurer shall accept
20 the standard exception form submitted by the insured's attending health
21 care provider;

22 (iii) this coverage shall include emergency contraception without
23 cost-sharing when provided pursuant to a prescription, order under
24 section sixty-eight hundred thirty-one of the education law, over-the-
25 counter, or when otherwise lawfully provided other than through a
26 prescription; and

27 (iv) this coverage shall allow for the dispensing of twelve months
28 worth of a contraceptive at one time;

29 (B) Voluntary sterilization procedures for women;

30 (C) Patient education and counseling on contraception; and

31 (D) Follow-up services related to the drugs, devices, products, and
32 procedures covered under this subsection, including, but not limited to,
33 management of side effects, counseling for continued adherence, and
34 device insertion and removal.

35 (2) A corporation subject to this paragraph shall not impose a deduct-
36 ible, coinsurance, copayment or any other cost-sharing requirement on
37 the coverage provided pursuant to this subsection.

38 (3) Except as otherwise authorized under this subsection, a corpo-
39 ration shall not impose any restrictions or delays on the coverage
40 required under this subsection.

41 (4) Notwithstanding any other provision of this subsection, a reli-
42 gious employer may request a contract without coverage for federal food
43 and drug administration approved contraceptive methods that are contrary
44 to the religious employer's religious tenets. If so requested, such
45 contract shall be provided without coverage for contraceptive methods.
46 This paragraph shall not be construed to deny an enrollee coverage of,
47 and timely access to, contraceptive methods.

48 (A) For purposes of this subsection, a "religious employer" is an
49 entity for which each of the following is true:

50 (i) The inculcation of religious values is the purpose of the entity.

51 (ii) The entity primarily employs persons who share the religious
52 tenets of the entity.

53 (iii) The entity serves primarily persons who share the religious
54 tenets of the entity.

55 (iv) The entity is a nonprofit organization as described in Section
56 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

(B) Every religious employer that invokes the exemption provided under this paragraph shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

~~[(2)]~~(5) (A) Where a group contractholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with paragraph ~~[one]~~ four of this subsection, each enrollee covered under the contract issued to that group contractholder shall have the right to directly purchase the rider required by this subsection from the insurer or health maintenance organization which issued the group contract at the prevailing small group community rate for such rider whether or not the employee is part of a small group.

(B) Where a group contractholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with paragraph ~~[one]~~ four of this subsection, the insurer or health maintenance organization that provides such coverage shall provide written notice to enrollees upon enrollment with the insurer or health maintenance organization of their right to directly purchase a rider for coverage for the cost of contraceptive drugs or devices. The notice shall also advise the enrollees of the additional premium for such coverage.

~~[(3)]~~(6) Nothing in this subsection shall be construed as authorizing a contract which provides coverage for prescription drugs to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes.

~~[(4) Such coverage may be subject to reasonable annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other drugs or devices covered under the policy.]~~

§ 4. Paragraph 17 of subsection (i) of section 3216 of the insurance law is amended by adding a new subparagraph (G) to read as follows:

(G)(i) In addition to subparagraphs (A), (B), (C), (D), or (E) of this paragraph, every policy that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for all of the following services and contraceptive methods:

(I) All FDA-approved contraceptive drugs, devices, and other products. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law. Notwithstanding this subparagraph, an insurer shall not be required to provide coverage of male condoms. The following applies to this coverage:

(aa) where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, an insurer is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing in accordance with this subparagraph;

(bb) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, the insurer shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. An insurer shall defer to the attending health care provider's determination of medical necessity. The superintendent may develop a standard exception form with instructions that an attending health care provider may use to recommend a particular contraceptive drug, device, procedure, service, or product based upon a determination of medical necessity for an insured. The

1 insurer shall accept the standard exception form submitted by the
2 insured's attending health care provider;

3 (cc) this coverage shall include emergency contraception without cost-
4 sharing when provided pursuant to a prescription, order under section
5 sixty-eight hundred thirty-one of the education law, over-the-counter,
6 or when otherwise lawfully provided other than pursuant to a
7 prescription; and

8 (dd) this coverage shall allow for the dispensing of twelve months-
9 worth of a contraceptive at one time;

10 (II) Voluntary sterilization procedures for women;

11 (III) Patient education and counseling on contraception; and

12 (IV) Follow-up services related to the drugs, devices, products, and
13 procedures covered under this subparagraph, including management of side
14 effects, counseling for continued adherence, and device insertion and
15 removal.

16 (ii) An insurer subject to this subparagraph shall not impose a deduc-
17 tible, coinsurance, copayment or any other cost-sharing requirement on
18 the coverage provided pursuant to this subparagraph.

19 (iii) Except as otherwise authorized under this subparagraph, an
20 insurer shall not impose any restrictions or delays on the coverage
21 required under this subparagraph.

22 § 5. Paragraph (d) of subdivision 3 of section 365-a of the social
23 services law, as amended by chapter 909 of the laws of 1974 and as
24 relettered by chapter 82 of the laws of 1995, is amended to read as
25 follows:

26 (d) family planning services and supplies for eligible persons of
27 childbearing age, including children under twenty-one years of age who
28 can be considered sexually active, who desire such services and
29 supplies, in accordance with the requirements of federal law and regu-
30 lations and the regulations of the department. Prescription contracep-
31 tives, when prescribed based on generally accepted medical practice, may
32 be dispensed at one time or up to twelve times within one year from the
33 date of the prescription. No person shall be compelled or coerced to
34 accept such services or supplies.

35 § 6. This act shall take effect January 1, 2020; provided that
36 sections two, three and four of this act shall apply to policies and
37 contracts issued, renewed, modified, altered or amended on and after
38 such date.

39 PART N

40 Section 1. Universal access commission. 1. There is hereby created a
41 universal access commission, which shall consider and advise the commis-
42 sioner of health and the superintendent of financial services on options
43 for achieving universal access to health care in New York State.

44 2. The universal access commission shall consist of independent health
45 policy and insurance experts appointed by the commissioner and super-
46 intendent. The commission shall consult with the legislature and stake-
47 holder groups and convene at least one meeting for members of the public
48 to review and discuss options for achieving universal access to care.

49 3. The commissioner and superintendent shall select the chair of the
50 commission from among the members of such commission and shall designate
51 at least one employee from each department to assist the commission in
52 the performance of its duties under this section. The commissioner and
53 superintendent shall adopt rules for the governance of the commission,
54 which shall meet as frequently as its business may require and at such

1 other times as determined by the commissioner and superintendent to be
2 necessary.

3 4. Members of the commission shall serve without compensation for
4 their services as members, but each shall be allowed the necessary and
5 actual expenses incurred in the performance of his or her duties under
6 this section.

7 5. The commission shall provide a report to the Governor on the
8 options for achieving universal access to health care in New York State
9 by December 1, 2019.

10 § 2. This act shall take effect immediately.

11 PART 0

12 Section 1. Subdivision 2 of section 605 of the public health law, as
13 amended by section 20 of part E of chapter 56 of the laws of 2013, is
14 amended to read as follows:

15 2. State aid reimbursement for public health services provided by a
16 municipality under this title, shall be made if the municipality is
17 providing some or all of the core public health services identified in
18 section six hundred two of this title, pursuant to an approved applica-
19 tion for state aid, at a rate of no less than thirty-six per centum,
20 except for the city of New York which shall receive no less than twenty
21 per centum, of the difference between the amount of moneys expended by
22 the municipality for public health services required by section six
23 hundred two of this title during the fiscal year and the base grant
24 provided pursuant to subdivision one of this section. No such reimburse-
25 ment shall be provided for services that are not eligible for state aid
26 pursuant to this article.

27 § 2. Subdivision 1 of section 616 of the public health law, as amended
28 by section 27 of part E of chapter 56 of the laws of 2013, is amended to
29 read as follows:

30 1. The total amount of state aid provided pursuant to this article
31 shall be limited to the amount of the annual appropriation made by the
32 legislature. In no event, however, shall such state aid be less than an
33 amount to provide the full base grant and, as otherwise provided by
34 ~~[paragraph (a) of]~~ subdivision two of section six hundred five of this
35 article, ~~[at least]~~ no less than thirty-six per centum, except for the
36 city of New York which shall receive no less than twenty per centum, of
37 the difference between the amount of moneys expended by the municipality
38 for eligible public health services pursuant to an approved application
39 for state aid during the fiscal year and the base grant provided pursu-
40 ant to subdivision one of section six hundred five of this article.

41 § 3. This act shall take effect July 1, 2019.

42 PART P

43 Section 1. Subdivision 6 of section 1370 of the public health law, as
44 amended by chapter 485 of the laws of 1992, is amended as follows:

45 6. "Elevated lead levels" means a blood lead level greater than or
46 equal to ~~[ten]~~ five micrograms of lead per deciliter of whole blood or
47 such lower blood lead level as may be established by the department
48 pursuant to rule or regulation.

49 § 2. The public health law is amended by adding a new section 1370-f
50 to read as follows:

51 § 1370-f. Lead safe residential rental properties. 1. Definitions.
52 For the purposes of this section:

1 (a) "residential rental property" shall mean a dwelling which is
2 either rented, leased, let or hired out, to be occupied, or is occupied
3 as the home, residence or sleeping place of one or more persons other
4 than the owner's family. Residential rental property shall not include
5 short term rental properties during which guests do not stay in excess
6 of twenty-eight days.

7 (b) "lead safe" shall mean any residential rental property that:

8 (i) has been determined through a lead-based paint inspection
9 conducted in accordance with appropriate federal regulations not to
10 contain lead-based paint; or

11 (ii) meets the minimum standards set forth in regulations promulgated
12 by the commissioner pursuant to this section.

13 2. The commissioner shall promulgate rules and regulations establish-
14 ing minimum standards for the maintenance of lead safe residential
15 rental properties. Such rules and regulations shall include:

16 (a) Minimum standards for maintaining internal and external painted
17 surfaces that contain lead-based paint; and

18 (b) A schedule by which owners of residential rental property must
19 implement and comply with such minimum standards.

20 3. It shall be the responsibility of an owner of any residential
21 rental property to maintain such property in a lead safe condition in
22 accordance with rules and regulations promulgated by the commissioner
23 pursuant to this section.

24 4. All paint on any residential rental property on which the original
25 construction was completed prior to January first, nineteen hundred
26 seventy-eight, shall be presumed to be lead-based paint. This presump-
27 tion may be overcome by a certification issued by a federally certified
28 lead-based paint inspector or risk assessor that the property has been
29 determined not to contain lead-based paint, or by such other means as
30 may be prescribed by the rules and regulations adopted by the commis-
31 sioner pursuant to this section.

32 5. The commissioner, local health officer of a county and, in the City
33 of New York, the commissioner of the New York City department of health
34 and mental hygiene, may enter into an agreement or contract with a
35 municipal government regarding inspection of the lead conditions in
36 residential rental properties and such health department may designate
37 the local housing maintenance code enforcement agency in which the
38 residential rental property is located as an agency authorized to
39 administer and ensure compliance with the provisions of this section
40 and subsequent regulations pursuant to subdivision one of section thir-
41 teen hundred seventy-five of this title.

42 6. If the commissioner, or other officer having jurisdiction, deter-
43 mines that an owner of residential rental property is in violation of
44 this section or any rules or regulations promulgated pursuant to this
45 section, the commissioner or other officer having jurisdiction shall
46 have the authority to order the abatement of any lead condition present
47 at the residential rental property and assess fines not to exceed two
48 thousand dollars for each violation.

49 § 3. Subdivision one of section three hundred eighty-three of the
50 executive law, as added by chapter 707 of the laws of 1984, paragraph c
51 as amended by chapter 772 of the laws of 1986, is amended by adding a
52 new paragraph d, to read as follows:

53 d. The regulations promulgated by the commissioner of health pursuant
54 to subdivision two of section thirteen hundred seventy-f of the public
55 health law

(i) shall not be superseded by the provisions of this article, by the provisions of the uniform fire prevention and building code, or by the provisions of the building and fire prevention codes in effect in a city with a population of over one million;

(ii) shall be applicable in addition to, and not in substitution for or limitation of, the provisions of the uniform fire prevention and building code and the provisions of building and fire prevention codes in effect in cities with a population of over one million; and

(iii) shall be administered and enforced by commissioner of health, the local health officer of a county, the commissioner of the New York City department of health and mental hygiene, or a municipal government entering into an agreement or contract authorized by subdivision five of section thirteen hundred seventy-f of the public health law, in the manner provided in said subdivision.

§ 4. This act shall take effect immediately.

PART Q

Section 1. Section 2825-f of the public health law is amended by adding two new subdivisions 4-a and 4-b to read as follows:

4-a. Notwithstanding subdivision two of this section or any inconsistent provision of law to the contrary, and upon approval of the director of the budget, the commissioner may, subject to the availability of lawful appropriation, award up to three hundred million dollars of the funds made available pursuant to this section for unfunded project applications submitted in response to the request for applications number 17648 issued by the department on January eighth, two thousand eighteen pursuant to section twenty-eight hundred twenty-five-e of this article, provided however that the provisions of subdivisions three and four of this section shall apply.

4-b. Authorized amounts to be awarded pursuant to applications submitted in response to the request for application number 17648 shall be awarded no later than May first, two thousand nineteen.

§ 2. This act shall take effect immediately.

PART R

Section 1. Legislative findings and intent. The legislature finds that maternal mortality and morbidity is a serious public health concern and has a serious family and societal impact. New York state has among the highest maternal mortality rates in the country and racial disparities remain significant. The U.S. Centers for Disease Control and Prevention has determined that a regular process for professional, multi-disciplinary, confidential review of all maternal deaths can help identify the causes of maternal mortality, and those findings can lead to clinical and social change that can help prevent maternal mortality. The same is true for severe maternal morbidity. Confidentiality is important to ensure that full information is made available in the review process to maximize protection of maternal health.

Section 3 of article 17 of the state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." The legislature finds that the creation of a state maternal mortality review board, and recognition and protection of any maternal mortality review

board, including a New York city maternal mortality review board, are a matter of state concern and an important exercise of the legislature's constitutional mandate to protect the public health.

§ 2. The public health law is amended by adding a new section 2509 to read as follows:

§ 2509. Maternal mortality review board. 1. (a) There is hereby established in the department the maternal mortality review board for the purpose of reviewing maternal deaths and severe maternal morbidity and developing findings, recommendations, and best practices to the commissioner to contribute to the prevention of maternal mortality and severe maternal morbidity. The board shall assess the cause of death, factors leading to death and preventability for each maternal death reviewed and, at the discretion of the board, cases of severe maternal morbidity, and shall develop strategies for reducing the risk of maternal mortality and severe maternal morbidity, where cases of severe maternal morbidity were reviewed, taking into account factors such as racial, economic, or other disparities. The boards' findings, recommendations and best practices shall be given to the commissioner for dissemination.

(b) Any maternal mortality review board, including a New York city maternal mortality review board, shall provide to the commissioner the results and the findings of its reviews, including recommendations and best practices and upon request information and data, including case summaries, to support statewide surveillance and enforcement.

2. As used in this section:

(a) "Advisory council" and "council" mean the advisory council on maternal mortality and severe maternal morbidity, established under this section.

(b) "Board" means a maternal mortality review board established by this section, referred to in this section as the "state board", or any board operating, including a New York city maternal mortality review board, under this section.

(c) "Maternal death" means the death of a woman during pregnancy or within a year from the end of pregnancy.

(d) "Severe maternal morbidity" means unexpected outcomes of pregnancy, labor, or delivery that result in significant short- or long-term consequences to a woman's health.

3. (a) The members of the state board shall be comprised of multidisciplinary experts in the field of maternal mortality, women's health and public health, and shall include health care professionals and other experts who serve and are representative of the racial and ethnic diversity of the women and mothers of the state.

(b) The state board shall be composed of at least fifteen members, all of whom shall be appointed by the commissioner.

(c) The terms of the state board members shall be three years. The commissioner may choose to reappoint state board members to additional three year terms.

(d) A majority of the appointed membership of the state board, no less than three, shall constitute a quorum.

(e) When any member of the state board fails to attend three consecutive regular meetings, unless such absence is for good cause, that membership may be deemed vacant for purposes of the appointment of a successor.

(f) Meetings of the state board shall be held at least twice a year but may be held more frequently as deemed necessary, subject to request of the department.

1 (g) Members of the state board shall be indemnified under section
2 seventeen of the public officers law.

3 (h) Members of the state board shall not be compensated for their
4 participation on the board but may receive reimbursement for their ordi-
5 nary and necessary expenses of participation.

6 (i) Membership on a board shall not disqualify any person from holding
7 any public office or employment.

8 (j) The board is not subject to Article 7 of the public officers law.

9 4. (a) The commissioner shall receive upon request from any depart-
10 ment, division, board, bureau, commission, local health departments or
11 other agency of the state or political subdivision thereof or any public
12 authority, as well as hospitals established pursuant to article twenty-
13 eight of this chapter, birthing facilities, medical examiners, coroners
14 and coroner physicians and any other facility providing services associ-
15 ated with maternal mortality, such information, including, but not
16 limited to, death records, medical records, autopsy reports, toxicology
17 reports, hospital discharge records, birth records and any other infor-
18 mation.

19 (b) The commissioner shall receive information, including oral or
20 written statements, relating to any maternal death and case of severe
21 maternal morbidity, from any family member or other interested party
22 (including the patient in a case of severe maternal morbidity) relating
23 to any case that may come before the board. Oral statements received
24 under this paragraph shall be transcribed or summarized in writing. The
25 commissioner and the city commissioner shall transmit that information
26 to the board considering the case.

27 (c) Before transmitting any information to the board, the commissioner
28 shall remove all personal identifying information of the woman, health
29 care practitioner or practitioners or anyone else individually named in
30 such information, as well as the hospital or facility that treated the
31 woman, and any other information such as geographic location that may
32 inadvertently identify the woman, practitioner or facility. This para-
33 graph shall not preclude the transmitting of information to the board
34 that is reasonably necessary to enable the board to perform an appropri-
35 ate review under this section.

36 5. Each board:

37 (a) shall make and report findings, recommendations and best practices
38 to the commissioner regarding the cause of death, factors leading to
39 death, and preventability of each maternal death case, and each case of
40 severe maternal morbidity reviewed by the board, by reviewing relevant
41 information for each case and consulting with experts as needed to eval-
42 uate the information for each death; and shall provide such de-identi-
43 fied findings and recommendations, including best practices and strate-
44 gies for reducing the risk of maternal mortality and severe maternal
45 morbidity, to the advisory council; provided that material provided to
46 the advisory council shall not include any information that would be
47 confidential under this section;

48 (b) shall develop recommendations to the commissioner for areas of
49 focus, including issues of severe maternal morbidity and issues of
50 racial, economic or other disparities in maternal outcomes;

51 (c) may, in addition to the findings, recommendations, and best prac-
52 tices made under this subdivision, and consistent with all applicable
53 confidentiality protections, bring any particular matter to the atten-
54 tion of the commissioner;

1 (d) the state board shall issue a report every other year to the
2 commissioner on its findings, recommendations, and best practices, and
3 it shall be a public document.

4 6. The commissioner and boards shall each keep confidential any infor-
5 mation collected or received under this section that includes personal
6 identifying information of the woman, health care practitioner or prac-
7 tioners or anyone else individually named in such information, as well
8 as the hospital or facility that treated the woman, and any other infor-
9 mation such as geographic location that may inadvertently identify the
10 woman, practitioner or facility, and shall use the information provided
11 or received under this section solely for the purposes of improvement of
12 the quality of health care of women and to prevent maternal mortality
13 and severe maternal morbidity. This subdivision shall not preclude the
14 transmitting of information to the board that is reasonably necessary to
15 enable the board to perform an appropriate review under this section.
16 All information and records received, meetings conducted, reports and
17 records made and maintained and all books and papers obtained by the
18 commissioner as well as the board shall be confidential and shall not be
19 made open or available, including under article six of the public offi-
20 cers law, and shall be limited to board members as well as those author-
21 ized by the commissioner. Such information shall not be discoverable or
22 admissible as evidence in any action in any court or before any other
23 tribunal, board, agency or person.

24 7. (a) There is hereby established in the department an advisory coun-
25 cil on maternal mortality and severe maternal morbidity.

26 (b) The advisory council:

27 (i) may review the findings, recommendations and best practices of the
28 boards;

29 (ii) may use the boards findings, recommendations and best practices
30 to develop recommendations on policies, best practices, and strategies
31 to prevent maternal mortality and severe maternal morbidity;

32 (iii) may hold public hearings on those matters; and

33 (iv) may make findings and issue reports, including an annual report,
34 on such matters;

35 (c) The advisory council shall consist of at least twenty members,
36 representative of the racial and ethnic diversity of the women and moth-
37 ers of the state to be determined by the commissioner. Ten of the
38 members of the council shall be representative of the population and
39 health care system of the city of New York. The commissioner shall
40 appoint the chair of the council.

41 (d) The members of the council shall be comprised of multidisciplinary
42 experts and lay persons knowledgeable in the field of maternal mortal-
43 ity, women's health and public health and shall include members who
44 serve and are representative of the diversity of the women and mothers
45 in medically underserved areas of the state or areas of the state with
46 disproportionately high occurrences of maternal mortality or severe
47 maternal morbidity.

48 (e) The terms of the council members shall be three years. The commis-
49 sioner may choose to reappoint council members to additional three-year
50 terms. Vacancies on the council shall be filled by appointment by the
51 commissioner. A majority of the appointed membership of the council
52 shall constitute a quorum. When any member of the council fails to
53 attend three consecutive regular meetings, unless such absence is for
54 good cause, that membership may be deemed vacant for purposes of the
55 appointment of a successor.

56 (f) Meetings of the council shall be held at least twice a year.

(g) Members of the council shall be indemnified under section seventeen of the public officers law. Members of the council shall not be compensated for their participation on the council but shall receive reimbursement for their ordinary and necessary expenses of participation. Membership on the council shall not disqualify any person from holding any public office or employment.

§ 3. This act shall take effect immediately.

PART S

Section 1. Legislative intent. The legislature finds that comprehensive reproductive health care, including contraception and abortion, is a fundamental component of a woman's health, privacy and equality. The New York Constitution and United States Constitution protect a woman's fundamental right to access safe, legal abortion, courts have repeatedly reaffirmed this right and further emphasized that states may not place undue burdens on women seeking to access such right.

Moreover, the legislature finds, as with other medical procedures, the safety of abortion is furthered by evidence-based practices developed and supported by medical professionals. Abortion is one of the safest medical procedures performed in the United States; the goal of medical regulation should be to improve the quality and availability of health care services.

Furthermore, the legislature declares that it is the public policy of New York State that every individual possesses a fundamental right of privacy and equality with respect to their personal reproductive decisions and should be able to safely effectuate those decisions, including by seeking and obtaining abortion care, free from discrimination in the provision of health care.

Therefore, it is the intent of the legislature to prevent the enforcement of laws or regulations that are not in furtherance of a legitimate state interest in protecting a woman's health that burden abortion access.

§ 2. The public health law is amended by adding a new article 25-A to read as follows:

ARTICLE 25-A

REPRODUCTIVE HEALTH ACT

Section 2599-aa. Policy and purpose.

2599-bb. Abortion.

§ 2599-aa. Policy and purpose. The legislature finds that comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality. Therefore, it is the policy of the state that:

1. Every individual has the fundamental right to choose or refuse contraception or sterilization.

2. Every individual who becomes pregnant has the fundamental right to choose to carry the pregnancy to term, to give birth to a child, or to have an abortion, pursuant to this article.

3. The state shall not discriminate against, deny, or interfere with the exercise of the rights set forth in this section in the regulation or provision of benefits, facilities, services or information.

§ 2599-bb. Abortion. 1. A health care practitioner licensed, certified, or authorized under title eight of the education law, acting within his or her lawful scope of practice, may perform an abortion when, according to the practitioner's reasonable and good faith professional judgment based on the facts of the patient's case: the patient is within

twenty-four weeks from the commencement of pregnancy, or there is an absence of fetal viability, or the abortion is necessary to protect the patient's life or health.

2. This article shall be construed and applied consistent with and subject to applicable laws and applicable and authorized regulations governing health care procedures.

§ 3. Section 4164 of the public health law is REPEALED.

§ 4. Subdivision 8 of section 6811 of the education law is REPEALED.

§ 5. Sections 125.40, 125.45, 125.50, 125.55 and 125.60 of the penal law are REPEALED, and the article heading of article 125 of the penal law is amended to read as follows:

HOMICIDE[~~ABORTION~~] AND RELATED OFFENSES

§ 6. Section 125.00 of the penal law is amended to read as follows:

§ 125.00 Homicide defined.

Homicide means conduct which causes the death of a person [~~or an unborn child with which a female has been pregnant for more than twenty-four weeks~~] under circumstances constituting murder, manslaughter in the first degree, manslaughter in the second degree, or criminally negligent homicide[~~ABORTION IN THE FIRST DEGREE OR SELF-ABORTION IN THE FIRST DEGREE~~].

§ 7. The section heading, opening paragraph and subdivision 1 of section 125.05 of the penal law are amended to read as follows:

Homicide[~~ABORTION~~] and related offenses; [~~definitions of terms~~] definition.

The following [~~definitions are~~] definition is applicable to this article:

[~~1.~~] "Person," when referring to the victim of a homicide, means a human being who has been born and is alive.

§ 7-a. Subdivisions 2 and 3 of section 125.05 of the penal law are REPEALED.

§ 8. Subdivision 2 of section 125.15 of the penal law is REPEALED.

§ 9. Subdivision 3 of section 125.20 of the penal law is REPEALED.

§ 10. Paragraph (b) of subdivision 8 of section 700.05 of the criminal procedure law, as amended by chapter 189 of the laws of 2018, is amended to read as follows:

(b) Any of the following felonies: assault in the second degree as defined in section 120.05 of the penal law, assault in the first degree as defined in section 120.10 of the penal law, reckless endangerment in the first degree as defined in section 120.25 of the penal law, promoting a suicide attempt as defined in section 120.30 of the penal law, strangulation in the second degree as defined in section 121.12 of the penal law, strangulation in the first degree as defined in section 121.13 of the penal law, criminally negligent homicide as defined in section 125.10 of the penal law, manslaughter in the second degree as defined in section 125.15 of the penal law, manslaughter in the first degree as defined in section 125.20 of the penal law, murder in the second degree as defined in section 125.25 of the penal law, murder in the first degree as defined in section 125.27 of the penal law, [~~ABORTION IN THE SECOND DEGREE AS DEFINED IN SECTION 125.40 OF THE PENAL LAW, ABORTION IN THE FIRST DEGREE AS DEFINED IN SECTION 125.45 OF THE PENAL LAW,~~] rape in the third degree as defined in section 130.25 of the penal law, rape in the second degree as defined in section 130.30 of the penal law, rape in the first degree as defined in section 130.35 of the penal law, criminal sexual act in the third degree as defined in section 130.40 of the penal law, criminal sexual act in the second degree as defined in section 130.45 of the penal law, criminal sexual act in the

1 first degree as defined in section 130.50 of the penal law, sexual abuse
2 in the first degree as defined in section 130.65 of the penal law,
3 unlawful imprisonment in the first degree as defined in section 135.10
4 of the penal law, kidnapping in the second degree as defined in section
5 135.20 of the penal law, kidnapping in the first degree as defined in
6 section 135.25 of the penal law, labor trafficking as defined in section
7 135.35 of the penal law, aggravated labor trafficking as defined in
8 section 135.37 of the penal law, custodial interference in the first
9 degree as defined in section 135.50 of the penal law, coercion in the
10 first degree as defined in section 135.65 of the penal law, criminal
11 trespass in the first degree as defined in section 140.17 of the penal
12 law, burglary in the third degree as defined in section 140.20 of the
13 penal law, burglary in the second degree as defined in section 140.25 of
14 the penal law, burglary in the first degree as defined in section 140.30
15 of the penal law, criminal mischief in the third degree as defined in
16 section 145.05 of the penal law, criminal mischief in the second degree
17 as defined in section 145.10 of the penal law, criminal mischief in the
18 first degree as defined in section 145.12 of the penal law, criminal
19 tampering in the first degree as defined in section 145.20 of the penal
20 law, arson in the fourth degree as defined in section 150.05 of the
21 penal law, arson in the third degree as defined in section 150.10 of the
22 penal law, arson in the second degree as defined in section 150.15 of
23 the penal law, arson in the first degree as defined in section 150.20 of
24 the penal law, grand larceny in the fourth degree as defined in section
25 155.30 of the penal law, grand larceny in the third degree as defined in
26 section 155.35 of the penal law, grand larceny in the second degree as
27 defined in section 155.40 of the penal law, grand larceny in the first
28 degree as defined in section 155.42 of the penal law, health care fraud
29 in the fourth degree as defined in section 177.10 of the penal law,
30 health care fraud in the third degree as defined in section 177.15 of
31 the penal law, health care fraud in the second degree as defined in
32 section 177.20 of the penal law, health care fraud in the first degree
33 as defined in section 177.25 of the penal law, robbery in the third
34 degree as defined in section 160.05 of the penal law, robbery in the
35 second degree as defined in section 160.10 of the penal law, robbery in
36 the first degree as defined in section 160.15 of the penal law, unlawful
37 use of secret scientific material as defined in section 165.07 of the
38 penal law, criminal possession of stolen property in the fourth degree
39 as defined in section 165.45 of the penal law, criminal possession of
40 stolen property in the third degree as defined in section 165.50 of the
41 penal law, criminal possession of stolen property in the second degree
42 as defined by section 165.52 of the penal law, criminal possession of
43 stolen property in the first degree as defined by section 165.54 of the
44 penal law, trademark counterfeiting in the second degree as defined in
45 section 165.72 of the penal law, trademark counterfeiting in the first
46 degree as defined in section 165.73 of the penal law, forgery in the
47 second degree as defined in section 170.10 of the penal law, forgery in
48 the first degree as defined in section 170.15 of the penal law, criminal
49 possession of a forged instrument in the second degree as defined in
50 section 170.25 of the penal law, criminal possession of a forged instru-
51 ment in the first degree as defined in section 170.30 of the penal law,
52 criminal possession of forgery devices as defined in section 170.40 of
53 the penal law, falsifying business records in the first degree as
54 defined in section 175.10 of the penal law, tampering with public
55 records in the first degree as defined in section 175.25 of the penal
56 law, offering a false instrument for filing in the first degree as

1 defined in section 175.35 of the penal law, issuing a false certificate
2 as defined in section 175.40 of the penal law, criminal diversion of
3 prescription medications and prescriptions in the second degree as
4 defined in section 178.20 of the penal law, criminal diversion of
5 prescription medications and prescriptions in the first degree as
6 defined in section 178.25 of the penal law, residential mortgage fraud
7 in the fourth degree as defined in section 187.10 of the penal law,
8 residential mortgage fraud in the third degree as defined in section
9 187.15 of the penal law, residential mortgage fraud in the second degree
10 as defined in section 187.20 of the penal law, residential mortgage
11 fraud in the first degree as defined in section 187.25 of the penal law,
12 escape in the second degree as defined in section 205.10 of the penal
13 law, escape in the first degree as defined in section 205.15 of the
14 penal law, absconding from temporary release in the first degree as
15 defined in section 205.17 of the penal law, promoting prison contraband
16 in the first degree as defined in section 205.25 of the penal law,
17 hindering prosecution in the second degree as defined in section 205.60
18 of the penal law, hindering prosecution in the first degree as defined
19 in section 205.65 of the penal law, sex trafficking as defined in
20 section 230.34 of the penal law, sex trafficking of a child as defined
21 in section 230.34-a of the penal law, criminal possession of a weapon in
22 the third degree as defined in subdivisions two, three and five of
23 section 265.02 of the penal law, criminal possession of a weapon in the
24 second degree as defined in section 265.03 of the penal law, criminal
25 possession of a weapon in the first degree as defined in section 265.04
26 of the penal law, manufacture, transport, disposition and defacement of
27 weapons and dangerous instruments and appliances defined as felonies in
28 subdivisions one, two, and three of section 265.10 of the penal law,
29 sections 265.11, 265.12 and 265.13 of the penal law, or prohibited use
30 of weapons as defined in subdivision two of section 265.35 of the penal
31 law, relating to firearms and other dangerous weapons, or failure to
32 disclose the origin of a recording in the first degree as defined in
33 section 275.40 of the penal law;

34 § 11. Subdivision 1 of section 673 of the county law, as added by
35 chapter 545 of the laws of 1965, is amended to read as follows:

36 1. A coroner or medical examiner has jurisdiction and authority to
37 investigate the death of every person dying within his county, or whose
38 body is found within the county, which is or appears to be:

39 (a) A violent death, whether by criminal violence, suicide or casual-
40 ty;

41 (b) A death caused by unlawful act or criminal neglect;

42 (c) A death occurring in a suspicious, unusual or unexplained manner;

43 (d) ~~[A death caused by suspected criminal abortion;~~

44 ~~(e)]~~ A death while unattended by a physician, so far as can be discov-
45 ered, or where no physician able to certify the cause of death as
46 provided in the public health law and in form as prescribed by the
47 commissioner of health can be found;

48 ~~[(f)]~~ (e) A death of a person confined in a public institution other
49 than a hospital, infirmary or nursing home.

50 § 12. Section 4 of the judiciary law, as amended by chapter 264 of the
51 laws of 2003, is amended to read as follows:

52 § 4. Sittings of courts to be public. The sittings of every court
53 within this state shall be public, and every citizen may freely attend
54 the same, except that in all proceedings and trials in cases for
55 divorce, seduction, ~~[abortion,~~ rape, assault with intent to commit
56 rape, criminal sexual act, bastardy or filiation, the court may, in its

1 discretion, exclude therefrom all persons who are not directly inter-
2 ested therein, excepting jurors, witnesses, and officers of the court.

3 § 13. Severability. If any provision of this act, or any application
4 of any provision of this act, is held to be invalid, that shall not
5 affect the validity or effectiveness of any other provision of this act,
6 or of any other application of any provision of this act, which can be
7 given effect without that provision or application; and to that end, the
8 provisions and applications of this act are severable.

9 § 14. This act shall take effect immediately.

10 PART T

11 Section 1. This act shall be known and may be cited as the "NY State
12 of Health, The Official Health Plan Marketplace Act".

13 § 2. Article 2 of the public health law is amended by adding a new
14 title VII to read as follows:

15 TITLE VII

16 NY STATE OF HEALTH

17 Section 268. Statement of policy and purposes.

18 268-a. Definitions.

19 268-b. Establishment of NY State of Health, The Official Health
20 Plan Marketplace.

21 268-c. Functions of the Marketplace.

22 268-d. Special functions of the Marketplace related to health
23 plan certification and qualified health plan oversight.

24 268-e. Appeals and appeal hearings; judicial review.

25 268-f. Marketplace advisory committee.

26 268-g. Funding of the Marketplace.

27 268-h. Construction.

28 § 268. Statement of policy and purposes. The purpose of this title is
29 to codify the establishment of the health benefit exchange in New York,
30 known as NY State of Health, The Official Health Plan Marketplace
31 (Marketplace), in conformance with Executive Order 42 (Cuomo) issued
32 April 12, 2012. The Marketplace shall continue to perform eligibility
33 determinations for federal and state insurance affordability programs
34 including medical assistance in accordance with section three hundred
35 sixty-six of the social services law, child health plus in accordance
36 with section twenty-five hundred eleven of this chapter, the basic
37 health program in accordance with section three hundred sixty-nine-gg of
38 the social services law, and premium tax credits and cost-sharing
39 reductions, together with performing eligibility determinations for
40 qualified health plans and such other health insurance programs as
41 determined by the commissioner. The Marketplace shall also facilitate
42 enrollment in insurance affordability programs, qualified health plans
43 and other health insurance programs as determined by the commissioner,
44 the purchase and sale of qualified health plans and/or other or addi-
45 tional health plans certified by the Marketplace pursuant to this title,
46 and shall continue to have the authority to operate a small business
47 health options program ("SHOP") to assist eligible small employers in
48 selecting qualified health plans and/or other or additional health plans
49 certified by the Marketplace and to determine small employer eligibility
50 for purposes of small employer tax credits. It is the intent of the
51 legislature, by codifying the Marketplace in state statute, to continue
52 to promote quality and affordable health coverage and care, reduce the
53 number of uninsured persons, provide a transparent marketplace, educate
54 consumers and assist individuals with access to coverage, premium

1 assistance tax credits and cost-sharing reductions. In addition, the
2 legislature declares the intent that the Marketplace continue to be
3 properly integrated with insurance affordability programs, including
4 Medicaid, child health plus and the basic health program, and such other
5 health insurance programs as determined by the commissioner.

6 § 268-a. Definitions. For purposes of this title, the following defi-
7 nitions shall apply:

8 1. "Commissioner" means the commissioner of health of the state of New
9 York.

10 2. "Marketplace" means the "NY State of Health, The official health
11 plan Marketplace" or "Marketplace" established as a health benefit
12 exchange or "marketplace" within the department of health pursuant to
13 Executive Order 42 (Cuomo) issued April 12, 2012 and this title.

14 3. "Federal act" means the patient protection and affordable care act,
15 public law 111-148, as amended by the health care and education recon-
16 ciliation act of 2010, public law 111-152, and any regulations or guid-
17 ance issued thereunder.

18 4. "Health plan" means a policy, contract or certificate, offered or
19 issued by an insurer to provide, deliver, arrange for, pay for or reim-
20 burse any of the costs of health care services. Health plan shall not
21 include the following:

22 (a) accident insurance or disability income insurance, or any combina-
23 tion thereof;

24 (b) coverage issued as a supplement to liability insurance;

25 (c) liability insurance, including general liability insurance and
26 automobile liability insurance;

27 (d) workers' compensation or similar insurance;

28 (e) automobile no-fault insurance;

29 (f) credit insurance;

30 (g) other similar insurance coverage, as specified in federal regu-
31 lations, under which benefits for medical care are secondary or inci-
32 idental to other insurance benefits;

33 (h) limited scope dental or vision benefits, benefits for long-term
34 care insurance, nursing home insurance, home care insurance, or any
35 combination thereof, or such other similar, limited benefits health
36 insurance as specified in federal regulations, if the benefits are
37 provided under a separate policy, certificate or contract of insurance
38 or are otherwise not an integral part of the plan;

39 (i) coverage only for a specified disease or illness, hospital indem-
40 nity, or other fixed indemnity coverage;

41 (j) Medicare supplemental insurance as defined in section 1882(g)(1)
42 of the federal social security act, coverage supplemental to the cover-
43 age provided under chapter 55 of title 10 of the United States Code, or
44 similar supplemental coverage provided under a group health plan if it
45 is offered as a separate policy, certificate or contract of insurance;
46 or

47 (k) the New York state medical indemnity fund established pursuant to
48 title four of article twenty-nine-D of the public health law.

49 5. "Insurer" means an insurance company subject to article forty-two
50 or a corporation subject to article forty-three of the insurance law, or
51 a health maintenance organization certified pursuant to article forty-
52 four of the public health law that contracts or offers to contract to
53 provide, deliver, arrange, pay or reimburse any of the costs of health
54 care services.

1 6. "Stand-Alone dental plan" means a dental services plan that has
2 been issued pursuant to applicable law and certified by the Marketplace
3 in accordance with section two hundred sixty-eight-d of this title.

4 7. "Qualified health plan" means a health plan that is issued pursuant
5 to applicable law and certified by the Marketplace in accordance with
6 section two hundred sixty-eight-d of this title, including a stand-alone
7 dental plan.

8 8. "Insurance affordability program" means Medicaid, child health
9 plus, the basic health program and any other health insurance subsidy
10 program designated as such by the commissioner.

11 9. "Eligible individual" means an individual, including a minor, who
12 is eligible to enroll in an insurance affordability program or other
13 health insurance program as determined by the commissioner.

14 10. "Qualified individual" means, with respect to qualified health
15 plans, an individual, including a minor, who:

16 (a) is eligible to enroll in a qualified health plan offered to indi-
17 viduals through the Marketplace;

18 (b) resides in this state;

19 (c) at the time of enrollment, is not incarcerated, other than incar-
20 ceration pending the disposition of charges; and

21 (d) is, and is reasonably expected to be, for the entire period for
22 which enrollment is sought, a citizen or national of the United States
23 or an alien lawfully present in the United States.

24 11. "Secretary" means the secretary of the United States department of
25 health and human services.

26 12. "SHOP" means the small business health options program operated by
27 the Marketplace to assist eligible small employers in this state in
28 selecting qualified health plans and/or other or additional health plans
29 certified by the Marketplace and to determine small employer eligibility
30 for purposes of small employer tax credits in accordance with applicable
31 federal and state laws and regulations.

32 13. "Small employer" means an employer which offers coverage where the
33 coverage such employer offers would be considered small group coverage
34 under the insurance law and regulations promulgated thereunder, provided
35 that it is not otherwise prohibited under the federal act.

36 14. "Small group market" means the health insurance market under which
37 individuals receive health insurance coverage on behalf of themselves
38 and their dependents through a group health plan maintained by a small
39 employer.

40 15. "Superintendent" means the superintendent of financial services.

41 16. "Essential health benefits" shall mean the categories of benefits
42 defined in subsection (a) of section three thousand two hundred seven-
43 teen-i and subsection (a) of section four thousand three hundred six-h
44 of the insurance law.

45 § 268-b. Establishment of NY State of Health, The Official Health Plan
46 Marketplace. 1. There is hereby established an office within the depart-
47 ment of health to be known as the "NY State of Health, The official
48 health plan Marketplace".

49 2. The purpose of the Marketplace is to facilitate enrollment in
50 health coverage and the purchase and sale of qualified health plans and
51 other health plans certified by the Marketplace; enroll individuals in
52 coverage for which they are eligible in accordance with federal and
53 state law; enable eligible individuals to receive premium tax credits,
54 cost-sharing reductions, and to access insurance affordability programs
55 and other health insurance programs as determined by the commissioner;
56 assist eligible small employers in selecting qualified health plans

1 and/or other, or additional health plans certified by the Marketplace
2 and to qualify for small employer tax credits in accordance with appli-
3 cable law; and to carry out other functions set forth in this title.

4 § 268-c. Functions of the Marketplace. The Marketplace shall:

5 1. (a) Perform eligibility determinations for federal and state insur-
6 ance affordability programs including medical assistance in accordance
7 with section three hundred sixty-six of the social services law, child
8 health plus in accordance with section twenty-five hundred eleven of
9 this chapter, the basic health program in accordance with section three
10 hundred sixty-nine-gg of the social services law, premium tax credits
11 and cost-sharing reductions and qualified health plans in accordance
12 with applicable law and other health insurance programs as determined by
13 the commissioner;

14 (b) certify and make available to qualified individuals, qualified
15 health plans, including dental plans, certified by the Marketplace
16 pursuant to applicable law, provided that coverage under such plans
17 shall not become effective prior to certification by the Marketplace;
18 and

19 (c) certify and/or make available to eligible individuals, health
20 plans certified by the Marketplace pursuant to applicable law, and/or
21 participating in an insurance affordability program pursuant to applica-
22 ble law, provided that coverage under such plans shall not become effec-
23 tive prior to certification by the Marketplace, and/or approval by the
24 commissioner.

25 2. Assign an actuarial value to each Marketplace certified plan
26 offered through the Marketplace in accordance with the criteria devel-
27 oped by the secretary pursuant to federal law or the superintendent
28 pursuant to the insurance law and/or requirements developed by the
29 Marketplace, and determine each health plan's level of coverage in
30 accordance with regulations issued by the secretary pursuant to federal
31 law or the superintendent pursuant to the insurance law.

32 3. Utilize a standardized format for presenting health benefit options
33 in the Marketplace, including the use of the uniform outline of coverage
34 established under section 2715 of the federal public health service act
35 or the insurance law.

36 4. Standardize the benefits available through the Marketplace at each
37 level of coverage defined by the superintendent in the insurance law.

38 5. Maintain enrollment periods in the best interest of qualified indi-
39 viduals consistent with federal and state law.

40 6. Implement procedures for the certification, recertification and
41 decertification of health plans as qualified health plans or health
42 plans approved for sale by the department of financial services or
43 department of health and certified by the Marketplace, consistent with
44 guidelines developed by the secretary pursuant to section 1311(c) of the
45 federal act and requirements developed by the Marketplace.

46 7. Contract for health care coverage offered to qualified individuals
47 through the Marketplace, and in doing so shall seek to provide health
48 care coverage choices that offer the optimal combination of choice,
49 value, quality, and service.

50 8. Contract for health care coverage offered to certain eligible indi-
51 viduals through the Marketplace, pursuant to health insurance programs
52 as determined by the commissioner, and in doing so shall seek to provide
53 health care coverage choices that offer the optimal combination of
54 choice, value, quality, and service;

1 9. Provide the minimum requirements an insurer shall meet to partic-
2 ipate in the Marketplace, in the best interest of qualified individuals
3 or eligible individuals;

4 10. Require qualified health plans and/or other health plans certified
5 by the Marketplace to offer those benefits determined to be essential
6 health benefits pursuant to state law or as required by the Marketplace.

7 11. Ensure that insurers offering health plans through the Marketplace
8 do not charge an individual enrollee a fee or penalty for termination of
9 coverage.

10 12. Provide for the operation of a toll-free telephone hotline to
11 respond to requests for assistance.

12 13. Maintain an internet website through which enrollees and prospec-
13 tive enrollees of qualified health plans and health plans certified by
14 the Marketplace may obtain standardized comparative information on such
15 plans and insurance affordability programs.

16 14. Make available by electronic means a calculator to determine the
17 actual cost of coverage after the application of any premium tax credit
18 under section 36B of the Internal Revenue Code of 1986 or applicable
19 state law and any cost-sharing reduction under federal or applicable
20 state law.

21 15. Operate a program under which the Marketplace awards grants to
22 entities to serve as navigators in accordance with applicable federal
23 law and regulations adopted thereunder, and/or a program under which the
24 Marketplace awards grants to entities to provide community based enroll-
25 ment assistance in accordance with requirements developed by the Market-
26 place; and/or a program under which the Marketplace certifies New York
27 state licensed producers to provide assistance to eligible individuals
28 and/or small employers pursuant to federal or state law.

29 16. In accordance with applicable federal and state law, inform indi-
30 viduals of eligibility requirements for the Medicaid program under title
31 XIX of the social security act and the social services law, the chil-
32 dren's health insurance program (CHIP) under title XXI of the social
33 security act and this chapter, the basic health program under section
34 three hundred sixty-nine-gg of the social services law, or any applica-
35 ble state or local public health insurance program and if, through
36 screening of the application by the Marketplace, the Marketplace deter-
37 mines that such individuals are eligible for any such program, enroll
38 such individuals in such program.

39 17. Grant a certification that an individual is exempt from the
40 requirement to maintain minimum essential coverage pursuant to federal
41 or state law and from any penalties imposed by such requirements
42 because:

43 (a) there is no affordable health plan available covering the individ-
44 ual, as defined by applicable law; or

45 (b) the individual meets the requirements for any other such exemption
46 from the requirement to maintain minimum essential coverage or to pay
47 the penalty pursuant to applicable federal or state law.

48 18. Operate a small business health options program ("SHOP") pursuant
49 to section 1311 of the federal act and applicable state law, through
50 which eligible small employers may select marketplace-certified quali-
51 fied health plans offered in the small group market, and through which
52 eligible small employers may receive assistance in qualifying for small
53 business tax credits available pursuant to federal and state law.

54 19. Enter into agreements as necessary with federal and state agencies
55 and other state Marketplaces to carry out its responsibilities under
56 this title, provided such agreements include adequate protections with

1 respect to the confidentiality of any information to be shared and
2 comply with all state and federal laws and regulations.

3 20. Perform duties required by the secretary, the secretary of the
4 United States department of the treasury or the commissioner related to
5 determining eligibility for premium tax credits or reduced cost-sharing
6 under applicable federal or state law.

7 21. Meet program integrity requirements under applicable law, includ-
8 ing keeping an accurate accounting of receipts and expenditures and
9 providing reports to the secretary regarding Marketplace related activ-
10 ities in accordance with applicable law.

11 22. Submit information provided by Marketplace applicants for verifi-
12 cation as required by section 1411(c) of the federal act and applicable
13 state law.

14 23. Establish rules and regulations that do not conflict with or
15 prevent the application of regulations promulgated by the secretary.

16 24. Determine eligibility, provide notices, and provide opportunities
17 for appeal and redetermination in accordance with the requirements of
18 federal and state law.

19 § 268-d. Special functions of the Marketplace related to health plan
20 certification and qualified health plan oversight. 1. Health plans
21 certified by the Marketplace shall meet the following requirements:

22 (a) The insurer offering the health plan:

23 (i) is licensed or certified by the superintendent or commissioner, in
24 good standing to offer health insurance coverage in this state, and
25 meets the requirements established by the Marketplace;

26 (ii) offers at least one qualified health plan and/or other or addi-
27 tional health plans authorized for sale by the department of financial
28 services or the department in each of the silver and gold levels as
29 required by state law, provided, however, that the Marketplace may
30 require additional benefit levels to be offered by all insurers partic-
31 ipating in the Marketplace;

32 (iii) has filed with and received approval from the superintendent of
33 its premium rates and policy or contract forms pursuant to the insurance
34 law and/or this chapter;

35 (iv) does not charge any cancellation fees or penalties for termi-
36 nation of coverage in violation of applicable law; and

37 (v) complies with the regulations developed by the secretary under
38 section 1311(c) of the federal act and such other requirements as the
39 Marketplace may establish.

40 (b) The health plan: (i) provides the essential health benefits pack-
41 age described in state law or required by the Marketplace and includes
42 such additional benefits as are mandated by state law, except that the
43 health plan shall not be required to provide essential benefits that
44 duplicate the minimum benefits of qualified dental plans if:

45 (A) the Marketplace has determined that at least one qualified dental
46 plan or dental plan approved by the department of financial services or
47 the department is available to supplement the health plan's coverage;
48 and

49 (B) the insurer makes prominent disclosure at the time it offers the
50 health plan, in a form approved by the Marketplace, that the plan does
51 not provide the full range of essential pediatric benefits, and that
52 qualified dental plans or dental plans approved by the department of
53 financial services or department of health providing those benefits and
54 other dental benefits not covered by the plan are offered through the
55 Marketplace;

(ii) provides at least a bronze level of coverage as defined by state law, unless the plan is certified as a qualified catastrophic plan, as defined in section 1302(e) of the federal act and the insurance law, and shall only be offered to individuals eligible for catastrophic coverage;

(iii) has cost-sharing requirements, including deductibles, which do not exceed the limits established under section 1302(c) of the federal act, state law and any requirements of the Marketplace;

(iv) complies with regulations promulgated by the secretary pursuant to section 1311(c) of the federal act and applicable state law, which include minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance;

(v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements; and

(vi) complies with the insurance law and this chapter requirements applicable to health insurance issued in this state and any regulations promulgated pursuant thereto that do not conflict with or prevent the application of federal requirements; and

(c) The Marketplace determines that making the health plan available through the Marketplace is in the interest of qualified individuals in this state.

2. The Marketplace shall not exclude a health plan:

(a) on the basis that the health plan is a fee-for-service plan;

(b) through the imposition of premium price controls by the Marketplace; or

(c) on the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Marketplace determines are inappropriate or too costly.

3. The Marketplace shall require each insurer certified or seeking certification of a health plan as a qualified health plan or plan approved for sale by the department of financial services or the department to:

(a) submit a justification for any premium increase pursuant to applicable law prior to implementation of such increase. The insurer shall prominently post the information on its internet website. Such rate increases shall be subject to the prior approval of the superintendent pursuant to the insurance law;

(b)(i) make available to the public and submit to the Marketplace, the secretary and the superintendent, accurate and timely disclosure of:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment and disenrollment;

(D) data on the number of claims that are denied;

(E) data on rating practices;

(F) information on cost-sharing and payments with respect to any out-of-network coverage;

(G) information on enrollee and participant rights under title I of the federal act; and

(H) other information as determined appropriate by the secretary or otherwise required by the Marketplace;

(ii) the information shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the federal act and state law,

1 and in guidance jointly issued thereunder by the secretary and the
2 federal secretary of labor; and

3 (c) provide to individuals, in a timely manner upon the request of the
4 individual, the amount of cost-sharing, including deductibles, copay-
5 ments, and coinsurance, under the individual's health plan or coverage
6 that the individual would be responsible for paying with respect to the
7 furnishing of a specific item or service by a participating provider. At
8 a minimum, this information shall be made available to the individual
9 through an internet website and through other means for individuals
10 without access to the internet.

11 4. The Marketplace shall not exempt any insurer seeking certification
12 of a health plan, regardless of the type or size of the insurer, from
13 licensing or solvency requirements under the insurance law or this chap-
14 ter, and shall apply the criteria of this section in a manner that
15 ensures a level playing field for insurers participating in the Market-
16 place.

17 5. (a) The provisions of this article that apply to qualified health
18 plans and plans approved for sale by the department of financial
19 services and the department also shall apply to the extent relevant to
20 qualified dental plans approved for sale by the department of financial
21 services or the department, except as modified in accordance with the
22 provisions of paragraphs (b) and (c) of this subdivision or otherwise
23 required by the Marketplace.

24 (b) The qualified dental plan or dental plan approved for sale by the
25 department of financial services and/or the department shall be limited
26 to dental and oral health benefits, without substantially duplicating
27 the benefits typically offered by health benefit plans without dental
28 coverage, and shall include, at a minimum, the essential pediatric
29 dental benefits prescribed by the secretary pursuant to section
30 1302(b)(1)(J) of the federal act, and such other dental benefits as the
31 Marketplace or secretary may specify in regulations.

32 (c) Insurers may jointly offer a comprehensive plan through the
33 Marketplace in which an insurer provides the dental benefits through a
34 qualified dental plan or plan approved by the department of financial
35 services or the department and an insurer provides the other benefits
36 through a qualified health plan, provided that the plans are priced
37 separately and also are made available for purchase separately at the
38 same price.

39 § 268-e. Appeals and appeal hearings; judicial review. 1. Any appli-
40 cant or enrollee, or any individual authorized to act on behalf of any
41 such applicant or enrollee, may appeal to the department from determi-
42 nations of department officials or failures to make determinations upon
43 grounds specified in subdivision four of this section. The department
44 must review the appeal de novo and give such person an opportunity for
45 an appeal hearing. The department may also, on its own motion, review
46 any decision made or any case in which a decision has not been made by
47 the Marketplace or a social services official within the time specified
48 by law or regulations of the department. The department may make such
49 additional investigation as it may deem necessary, and the commissioner
50 must make such determination as is justified and in accordance with
51 applicable law.

52 2. Regarding any appeal pursuant to this section, with or without an
53 appeal hearing, the commissioner may designate and authorize one or more
54 appropriate members of his staff to consider and decide such appeals.
55 Any staff member so designated and authorized will have authority to
56 decide such appeals on behalf of the commissioner with the same force

1 and effect as if the commissioner had made the decisions. Appeal hear-
2 ings must be held on behalf of the commissioner by members of his staff
3 who are employed for such purposes or who have been designated and
4 authorized by the commissioner.

5 3. Persons entitled to appeal to the department pursuant to this
6 section must include:

7 (a) applicants for or enrollees in insurance affordability programs
8 and qualified health plans; and

9 (b) other persons entitled to an opportunity for an appeal hearing as
10 directed by the commissioner.

11 4. An applicant or enrollee has the right to appeal at least the
12 following issues:

13 (a) An eligibility determination made in accordance with this article
14 and applicable law, including:

15 (i) An initial determination of eligibility, including:

16 (A) eligibility to enroll in a qualified health plan;

17 (B) eligibility for Medicaid;

18 (C) eligibility for Child Health Plus;

19 (D) eligibility for the Basic Health Program;

20 (E) the amount of advance payments of the premium tax credit and level
21 of cost-sharing reductions;

22 (F) the amount of any other subsidy that may be available under law;
23 and

24 (G) eligibility for such other health insurance programs as determined
25 by the commissioner; and

26 (ii) a re-determination of eligibility of the programs under this
27 subdivision.

28 (b) An eligibility determination for an exemption for any mandate to
29 purchase health insurance.

30 (c) A failure by NY State of Health to provide timely written notice
31 of an eligibility determination made in accordance with applicable law.

32 5. The department may, subject to the discretion of the commissioner,
33 promulgate such regulations, consistent with federal or state law, as
34 may be necessary to implement the provisions of this section.

35 6. Regarding every decision of an appeal pursuant to this section, the
36 department must inform every party, and his or her representative, if
37 any, of the availability of judicial review and the time limitation to
38 pursue future review.

39 7. Applicants and enrollees of qualified health plans, with or without
40 advance payments of the premium tax credit and cost-sharing reductions,
41 also have the right to appeal to the United States Department of Health
42 and Human Services appeal entity:

43 (a) appeals decisions issued by NY State of Health upon the exhaustion
44 of the NY State of Health appeals process; and

45 (b) a denial of a request to vacate a dismissal made by the NY State
46 of Health appeals entity.

47 8. The department must include notice of the right to appeal as
48 provided by subdivision four of this section and instructions regarding
49 how to file an appeal in any eligibility determination issued to the
50 applicant or enrollee in accordance with applicable law. Such notice
51 shall include:

52 (a) an explanation of the applicant or enrollee's appeal rights;

53 (b) a description of the procedures by which the applicant or enrollee
54 may request an appeal;

1 (c) information on the applicant or enrollee's right to represent
2 himself or herself, or to be represented by legal counsel or another
3 representative;

4 (d) an explanation of the circumstances under which the appellant's
5 eligibility may be maintained or reinstated pending an appeal decision;
6 and

7 (e) an explanation that an appeal decision for one household member
8 may result in a change in eligibility for other household members and
9 that such a change will be handled as a redetermination of eligibility
10 for all household members in accordance with the standards specified in
11 applicable law.

12 § 268-f. Marketplace advisory committee. 1. There is hereby created
13 the marketplace advisory committee, which shall consider and advise the
14 department and commissioner on matters concerning the provision of
15 health care coverage through the NY State of Health or Marketplace.

16 2. The marketplace advisory committee shall consist of up to twenty-
17 eight members appointed by the commissioner, representative of each
18 geographic area of the state and including:

19 (a) representatives from the following categories, but not more than
20 six from any single category:

21 (i) health plan consumer advocates;

22 (ii) small business consumer representatives;

23 (iii) health care provider representatives;

24 (iv) representatives of the health insurance industry;

25 (b) representatives from the following categories, but not more than
26 two from either category:

27 (i) licensed insurance producers; and

28 (ii) representatives of labor organizations.

29 3. The Marketplace shall select the chair of the advisory committee
30 from among the members of such committee and shall designate an officer
31 or employee of the department to assist the marketplace advisory commit-
32 tee in the performance of its duties under this section. The Marketplace
33 shall adopt rules for the governance of the advisory committee, which
34 shall meet as frequently as its business may require and at such other
35 times as determined by the Marketplace to be necessary.

36 4. Members of the advisory committee shall serve without compensation
37 for their services as members, but each shall be allowed the necessary
38 and actual expenses incurred in the performance of his or her duties
39 under this section.

40 § 268-g. Funding of the Marketplace. 1. The Marketplace shall be fund-
41 ed by state and federal sources as authorized by applicable law, includ-
42 ing but not limited to applicable law authorizing the respective insur-
43 ance affordability programs available through the Marketplace.

44 2. The accounts of the Marketplace shall be subject to supervision of
45 the comptroller and such accounts shall include receipts, expenditures,
46 contracts and other matters which pertain to the fiscal soundness of the
47 Marketplace.

48 3. Notwithstanding any law to the contrary, and in accordance with
49 section four of the state finance law, upon request of the director of
50 the budget, in consultation with the commissioner, the superintendent
51 and the executive director of the Marketplace, the comptroller is hereby
52 authorized and directed to sub-allocate or transfer special revenue
53 federal funds appropriated to the department for planning and implement-
54 ing various healthcare and insurance reform initiatives authorized by
55 applicable law. Marketplace moneys sub-allocated or transferred pursu-
56 ant to this section shall be paid out of the fund upon audit and warrant

1 of the state comptroller on vouchers certified or approved by the
2 Marketplace.

3 § 268-h. Construction. Nothing in this article, and no action taken by
4 the Marketplace pursuant hereto, shall be construed to:

5 1. preempt or supersede the authority of the superintendent or the
6 commissioner; or

7 2. exempt insurers, insurance producers or qualified health plans from
8 this chapter or the insurance law and any regulations promulgated there-
9 under.

10 § 3. Severability. If any provision of this article, or the applica-
11 tion thereof to any person or circumstances is held invalid or unconsti-
12 tutional, that invalidity or unconstitutionality shall not affect other
13 provisions or applications of this article that can be given effect
14 without the invalid or unconstitutional provision or application, and to
15 this end the provisions and application of this article are severable.

16 § 4. This act shall take effect immediately.

17 PART U

18 Section 1. Section 203 of the elder law is amended by adding a new
19 subdivision 12 to read as follows:

20 12. The director is hereby authorized to implement private pay proto-
21 cols for all programs administered by the office. These protocols may be
22 implemented by area agencies on aging at their option and such protocols
23 may not be applied to clients whose services are paid for with federal
24 funds or funds designated as federal match. All private payments
25 received directly by an area agency on aging or indirectly by one of its
26 contractors shall be used to supplement, not supplant, funds by state,
27 federal, or county appropriations. Private pay payments received under
28 this subdivision shall be used by the area agency on aging to support
29 and enhance services or programs provided by the area agency on aging.
30 Participant payments under this subdivision shall not be required of
31 individuals with incomes below four hundred percent of the federal
32 poverty level. No participant, regardless of income, shall be required
33 to pay for any service that they are receiving at the time these proto-
34 cols are implemented by the area agency on aging. This subdivision shall
35 not prevent cost sharing for the programs established pursuant to
36 section two hundred fourteen of this title for individuals below four
37 hundred percent of the federal poverty level.

38 § 2. This act shall take effect immediately.

39 PART V

40 Section 1. Paragraph (d) of subdivision 32 of section 364-j of the
41 social services law, as amended by section 15 of part B of chapter 59 of
42 the laws of 2016, is amended to read as follows:

43 (d) (i) Penalties under this subdivision may be applied to any and all
44 circumstances described in paragraph (b) of this subdivision until the
45 managed care organization complies with the requirements for submission
46 of encounter data.

47 (ii) No penalties for late, incomplete or inaccurate encounter data
48 shall be assessed against managed care organizations in addition to
49 those provided for in this subdivision, provided, however, that nothing
50 in this paragraph shall prohibit the imposition of penalties, in cases
51 of fraud or abuse, otherwise authorized by law.

§ 2. Section 364-j of the social services law is amended by adding a new subdivision 34 read as follows:

34. Any payment made pursuant to the state's managed care program, including payments made by managed long term care plans, shall be deemed a payment by the state's medical assistance program.

§ 3. Section 364-j of the social services law is amended by adding a new subdivision 36 to read as follows:

36. Medicaid Program Integrity Reviews. (a) For purposes of this subdivision, managed care provider shall also include managed long term care plans.

(b) The Medicaid inspector general shall conduct periodic reviews of the contractual performance of each managed care provider as it relates to the managed care provider's program integrity obligations under its contract with the department. The Medicaid inspector general, in consultation with the commissioner, shall publish a list of those contractual obligations which may be subject to review and how they shall be evaluated, including benchmarks, prior to commencing any review.

(c) If, as a result of his or her review, the Medicaid inspector general determines that a managed care provider is not meeting its program integrity obligations, the Medicaid inspector general may recover from the managed care provider up to two percent of the Medicaid premiums paid to the managed care provider for the period under review. Any premium recovery under this subdivision shall be a percentage of the administrative component of the Medicaid premium calculated by the department and may be recovered by the department in the same manner it recovers overpayments.

(d) The managed care provider shall be entitled to receive a draft audit report and final audit report containing the results of the Medicaid inspector general's review. If the Medicaid inspector general determines to recover a percentage of the premium as described in paragraph (c) of this subdivision, the managed care provider shall have an opportunity to be heard in accordance with section twenty-two of this chapter.

§ 4. Subdivision 3 of section 363-d of the social services law, as amended by section 44 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

3. Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section. Additionally, the commissioner of health and Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of this section.

(a) A compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this section, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(b) A compliance program that meets Federal requirements for managed care provider compliance programs, as specified in the contract or contracts between the department and the Medicaid managed care provider shall be deemed in compliance with the provisions in this section, so long as such programs adequately address medical assistance program risk areas and compliance issues. For purposes of this section, a managed care provider is as defined in paragraph (c) of subdivision one of

section three hundred sixty-four-j of this chapter, and includes managed long term care plans.

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

§ 5. Section 3613 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-a. Each home care services worker shall obtain an individual National Provider Identifier (NPI) number from the National Provider Plan and Provider Enumeration System (NPES).

§ 6. Section 364-j of the social services law is amended by adding a new subdivision 35 to read as follows:

35. Recovery of overpayments from network providers. (a) Where the Medicaid inspector general during the course of an audit, investigation, or review, or the deputy attorney general for the Medicaid fraud control unit during the course of an investigation or prosecution for Medicaid fraud, identifies medical assistance overpayments made by a managed care provider or managed long term care plan to its subcontractor or subcontractors or provider or providers, the state shall have the right to recover the overpayment from the subcontractor or subcontractors, provider or providers, or the managed care provider or managed long term care plan.

(b) Where the state is unsuccessful in recovering an overpayment from the subcontractor or subcontractors or provider or providers, the Medicaid inspector general may require the managed care provider or managed long term care plan to recover the medical assistance overpayment identified in paragraph (a) of this subdivision on behalf of the state. The managed care provider or managed long term care plan shall remit to the state the full amount of the identified overpayment no later than six months after receiving notice of the overpayment from the state.

§ 7. This act shall take effect immediately; provided, however, that the amendments to section 364-j of the social services law made by sections one, two, three, and six of this act shall not affect the repeal of such section and shall be deemed repealed therewith; provided further, that section three of this act shall apply to a contract or contracts in effect as of January 1, 2015 and any review period in section three of this act shall not begin before January 1, 2018.

PART W

Section 1. Section 1 of part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, as amended by section 1 of part H of chapter 59 of the laws of 2016, is amended to read as follows:

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commis-

1 sioner of mental health. Recovery of such excess income shall be for the
2 following fiscal periods: for programs in counties located outside of
3 the city of New York, the applicable fiscal periods shall be January 1,
4 2003 through December 31, 2009 and January 1, 2011 through December 31,
5 ~~2019~~ 2022; and for programs located within the city of New York, the
6 applicable fiscal periods shall be July 1, 2003 through June 30, 2010
7 and July 1, 2011 through June 30, ~~2019~~ 2022.

8 § 2. This act shall take effect immediately.

9

PART X

10 Section 1. Subdivision 9 of section 730.10 of the criminal procedure
11 law, as added by section 1 of part Q of chapter 56 of the laws of 2012,
12 is amended to read as follows:

13 9. "Appropriate institution" means: (a) a hospital operated by the
14 office of mental health or a developmental center operated by the office
15 for people with developmental disabilities; ~~or~~ (b) a hospital licensed
16 by the department of health which operates a psychiatric unit licensed
17 by the office of mental health, as determined by the commissioner
18 provided, however, that any such hospital that is not operated by the
19 state shall qualify as an "appropriate institution" only pursuant to the
20 terms of an agreement between the commissioner and the hospital; or (c)
21 a mental health unit operating within a local correctional facility
22 except those located within a city with a population of one million or
23 more; provided however, that any such mental health unit operating with-
24 in a local correctional facility shall qualify as an "appropriate insti-
25 tution" only pursuant to the terms of an agreement between the commis-
26 sioner of mental health, director of community services and the sheriff
27 for the respective locality. Nothing in this article shall be construed
28 as requiring a hospital or local correctional facility to consent to
29 providing care and treatment to an incapacitated person at such hospital
30 or local correctional facility. The commissioner of mental health shall
31 promulgate regulations for demonstration programs at no more than two
32 counties to implement restoration to competency within a local correc-
33 tional facility. Subject to annual appropriation, the commissioner of
34 mental health may, at such commissioner's discretion, make funds avail-
35 able for state aid grants to any county that develops and operates a
36 mental health unit within a local correctional facility pursuant to this
37 section. Nothing in this article shall be construed as requiring a
38 hospital or local correctional facility to consent to providing care and
39 treatment to an incapacitated person at such hospital or local correc-
40 tional facility.

41 § 2. This act shall take effect immediately and shall be deemed to
42 have been in full force and effect on and after April 1, 2019; provided,
43 however, that this act shall expire and be deemed repealed March 31,
44 2024; effective immediately, the addition, amendment and/or repeal of
45 any rule or regulation necessary for the implementation of this act on
46 its effective date are authorized to be made and completed on or before
47 such effective date.

48

PART Y

49 Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter
50 57 of the laws of 2006, relating to establishing a cost of living
51 adjustment for designated human services programs, as amended by section

1 of part AA of chapter 57 of the laws of 2018, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and ending March 31, ~~[2019]~~ 2020, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement~~[, provided that the commissioners of the office for people with developmental disabilities, the office of mental health, and the office of alcoholism and substance abuse services shall not include a COLA beginning April 1, 2017 and ending March 31, 2019]~~.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, ~~[2019]~~ 2020 and ending March 31, ~~[2022]~~ 2023, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART Z

Section 1. Subdivision 1 of section 2801 of the public health law, as amended by section 1 of subpart B of part S of chapter 57 of the laws of 2018, is amended to read as follows:

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health ~~[or]~~ substance use disorder services or developmental disability services

1 that can be provided by a provider of primary care services licensed
2 under this article and authorized to provide integrated services in
3 accordance with regulations issued by the commissioner in consultation
4 with the commissioner of the office of mental health [and], the commis-
5 sioner of the office of alcoholism and substance abuse services and the
6 commissioner of the office for people with developmental disabilities,
7 including regulations issued pursuant to subdivision seven of section
8 three hundred sixty-five-1 of the social services law or part L of chap-
9 ter fifty-six of the laws of two thousand twelve; (b) require a provider
10 licensed pursuant to article thirty-one of the mental hygiene law or
11 certified pursuant to article sixteen or article thirty-two of the
12 mental hygiene law to obtain an operating certificate from the depart-
13 ment if such provider has been authorized to provide integrated services
14 in accordance with regulations issued by the commissioner in consulta-
15 tion with the commissioner of the office of mental health [and], the
16 commissioner of the office of alcoholism and substance abuse services
17 and the commissioner of the office for people with developmental disa-
18 bilities, including regulations issued pursuant to subdivision seven of
19 section three hundred sixty-five-1 of the social services law or part L
20 of chapter fifty-six of the laws of two thousand twelve.

21 § 2. Subdivision (f) of section 31.02 of the mental hygiene law, as
22 added by section 2 of subpart B of part S of chapter 57 of the laws of
23 2018, is amended to read as follows:

24 (f) No provision of this article or any other provision of law shall
25 be construed to require a provider licensed pursuant to article twenty-
26 eight of the public health law or certified pursuant to article sixteen
27 or article thirty-two of this chapter to obtain an operating certificate
28 from the office of mental health if such provider has been authorized to
29 provide integrated services in accordance with regulations issued by the
30 commissioner of the office of mental health in consultation with the
31 commissioner of the department of health [and], the commissioner of the
32 office of alcoholism and substance abuse services and the commissioner
33 of the office for people with developmental disabilities, including
34 regulations issued pursuant to subdivision seven of section three
35 hundred sixty-five-1 of the social services law or part L of chapter
36 fifty-six of the laws of two thousand twelve.

37 § 3. Subdivision (b) of section 32.05 of the mental hygiene law, as
38 amended by section 3 of subpart B of part S of chapter 57 of the laws of
39 2018, is amended to read as follow:

40 (b) (i) Methadone, or such other controlled substance designated by
41 the commissioner of health as appropriate for such use, may be adminis-
42 tered to an addict, as defined in section thirty-three hundred two of
43 the public health law, by individual physicians, groups of physicians
44 and public or private medical facilities certified pursuant to article
45 twenty-eight or thirty-three of the public health law as part of a chem-
46 ical dependence program which has been issued an operating certificate
47 by the commissioner pursuant to subdivision (b) of section 32.09 of this
48 article, provided, however, that such administration must be done in
49 accordance with all applicable federal and state laws and regulations.
50 Individual physicians or groups of physicians who have obtained authori-
51 zation from the federal government to administer buprenorphine to
52 addicts may do so without obtaining an operating certificate from the
53 commissioner. (ii) No provision of this article or any other provision
54 of law shall be construed to require a provider licensed pursuant to
55 article twenty-eight of the public health law or article thirty-one of
56 this chapter to obtain an operating certificate from the office of alco-

1 holism and substance abuse services if such provider has been authorized
2 to provide integrated services in accordance with regulations issued by
3 the commissioner of alcoholism and substance abuse services in consulta-
4 tion with the commissioner of the department of health ~~[and]~~, the
5 commissioner of the office of mental health and the commissioner of the
6 office for people with developmental disabilities, including regulations
7 issued pursuant to subdivision seven of section three hundred sixty-
8 five-1 of the social services law or part L of chapter fifty-six of the
9 laws of two thousand twelve.

10 § 4. Section 16.03 of the mental hygiene law is amended by adding a
11 new subdivision (g) to read as follows:

12 (g) No provision of this article or any other provision of law shall
13 be construed to require a provider licensed pursuant to article twenty-
14 eight of the public health law or certified pursuant to article thirty-
15 one or thirty-two of this chapter to obtain an operating certificate
16 from the office for people with developmental disabilities if such
17 provider has been authorized to provide integrated services in accord-
18 ance with regulations issued by the commissioner of the office for
19 people with developmental disabilities, in consultation with the commis-
20 sioner of the department of health, the commissioner and the commis-
21 ioner of the office of alcoholism and substance abuse services, including
22 regulations issued pursuant to subdivision seven of section three
23 hundred sixty-five-1 of the social services law or part L of chapter
24 fifty-six of the laws of two thousand twelve.

25 § 5. This act shall take effect October 1, 2019; provided, however,
26 that the commissioner of the department of health, the commissioner of
27 the office of mental health, the commissioner of the office of alcohol-
28 ism and substance abuse services, and the commissioner of the office for
29 people with developmental disabilities are authorized to issue any rule
30 or regulation necessary for the implementation of this act on or before
31 its effective date.

32 PART AA

33 Section 1. Paragraph (a) of subdivision 4 of section 488 of the social
34 services law, as amended by section 2 of part MM of chapter 58 of the
35 laws of 2015, is amended to read as follows:

36 (a) a facility or program in which services are provided and which is
37 operated, licensed or certified by the office of mental health, the
38 office for people with developmental disabilities or the office of alco-
39 holism and substance abuse services, including but not limited to
40 psychiatric centers, ~~[inpatient psychiatric units of a general hospi-~~
41 ~~tal]~~ developmental centers, intermediate care facilities, community
42 residences, group homes and family care homes, provided, however, that
43 such term shall not include a secure treatment facility as defined in
44 section 10.03 of the mental hygiene law, services defined in subpara-
45 graph four of subdivision (a) of section 16.03 of the mental hygiene
46 law, ~~[or]~~ services provided in programs or facilities that are operated
47 by the office of mental health and located in state correctional facili-
48 ties under the jurisdiction of the department of corrections and commu-
49 nity supervision or services provided in a unit of a hospital, as
50 defined in subdivision one of section twenty-eight hundred one of the
51 public health law that is licensed or certified by the office of mental
52 health or the office of alcoholism and substance abuse services;

53 § 2. Paragraphs (c), (d) and (e) of subdivision 4 of section 488 of
54 the social services law, as added by section 1 of part B of chapter 501

1 of the laws of 2012, paragraph (d) as amended by chapter 126 of the laws
2 of 2014, and paragraph (e) as amended by chapter 83 of the laws of 2013,
3 are amended to read as follows:

4 (c) adult care facilities, which shall mean adult homes or enriched
5 housing programs licensed pursuant to article seven of this chapter: (i)
6 (A) that have a licensed capacity of eighty or more beds; and (B) in
7 which at least twenty-five percent of the residents are persons with
8 serious mental illness as defined by subdivision fifty-two of section
9 1.03 of the mental hygiene law; (ii) but not including an adult home or
10 enriched housing program which is authorized to operate fifty-five
11 percent or more of its total licensed capacity of beds as assisted
12 living program beds pursuant to section four hundred sixty-one-1 of this
13 chapter; **or**

14 ~~(d) [any overnight, summer day and traveling summer day camps for~~
15 ~~children with developmental disabilities as defined in regulations~~
16 ~~promulgated by the commissioner of health; or~~

17 ~~(e)]~~ the New York state school for the blind and the New York state
18 school for the deaf, which operate pursuant to articles eighty-seven and
19 eighty-eight of the education law; an institution for the instruction of
20 the deaf and the blind which has a residential component and is subject
21 to the visitation of the commissioner of education pursuant to article
22 eighty-five of the education law with respect to its day and residential
23 components; special act school districts serving students with disabili-
24 ties; or in-state private schools which have been approved by the
25 commissioner of education for special education services or programs,
26 and which have a residential program.

27 § 3. This act shall take effect August 1, 2019 and shall apply to
28 reports of abuse or neglect made on or after such date; provided that,
29 any reports of abuse or neglect reported to the justice center prior to
30 the effective date of this act shall be completed by the justice center.

31 PART BB

32 Section 1. This part enacts into law major components of legislation
33 which are necessary to effectuate provisions relating to mental health
34 and substance use disorder treatment. Each component is wholly
35 contained within a Subpart identified as Subparts A through E. The
36 effective date for each particular provision contained within such
37 Subpart is set forth in the last section of such Subpart. Any provision
38 in any section contained within a Subpart, including the effective date
39 of the Subpart, which makes a reference to a section "of this act", when
40 used in connection with that particular component, shall be deemed to
41 mean and refer to the corresponding section of the Subpart in which it
42 is found. Section three of this Part sets forth the general effective
43 date of this Part.

44 SUBPART A

45 Section 1. Paragraph 4 of subsection (i) of section 3216 of the insur-
46 ance law is amended to read as follows:

47 (4) If a policy provides for reimbursement for psychiatric or psycho-
48 logical services or for diagnosis and treatment of mental~~, nervous, or~~
49 ~~emotional disorders or ailments,~~ **health conditions** however defined in
50 the policy, the insured shall be entitled to reimbursement for such
51 services, diagnosis or treatment whether performed by a physician,
52 psychiatrist ~~[or]~~, a certified and registered psychologist, **or a nurse**

1 practitioner when the services rendered are within the lawful scope of
2 their practice.

3 § 2. Subparagraph (B) of paragraph 25 of subsection (i) of section
4 3216 of the insurance law, as amended by section 38 of part D of chapter
5 56 of the laws of 2013, is amended to read as follows:

6 (B) Every policy that provides physician services, medical, major
7 medical or similar comprehensive-type coverage shall provide coverage
8 for the screening, diagnosis and treatment of autism spectrum disorder
9 in accordance with this paragraph and shall not exclude coverage for the
10 screening, diagnosis or treatment of medical conditions otherwise
11 covered by the policy because the individual is diagnosed with autism
12 spectrum disorder. Such coverage may be subject to annual deductibles,
13 copayments and coinsurance as may be deemed appropriate by the super-
14 intendent and shall be consistent with those imposed on other benefits
15 under the policy. ~~[Coverage for applied behavior analysis shall be~~
16 ~~subject to a maximum benefit of six hundred eighty hours of treatment~~
17 ~~per policy or calendar year per covered individual.]~~ This paragraph
18 shall not be construed as limiting the benefits that are otherwise
19 available to an individual under the policy, provided however that such
20 policy shall not contain any limitations on visits that are solely
21 applied to the treatment of autism spectrum disorder. No insurer shall
22 terminate coverage or refuse to deliver, execute, issue, amend, adjust,
23 or renew coverage to an individual solely because the individual is
24 diagnosed with autism spectrum disorder or has received treatment for
25 autism spectrum disorder. Coverage shall be subject to utilization
26 review and external appeals of health care services pursuant to article
27 forty-nine of this chapter as well as[7] case management[7] and other
28 managed care provisions.

29 § 3. Items (i) and (iii) of subparagraph (C) of paragraph 25 of
30 subsection (i) of section 3216 of the insurance law, as amended by chap-
31 ter 596 of the laws of 2011, are amended to read as follows:

32 (i) "autism spectrum disorder" means any pervasive developmental
33 disorder as defined in the most recent edition of the diagnostic and
34 statistical manual of mental disorders~~[, including autistic disorder,~~
35 ~~Asperger's disorder, Rett's disorder, childhood disintegrative disorder,~~
36 ~~or pervasive developmental disorder not otherwise specified (PDD-NOS)].~~

37 (iii) "behavioral health treatment" means counseling and treatment
38 programs, when provided by a licensed provider, and applied behavior
39 analysis, when provided ~~[or supervised] by a [behavior analyst certified~~
40 ~~pursuant to the behavior analyst certification board]~~ person licensed,
41 certified or otherwise authorized to provide applied behavior analysis,
42 that are necessary to develop, maintain, or restore, to the maximum
43 extent practicable, the functioning of an individual. ~~[Individuals that~~
44 ~~provide behavioral health treatment under the supervision of a certified~~
45 ~~behavior analyst pursuant to this paragraph shall be subject to stand-~~
46 ~~ards of professionalism, supervision and relevant experience pursuant to~~
47 ~~regulations promulgated by the superintendent in consultation with the~~
48 ~~commissioners of health and education.]~~

49 § 4. Paragraph 25 of subsection (i) of section 3216 of the insurance
50 law is amended by adding four new subparagraphs (H), (I), (J), and (K)
51 to read as follows:

52 (H) Coverage under this paragraph shall not apply financial require-
53 ments or treatment limitations to autism spectrum disorder benefits that
54 are more restrictive than the predominant financial requirements and
55 treatment limitations applied to substantially all medical and surgical
56 benefits covered by the policy.

1 (I) The criteria for medical necessity determinations under the policy
2 with respect to autism spectrum disorder benefits shall be made avail-
3 able by the insurer to any insured, prospective insured, or in-network
4 provider upon request.

5 (J) For purposes of this paragraph:

6 (i) "financial requirement" means deductible, copayments, coinsurance
7 and out-of-pocket expenses;

8 (ii) "predominant" means that a financial requirement or treatment
9 limitation is the most common or frequent of such type of limit or
10 requirement; and

11 (iii) "treatment limitation" means limits on the frequency of treat-
12 ment, number of visits, days of coverage, or other similar limits on the
13 scope or duration of treatment and includes nonquantitative treatment
14 limitations such as: medical management standards limiting or excluding
15 benefits based on medical necessity, or based on whether the treatment
16 is experimental or investigational; formulary design for prescription
17 drugs; network tier design; standards for provider admission to partic-
18 ipate in a network, including reimbursement rates; methods for deter-
19 mining usual, customary, and reasonable charges; fail-first or step
20 therapy protocols; exclusions based on failure to complete a course of
21 treatment; and restrictions based on geographic location, facility type,
22 provider specialty, and other criteria that limit the scope or duration
23 of benefits for services provided under the policy.

24 (K) An insurer shall provide coverage under this paragraph, at a mini-
25 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
26 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

27 § 5. Paragraph 30 of subsection (i) of section 3216 of the insurance
28 law, as amended by section 1 of part B of chapter 71 of the laws of
29 2016, is amended to read as follows:

30 (30)(A) Every policy that provides hospital, major medical or similar
31 comprehensive coverage ~~[must]~~ shall provide inpatient coverage for the
32 diagnosis and treatment of substance use disorder, including detoxifica-
33 tion and rehabilitation services. Such inpatient coverage shall include
34 unlimited medically necessary treatment for substance use disorder
35 treatment services provided in residential settings ~~[as required by the~~
36 ~~Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §~~
37 ~~1185a)]~~. Further, such inpatient coverage shall not apply financial
38 requirements or treatment limitations, including utilization review
39 requirements, to inpatient substance use disorder benefits that are more
40 restrictive than the predominant financial requirements and treatment
41 limitations applied to substantially all medical and surgical benefits
42 covered by the policy. ~~[Further, such coverage shall be provided~~
43 ~~consistent with the federal Paul Wellstone and Pete Domenici Mental~~
44 ~~Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]~~

45 (B) Coverage provided under this paragraph may be limited to facili-
46 ties in New York state ~~[which are certified]~~ that are licensed, certi-
47 fied or otherwise authorized by the office of alcoholism and substance
48 abuse services and, in other states, to those which are accredited by
49 the joint commission as alcoholism, substance abuse, or chemical depend-
50 ence treatment programs and are similarly licensed, certified or other-
51 wise authorized in the state in which the facility is located.

52 (C) Coverage provided under this paragraph may be subject to annual
53 deductibles and co-insurance as deemed appropriate by the superintendent
54 and that are consistent with those imposed on other benefits within a
55 given policy.

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first ~~[fourteen]~~ twenty-one days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within ~~[forty-eight hours]~~ two business days of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first ~~[fourteen]~~ twenty-one days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial ~~[fourteen]~~ twenty-one day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(E) An insurer shall make available to any insured, prospective insured, or in-network provider, upon request, the criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits.

(F) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice, such as the international classification of diseases.

(G) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 6. Paragraph 31 of subsection (i) of section 3216 of the insurance law, as added by chapter 41 of the laws of 2014 and subparagraph (E) as added by section 3 of part MM of chapter 57 of the laws of 2018, is amended to read as follows:

(31) (A) Every policy that provides medical, major medical or similar comprehensive-type coverage ~~[must]~~ shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. ~~[Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]~~

(B) Coverage under this paragraph may be limited to facilities in New York state ~~[certified]~~ that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services ~~[or licensed by such office as outpatient clinics or medically supervised ambulatory]~~ to provide outpatient substance ~~[abuse programs]~~ use disorder services and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence substance abuse treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

(C) Coverage provided under this paragraph may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given policy.

(D) A policy providing coverage for substance use disorder services pursuant to this paragraph shall provide up to twenty outpatient visits per policy or calendar year to an individual who identifies him or herself as a family member of a person suffering from substance use disorder and who seeks treatment as a family member who is otherwise covered by the applicable policy pursuant to this paragraph. The coverage required by this paragraph shall include treatment as a family member pursuant to such family member's own policy provided such family member:

(i) does not exceed the allowable number of family visits provided by the applicable policy pursuant to this paragraph; and

(ii) is otherwise entitled to coverage pursuant to this paragraph and such family member's applicable policy.

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first ~~[two]~~ three weeks of continuous treatment, not to exceed ~~[fourteen]~~ twenty-one visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within ~~[forty-eight hours]~~ two business days. The facility shall perform clinical assessment of the patient at each visit, including the periodic

1 consultation with the insurer to ensure that the facility is using the
2 evidence-based and peer reviewed clinical review tool utilized by the
3 insurer which is designated by the office of alcoholism and substance
4 abuse services and appropriate to the age of the patient, to ensure that
5 the outpatient treatment is medically necessary for the patient. Any
6 utilization review of the treatment provided under this subparagraph may
7 include a review of all services provided during such outpatient treat-
8 ment, including all services provided during the first [~~two~~] three weeks
9 of continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, of
10 such outpatient treatment. Provided, however, the insurer shall only
11 deny coverage for any portion of the initial [~~two~~] three weeks of
12 continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, for
13 outpatient treatment on the basis that such treatment was not medically
14 necessary if such outpatient treatment was contrary to the evidence-
15 based and peer reviewed clinical review tool utilized by the insurer
16 which is designated by the office of alcoholism and substance abuse
17 services. An insured shall not have any financial obligation to the
18 facility for any treatment under this subparagraph other than any copay-
19 ment, coinsurance, or deductible otherwise required under the policy.

20 (F) The criteria for medical necessity determinations under the policy
21 with respect to outpatient substance use disorder benefits shall be made
22 available by the insurer to any insured, prospective insured, or in-net-
23 work provider upon request.

24 (G) For purposes of this paragraph:

25 (i) "financial requirement" means deductible, copayments, coinsurance
26 and out-of-pocket expenses;

27 (ii) "predominant" means that a financial requirement or treatment
28 limitation is the most common or frequent of such type of limit or
29 requirement;

30 (iii) "treatment limitation" means limits on the frequency of treat-
31 ment, number of visits, days of coverage, or other similar limits on the
32 scope or duration of treatment and includes nonquantitative treatment
33 limitations such as: medical management standards limiting or excluding
34 benefits based on medical necessity, or based on whether the treatment
35 is experimental or investigational; formulary design for prescription
36 drugs; network tier design; standards for provider admission to partic-
37 ipate in a network, including reimbursement rates; methods for determin-
38 ing usual, customary, and reasonable charges; fail-first or step therapy
39 protocols; exclusions based on failure to complete a course of treat-
40 ment; and restrictions based on geographic location, facility type,
41 provider specialty, and other criteria that limit the scope or duration
42 of benefits for services provided under the policy; and

43 (iv) "substance use disorder" shall have the meaning set forth in the
44 most recent edition of the diagnostic and statistical manual of mental
45 disorders or the most recent edition of another generally recognized
46 independent standard of current medical practice such as the interna-
47 tional classification of diseases.

48 (H) An insurer shall provide coverage under this paragraph, at a mini-
49 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
50 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

51 § 7. Paragraph 31-a of subsection (i) of section 3216 of the insurance
52 law, as added by section 1 of part B of chapter 69 of the laws of 2016,
53 is amended to read as follows:

54 (31-a) [~~(A)~~] Every policy that provides medical, major medical or
55 similar comprehensive-type coverage and provides coverage for
56 prescription drugs for medication for the treatment of a substance use

1 disorder shall include immediate access, without prior authorization, to
2 ~~[a five day emergency supply]~~ the formulary forms of prescribed medica-
3 tions covered under the policy for the treatment of substance use disorder
4 ~~[where an emergency condition exists]~~, including a prescribed drug
5 or medication associated with the management of opioid withdrawal and/or
6 stabilization, except where otherwise prohibited by law. Further, cover-
7 age ~~[of an emergency supply]~~ without prior authorization shall include
8 formulary forms of medication for opioid overdose reversal otherwise
9 covered under the policy prescribed or dispensed to an individual
10 covered by the policy.

11 ~~[(B) For purposes of this paragraph, an "emergency condition" means a~~
12 ~~substance use disorder condition that manifests itself by acute symptoms~~
13 ~~of sufficient severity, including severe pain or the expectation of~~
14 ~~severe pain, such that a prudent layperson, possessing an average know-~~
15 ~~ledge of medicine and health, could reasonably expect the absence of~~
16 ~~immediate medical attention to result in:~~

17 ~~(i) placing the health of the person afflicted with such condition in~~
18 ~~serious jeopardy, or in the case of a behavioral condition, placing the~~
19 ~~health of such person or others in serious jeopardy;~~

20 ~~(ii) serious impairment to such person's bodily functions;~~

21 ~~(iii) serious dysfunction of any bodily organ or part of such person;~~

22 ~~(iv) serious disfigurement of such person; or~~

23 ~~(v) a condition described in clause (i), (ii), or (iii) of section~~
24 ~~1867(e)(1)(A) of the Social Security Act.~~

25 ~~[(C) Coverage provided under this paragraph may be subject to copay-~~
26 ~~ments, coinsurance, and annual deductibles that are consistent with~~
27 ~~those imposed on other benefits within the policy; provided, however, no~~
28 ~~policy shall impose an additional copayment or coinsurance on an insured~~
29 ~~who received an emergency supply of medication and then received up to a~~
30 ~~thirty day supply of the same medication in the same thirty day period~~
31 ~~in which the emergency supply of medication was dispensed. This subpara-~~
32 ~~graph shall not preclude the imposition of a copayment or coinsurance on~~
33 ~~the initial emergency supply of medication in an amount that is less~~
34 ~~than the copayment or coinsurance otherwise applicable to a thirty day~~
35 ~~supply of such medication, provided that the total sum of the copayments~~
36 ~~or coinsurance for an entire thirty day supply of the medication does~~
37 ~~not exceed the copayment or coinsurance otherwise applicable to a thirty~~
38 ~~day supply of such medication.]~~

39 § 8. Subsection (i) of section 3216 of the insurance law is amended by
40 adding a new paragraph 35 to read as follows:

41 (35) (A) Every policy delivered or issued for delivery in this state
42 that provides coverage for inpatient hospital care or coverage for
43 physician services shall provide coverage for the diagnosis and treat-
44 ment of mental health conditions as follows:

45 (i) where the policy provides coverage for inpatient hospital care,
46 benefits for inpatient care in a hospital as defined by subdivision ten
47 of section 1.03 of the mental hygiene law and benefits for outpatient
48 care provided in a facility issued an operating certificate by the
49 commissioner of mental health pursuant to the provisions of article
50 thirty-one of the mental hygiene law, or in a facility operated by the
51 office of mental health, or, for care provided in other states, to simi-
52 larly licensed or certified hospitals or facilities; and

53 (ii) where the policy provides coverage for physician services, bene-
54 fits for outpatient care provided by a psychiatrist or psychologist
55 licensed to practice in this state, a licensed clinical social worker
56 who meets the requirements of subparagraph (D) of paragraph four of

1 subsection (1) of section three thousand two hundred twenty-one of this
2 article, a nurse practitioner licensed to practice in this state, or a
3 professional corporation or university faculty practice corporation
4 thereof.

5 (B) Coverage required by this paragraph may be subject to annual
6 deductibles, copayments and coinsurance as may be deemed appropriate by
7 the superintendent and shall be consistent with those imposed on other
8 benefits under the policy.

9 (C) Coverage under this paragraph shall not apply financial require-
10 ments or treatment limitations to mental health benefits that are more
11 restrictive than the predominant financial requirements and treatment
12 limitations applied to substantially all medical and surgical benefits
13 covered by the policy.

14 (D) The criteria for medical necessity determinations under the policy
15 with respect to mental health benefits shall be made available by the
16 insurer to any insured, prospective insured, or in-network provider upon
17 request.

18 (E) For purposes of this paragraph:

19 (i) "financial requirement" means deductible, copayments, coinsurance
20 and out-of-pocket expenses;

21 (ii) "predominant" means that a financial requirement or treatment
22 limitation is the most common or frequent of such type of limit or
23 requirement;

24 (iii) "treatment limitation" means limits on the frequency of treat-
25 ment, number of visits, days of coverage, or other similar limits on the
26 scope or duration of treatment and includes nonquantitative treatment
27 limitations such as: medical management standards limiting or excluding
28 benefits based on medical necessity, or based on whether the treatment
29 is experimental or investigational; formulary design for prescription
30 drugs; network tier design; standards for provider admission to partic-
31 ipate in a network, including reimbursement rates; methods for determin-
32 ing usual, customary, and reasonable charges; fail-first or step therapy
33 protocols; exclusions based on failure to complete a course of treat-
34 ment; and restrictions based on geographic location, facility type,
35 provider specialty, and other criteria that limit the scope or duration
36 of benefits for services provided under the policy; and

37 (iv) "mental health condition" means any mental health disorder as
38 defined in the most recent edition of the diagnostic and statistical
39 manual of mental disorders or the most recent edition of another gener-
40 ally recognized independent standard of current medical practice such as
41 the international classification of diseases.

42 (F) An insurer shall provide coverage under this paragraph, at a mini-
43 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
44 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

45 (G) This subparagraph shall apply to hospitals in this state that are
46 licensed by the office of mental health that are participating in the
47 insurer's provider network. Where the policy provides coverage for inpa-
48 tient hospital care, benefits for inpatient hospital care in a hospital
49 as defined by subdivision ten of section 1.03 of the mental hygiene law
50 provided to individuals who have not attained the age of eighteen shall
51 not be subject to preauthorization. Coverage provided under this para-
52 graph shall also not be subject to concurrent utilization review during
53 the first fourteen days of the inpatient admission, provided the facili-
54 ty notifies the insurer of both the admission and the initial treatment
55 plan within two business days of the admission, performs daily clinical
56 review of the patient, and participates in periodic consultation with

the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the patient, to ensure that the inpatient care is medically necessary for the patient. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

§ 9. Paragraphs 17, 19 and 20 of subsection 2 of section 3217-a of the insurance law, paragraph 17 as amended and paragraphs 19 and 20 as added by section 1 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph 21 is added to read as follows:

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of alcoholism and substance abuse services, and any restrictions regarding the availability of the individual provider's services; and [~~in addition,~~] (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

(19) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; [~~and~~]

(20) information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[~~+~~]; and

(21) the most recent comparative analysis performed by the insurer to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under those acts.

§ 10. Subsection (b) of section 3217-b of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) No insurer subject to this article shall by contract, written policy [~~or~~], written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such insurer which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall an insurer subject to this article take any adverse action, including but

not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such insurer which may violate this chapter including paragraphs thirty, as added by chapter forty-one of the laws of 2014, thirty-one, thirty-one-a and thirty-five of subsection (i) of section thirty-two hundred sixteen and paragraphs five, six, seven, seven-a and seven-b of subsection (1) of section thirty-two hundred twenty-one of this article.

§ 11. Subparagraph (A) of paragraph 4 of subsection (1) of section 3221 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, ~~[which]~~ that provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental~~[, nervous or emotional disorders and ailments]~~ health conditions, however defined in such policy, by physicians, psychiatrists or psychologists, ~~[must]~~ shall make available and if requested by the policyholder provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

§ 12. Subparagraph (D) of paragraph 4 of subsection (1) of section 3221 of the insurance law, as amended by section 50 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state where the policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental~~[, nervous or emotional disorders and ailments]~~ health conditions, however defined in such policy, by physicians, psychiatrists or psychologists, shall provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either: (i) three or more additional years experience in psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior that are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental~~[, nervous or emotional disorders or ailments]~~ health conditions; (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection (e) of this section, or (iii) a combination of the experience specified in items (i) and (ii) of this subparagraph totaling three years, satisfactory to the state board for social work.

§ 13. Subparagraphs (A) and (B) of paragraph 5 of subsection (1) of section 3221 of the insurance law, as amended by chapter 502 of the laws of 2007, are amended to read as follows:

(A) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services shall provide ~~[as part of such policy broad-based]~~ coverage for the diagnosis and treatment of mental ~~[, nervous or emotional disorders or ailments, however defined in such policy, at least equal to the coverage provided for other]~~ health conditions and:

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law ~~[, which benefits may be limited to not less than thirty days of active treatment in any contract year, plan year or calendar year,]~~ and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health ~~[, which benefits may be limited to not less than twenty visits in any contract year, plan year or calendar year. Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day of treatment.]~~ or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

(ii) where the policy provides coverage for physician services, it shall include benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subparagraph (D) of paragraph four of this subsection, a nurse practitioner licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof. ~~[Such benefits may be limited to not less than twenty visits in any contract year, plan year, or calendar year.]~~

~~[(iii)]~~ (B) Coverage required by this paragraph may be ~~[provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the policy. Such coverage may be]~~ subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. ~~[In the event that a policy provides coverage for both inpatient hospital care and physician services, the aggregate of the benefits for outpatient care obtained under this paragraph may be limited to not less than twenty visits in any contract year, plan year or calendar year.]~~

~~(iv) In this paragraph, "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.~~

~~(B) (i) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services, shall provide comparable coverage for adults and children with biologically based mental illness. Such group policies issued or delivered in this state shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the policy, including network limitations or variations, exclu-~~

~~sions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a policy provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the policy is written under one license or two licenses.~~

~~(ii) For purposes of this paragraph, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.]~~ Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the policy.

§ 14. Subparagraphs (C), (D) and (E) of paragraph 5 of subsection (1) of section 3221 of the insurance law are REPEALED and five new subparagraphs (C), (D), (E), (F) and (G) are added to read as follows:

(C) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(D) The criteria for medical necessity determinations under the policy with respect to mental health benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(E) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

1 (F) An insurer shall provide coverage under this paragraph, at a mini-
2 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
3 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

4 (G) This subparagraph shall apply to hospitals in this state that are
5 licensed by the office of mental health that are participating in the
6 insurer's provider network. Where the policy provides coverage for inpa-
7 tient hospital care, benefits for inpatient hospital care in a hospital
8 as defined by subdivision ten of section 1.03 of the mental hygiene law
9 provided to individuals who have not attained the age of eighteen shall
10 not be subject to preauthorization. Coverage provided under this para-
11 graph shall also not be subject to concurrent utilization review during
12 the first fourteen days of the inpatient admission, provided the facili-
13 ty notifies the insurer of both the admission and the initial treatment
14 plan within two business days of the admission, performs daily clinical
15 review of the patient, and participates in periodic consultation with
16 the insurer to ensure that the facility is using the evidence-based and
17 peer reviewed clinical review criteria utilized by the insurer which is
18 approved by the office of mental health and appropriate to the age of
19 the patient, to ensure that the inpatient care is medically necessary
20 for the patient. All treatment provided under this subparagraph may be
21 reviewed retrospectively. Where care is denied retrospectively, an
22 insured shall not have any financial obligation to the facility for any
23 treatment under this subparagraph other than any copayment, coinsurance,
24 or deductible otherwise required under the policy.

25 § 15. Subparagraphs (A), (B) and (D) of paragraph 6 of subsection (1)
26 of section 3221 of the insurance law, as amended by section 2 of part B
27 of chapter 71 of the laws of 2016, are amended and three new subpara-
28 graphs (E), (F) and (G) are added to read as follows:

29 (A) Every policy that provides hospital, major medical or similar
30 comprehensive coverage ~~[must]~~ shall provide inpatient coverage for the
31 diagnosis and treatment of substance use disorder, including detoxifica-
32 tion and rehabilitation services. Such inpatient coverage shall include
33 unlimited medically necessary treatment for substance use disorder
34 treatment services provided in residential settings ~~[as required by the~~
35 ~~Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §~~
36 ~~1185a)]~~. Further, such inpatient coverage shall not apply financial
37 requirements or treatment limitations, including utilization review
38 requirements, to inpatient substance use disorder benefits that are more
39 restrictive than the predominant financial requirements and treatment
40 limitations applied to substantially all medical and surgical benefits
41 covered by the policy. ~~[Further, such coverage shall be provided~~
42 ~~consistent with the federal Paul Wellstone and Pete Domenici Mental~~
43 ~~Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]~~

44 (B) Coverage provided under this paragraph may be limited to facili-
45 ties in New York state ~~[which are certified]~~ that are licensed, certi-
46 fied or otherwise authorized by the office of alcoholism and substance
47 abuse services and, in other states, to those which are accredited by
48 the joint commission as alcoholism, substance abuse or chemical depend-
49 ence treatment programs and are similarly licensed, certified, or other-
50 wise authorized in the state in which the facility is located.

51 (D) This subparagraph shall apply to facilities in this state that are
52 licensed, certified or otherwise authorized by the office of alcoholism
53 and substance abuse services that are participating in the insurer's
54 provider network. Coverage provided under this paragraph shall not be
55 subject to preauthorization. Coverage provided under this paragraph
56 shall also not be subject to concurrent utilization review during the

1 first [~~fourteen~~] twenty-one days of the inpatient admission provided
2 that the facility notifies the insurer of both the admission and the
3 initial treatment plan within [~~forty-eight hours~~] two business days of
4 the admission. The facility shall perform daily clinical review of the
5 patient, including the periodic consultation with the insurer to ensure
6 that the facility is using the evidence-based and peer reviewed clinical
7 review tool utilized by the insurer which is designated by the office of
8 alcoholism and substance abuse services and appropriate to the age of
9 the patient, to ensure that the inpatient treatment is medically neces-
10 sary for the patient. Any utilization review of treatment provided under
11 this subparagraph may include a review of all services provided during
12 such inpatient treatment, including all services provided during the
13 first [~~fourteen~~] twenty-one days of such inpatient treatment. Provided,
14 however, the insurer shall only deny coverage for any portion of the
15 initial [~~fourteen~~] twenty-one day inpatient treatment on the basis that
16 such treatment was not medically necessary if such inpatient treatment
17 was contrary to the evidence-based and peer reviewed clinical review
18 tool utilized by the insurer which is designated by the office of alco-
19 holism and substance abuse services. An insured shall not have any
20 financial obligation to the facility for any treatment under this
21 subparagraph other than any copayment, coinsurance, or deductible other-
22 wise required under the policy.

23 (E) The criteria for medical necessity determinations under the policy
24 with respect to inpatient substance use disorder benefits shall be made
25 available by the insurer to any insured, prospective insured, or in-net-
26 work provider upon request.

27 (F) For purposes of this paragraph:

28 (i) "financial requirement" means deductible, copayments, coinsurance
29 and out-of-pocket expenses;

30 (ii) "predominant" means that a financial requirement or treatment
31 limitation is the most common or frequent of such type of limit or
32 requirement;

33 (iii) "treatment limitation" means limits on the frequency of treat-
34 ment, number of visits, days of coverage, or other similar limits on the
35 scope or duration of treatment and includes nonquantitative treatment
36 limitations such as: medical management standards limiting or excluding
37 benefits based on medical necessity, or based on whether the treatment
38 is experimental or investigational; formulary design for prescription
39 drugs; network tier design; standards for provider admission to partic-
40 ipate in a network, including reimbursement rates; methods for determin-
41 ing usual, customary, and reasonable charges; fail-first or step therapy
42 protocols; exclusions based on failure to complete a course of treat-
43 ment; and restrictions based on geographic location, facility type,
44 provider specialty, and other criteria that limit the scope or duration
45 of benefits for services provided under the policy; and

46 (iv) "substance use disorder" shall have the meaning set forth in the
47 most recent edition of the diagnostic and statistical manual of mental
48 disorders or the most recent edition of another generally recognized
49 independent standard of current medical practice such as the interna-
50 tional classification of diseases.

51 (G) An insurer shall provide coverage under this paragraph, at a mini-
52 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
53 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

54 § 16. Subparagraphs (A) and (B) of paragraph 7 of subsection (1) of
55 section 3221 of the insurance law, as amended by chapter 41 of the laws

1 of 2014, are amended and a new subparagraph (C-1) is added to read as
2 follows:

3 (A) Every policy that provides medical, major medical or similar
4 comprehensive-type coverage ~~[must]~~ shall provide outpatient coverage for
5 the diagnosis and treatment of substance use disorder, including detoxi-
6 fication and rehabilitation services. Such coverage shall not apply
7 financial requirements or treatment limitations to outpatient substance
8 use disorder benefits that are more restrictive than the predominant
9 financial requirements and treatment limitations applied to substantial-
10 ly all medical and surgical benefits covered by the policy. ~~[Further,~~
11 ~~such coverage shall be provided consistent with the federal Paul Well-~~
12 ~~stone and Pete Domenici Mental Health Parity and Addiction Equity Act of~~
13 ~~2008 (29 U.S.C. § 1185a).]~~

14 (B) Coverage under this paragraph may be limited to facilities in New
15 York state that are licensed, certified or otherwise authorized by the
16 office of alcoholism and substance abuse services ~~[or licensed by such~~
17 ~~office as outpatient clinics or medically supervised ambulatory~~
18 ~~substance abuse programs]~~ to provide outpatient substance use disorder
19 services and, in other states, to those which are accredited by the
20 joint commission as alcoholism or chemical dependence treatment programs
21 and similarly licensed, certified or otherwise authorized in the state
22 in which the facility is located.

23 (C-1) A large group policy that provides coverage under this paragraph
24 may not impose copayments or coinsurance for outpatient substance use
25 disorder services that exceeds the copayment or coinsurance imposed for
26 a primary care office visit. Provided that only one such copayment may
27 be imposed for all services provided in a single day by a facility
28 licensed, certified or otherwise authorized by the office of alcoholism
29 and substance abuse services to provide outpatient substance use disor-
30 der services.

31 § 17. Subparagraph (E) of paragraph 7 of subsection (1) of section
32 3221 of the insurance law, as added by section 4 of part MM of chapter
33 57 of the laws of 2018, is amended and three new subparagraphs (F), (G)
34 and (H) are added to read as follows:

35 (E) This subparagraph shall apply to facilities in this state that are
36 licensed, certified or otherwise authorized by the office of alcoholism
37 and substance abuse services for the provision of outpatient, intensive
38 outpatient, outpatient rehabilitation and opioid treatment that are
39 participating in the insurer's provider network. Coverage provided under
40 this paragraph shall not be subject to preauthorization. Coverage
41 provided under this paragraph shall not be subject to concurrent review
42 for the first ~~[two]~~ three weeks of continuous treatment, not to exceed
43 ~~[fourteen]~~ twenty-one visits, provided the facility notifies the insurer
44 of both the start of treatment and the initial treatment plan within
45 ~~[forty-eight hours]~~ two business days. The facility shall perform clin-
46 ical assessment of the patient at each visit, including the periodic
47 consultation with the insurer to ensure that the facility is using the
48 evidence-based and peer reviewed clinical review tool utilized by the
49 insurer which is designated by the office of alcoholism and substance
50 abuse services and appropriate to the age of the patient, to ensure that
51 the outpatient treatment is medically necessary for the patient. Any
52 utilization review of the treatment provided under this subparagraph may
53 include a review of all services provided during such outpatient treat-
54 ment, including all services provided during the first ~~[two]~~ three weeks
55 of continuous treatment, not to exceed ~~[fourteen]~~ twenty-one visits, of
56 such outpatient treatment. Provided, however, the insurer shall only

1 deny coverage for any portion of the initial [~~two~~] three weeks of
2 continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, for
3 outpatient treatment on the basis that such treatment was not medically
4 necessary if such outpatient treatment was contrary to the evidence-
5 based and peer reviewed clinical review tool utilized by the insurer
6 which is designated by the office of alcoholism and substance abuse
7 services. An insured shall not have any financial obligation to the
8 facility for any treatment under this subparagraph other than any copay-
9 ment, coinsurance, or deductible otherwise required under the policy.

10 (F) The criteria for medical necessity determinations under the policy
11 with respect to outpatient substance use disorder benefits shall be made
12 available by the insurer to any insured, prospective insured, or in-net-
13 work provider upon request.

14 (G) For purposes of this paragraph:

15 (i) "financial requirement" means deductible, copayments, coinsurance
16 and out-of-pocket expenses;

17 (ii) "predominant" means that a financial requirement or treatment
18 limitation is the most common or frequent of such type of limit or
19 requirement;

20 (iii) "treatment limitation" means limits on the frequency of treat-
21 ment, number of visits, days of coverage, or other similar limits on the
22 scope or duration of treatment and includes nonquantitative treatment
23 limitations such as: medical management standards limiting or excluding
24 benefits based on medical necessity, or based on whether the treatment
25 is experimental or investigational; formulary design for prescription
26 drugs; network tier design; standards for provider admission to partic-
27 ipate in a network, including reimbursement rates; methods for determin-
28 ing usual, customary, and reasonable charges; fail-first or step therapy
29 protocols; exclusions based on failure to complete a course of treat-
30 ment; and restrictions based on geographic location, facility type,
31 provider specialty, and other criteria that limit the scope or duration
32 of benefits for services provided under the policy; and

33 (iv) "substance use disorder" shall have the meaning set forth in the
34 most recent edition of the diagnostic and statistical manual of mental
35 disorders or the most recent edition of another generally recognized
36 independent standard of current medical practice such as the interna-
37 tional classification of diseases.

38 (H) An insurer shall provide coverage under this paragraph, at a mini-
39 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
40 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

41 § 18. Paragraph 7-b of subsection (1) of section 3221 of the insurance
42 law, as added by section 2 of part B of chapter 69 of the laws of 2016,
43 is amended to read as follows:

44 (7-b) [~~(A)~~] Every policy that provides medical, major medical or simi-
45 lar comprehensive-type coverage and provides coverage for prescription
46 drugs for medication for the treatment of a substance use disorder shall
47 include immediate access, without prior authorization, [~~to a five-day~~
48 ~~emergency supply~~] to the formulary forms of prescribed medications
49 covered under the policy for the treatment of substance use disorder
50 [~~where an emergency condition exists~~], including a prescribed drug or
51 medication associated with the management of opioid withdrawal and/or
52 stabilization, except where otherwise prohibited by law. Further, cover-
53 age [~~of an emergency supply~~] without prior authorization shall include
54 formulary forms medication for opioid overdose reversal otherwise
55 covered under the policy prescribed or dispensed to an individual
56 covered by the policy.

~~1 [(B) For purposes of this paragraph, an "emergency condition" means a~~
~~2 substance use disorder condition that manifests itself by acute symptoms~~
~~3 of sufficient severity, including severe pain or the expectation of~~
~~4 severe pain, such that a prudent layperson, possessing an average know-~~
~~5 ledge of medicine and health, could reasonably expect the absence of~~
~~6 immediate medical attention to result in:~~

~~7 (i) placing the health of the person afflicted with such condition in~~
~~8 serious jeopardy, or in the case of a behavioral condition, placing the~~
~~9 health of such person or others in serious jeopardy;~~

~~10 (ii) serious impairment to such person's bodily functions;~~

~~11 (iii) serious dysfunction of any bodily organ or part of such person;~~

~~12 (iv) serious disfigurement of such person; or~~

~~13 (v) a condition described in clause (i), (ii), or (iii) of section~~
~~14 1867(e)(1)(A) of the Social Security Act.~~

~~15 (C) Coverage provided under this paragraph may be subject to copay-~~
~~16 ments, coinsurance, and annual deductibles that are consistent with~~
~~17 those imposed on other benefits within the policy; provided, however, no~~
~~18 policy shall impose an additional copayment or coinsurance on an insured~~
~~19 who received an emergency supply of medication and then received up to a~~
~~20 thirty day supply of the same medication in the same thirty day period~~
~~21 in which the emergency supply of medication was dispensed. This subpara-~~
~~22 graph shall not preclude the imposition of a copayment or coinsurance on~~
~~23 the initial emergency supply of medication in an amount that is less~~
~~24 than the copayment or coinsurance otherwise applicable to a thirty day~~
~~25 supply of such medication, provided that the total sum of the copayments~~
~~26 or coinsurance for an entire thirty day supply of the medication does~~
~~27 not exceed the copayment or coinsurance otherwise applicable to a thirty~~
~~28 day supply of such medication.]~~

~~29 § 19. Subparagraph (B) of paragraph 17 of subsection (1) of section~~
~~30 3221 of the insurance law, as amended by section 39 of part D of chapter~~
~~31 56 of the laws of 2013, is amended to read as follows:~~

~~32 (B) Every group or blanket policy that provides physician services,~~
~~33 medical, major medical or similar comprehensive-type coverage shall~~
~~34 provide coverage for the screening, diagnosis and treatment of autism~~
~~35 spectrum disorder in accordance with this paragraph and shall not~~
~~36 exclude coverage for the screening, diagnosis or treatment of medical~~
~~37 conditions otherwise covered by the policy because the individual is~~
~~38 diagnosed with autism spectrum disorder. Such coverage may be subject to~~
~~39 annual deductibles, copayments and coinsurance as may be deemed appro-~~
~~40 priate by the superintendent and shall be consistent with those imposed~~
~~41 on other benefits under the group or blanket policy. [Coverage for~~
~~42 applied behavior analysis shall be subject to a maximum benefit of six~~
~~43 hundred eighty hours of treatment per policy or calendar year per~~
~~44 covered individual.]~~

~~45 This paragraph shall not be construed as limiting~~
~~46 the benefits that are otherwise available to an individual under the~~
~~47 group or blanket policy, provided however that such policy shall not~~
~~48 contain any limitations on visits that are solely applied to the treat-~~
~~49 ment of autism spectrum disorder. No insurer shall terminate coverage or~~
~~50 refuse to deliver, execute, issue, amend, adjust, or renew coverage to~~
~~51 an individual solely because the individual is diagnosed with autism~~
~~52 spectrum disorder or has received treatment for autism spectrum disor-~~
~~53 der. Coverage shall be subject to utilization review and external~~
~~54 appeals of health care services pursuant to article forty-nine of this~~
~~55 chapter as well as[7] case management[7] and other managed care~~
~~provisions.~~

§ 20. Items (i) and (iii) of subparagraph (C) of paragraph 17 of subsection (l) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

(i) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders~~[, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS)].~~

(iii) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided ~~[or supervised]~~ by a ~~[behavior analyst]~~ person licensed, certified [pursuant to the behavior analyst certification board,] or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. ~~[Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this paragraph shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.]~~

§ 21. Paragraph 17 of subsection (l) of section 3221 of the insurance law is amended by adding four new subparagraphs (H), (I), (J) and (K) to read as follows:

(H) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(I) The criteria for medical necessity determinations under the policy with respect to autism spectrum disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(J) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement; and

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy.

(K) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 22. Paragraphs 1, 2, and 3 of subsection (g) of section 4303 of the insurance law, as amended by chapter 502 of the laws of 2007, are amended to read as follows:

~~[(1)]~~ A medical expense indemnity corporation, hospital service corporation or a health service corporation, ~~[which]~~ that provides group, group remittance or school blanket coverage for inpatient hospital care~~[,]~~ or coverage for physician services shall provide as part of its contract ~~[broad-based]~~ coverage for the diagnosis and treatment of mental~~[, nervous or emotional disorders or ailments, however defined in such contract, at least equal to the coverage provided for other]~~ health conditions and ~~[shall include]~~:

~~[(A)]~~
(1) where the contract provides coverage for inpatient hospital care, benefits for in-patient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law~~[, which benefits may be limited to not less than thirty days of active treatment in any contract year, plan year or calendar year.~~

~~[(B)]~~ or for inpatient care provided in other states, to similarly licensed hospitals, and benefits for out-patient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or in a facility operated by the office of mental health~~[, which benefits may be limited to not less than twenty visits in any contract year, plan year or calendar year. Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day of treatment.~~

~~[(C)]~~ Such coverage may be provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the contract.] or for out-patient care provided in other states, to similarly certified facilities; and

(2) where the contract provides coverage for physician services benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subsection (n) of this section, a nurse practitioner licensed to practice on this state, or professional corporation or university faculty practice corporation thereof.

(3) Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the contract.

~~[(D)]~~ For the purpose of this subsection, "active treatment" means treatment furnished in conjunction with in-patient confinement for mental, nervous or emotional disorders or ailments that meet such standards as shall be prescribed pursuant to the regulations of the commissioner of mental health.

~~[(E)]~~ In the event the group remittance group or contract holder is provided coverage under this subsection and under paragraph one of subsection (h) of this section from the same health service corporation, or under a contract that is jointly underwritten by two health service corporations or by a health service corporation and a medical expense indemnity corporation, the aggregate of the benefits for outpatient care obtained under subparagraph (B) of this paragraph and paragraph one of

~~subsection (h) of this section may be limited to not less than twenty visits in any contract year, plan year or calendar year.~~

~~(2) (A) A hospital service corporation or a health service corporation, which provides group, group remittance or school blanket coverage for inpatient hospital care, shall provide comparable coverage for adults and children with biologically based mental illness. Such hospital service corporation or health service corporation shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the contract, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a contract provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the contract is written under one license or two licenses.~~

~~(B) For purposes of this subsection, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, anorexia, and bulimia.~~

~~(3) For purposes of this subsection, the term "children with serious emotional disturbances" means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:~~

~~(A) serious suicidal symptoms or other life threatening self-destructive behaviors;~~

~~(B) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);~~

~~(C) behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or~~

~~(D) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.]~~

§ 23. Paragraphs 4 and 5 of subsection (g) of section 4303 of the insurance law are REPEALED and five new paragraphs 4, 5, 6, 7 and 8 are added to read as follows:

(4) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(5) The criteria for medical necessity determinations under the contract with respect to mental health benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(6) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

1 (C) "treatment limitation" means limits on the frequency of treatment,
2 number of visits, days of coverage, or other similar limits on the
3 scope or duration of treatment and includes nonquantitative treatment
4 limitations such as: medical management standards limiting or excluding
5 benefits based on medical necessity, or based on whether the treatment
6 is experimental or investigational; formulary design for prescription
7 drugs; network tier design; standards for provider admission to partic-
8 ipate in a network, including reimbursement rates; methods for deter-
9 mining usual, customary, and reasonable charges; fail-first or step
10 therapy protocols; exclusions based on failure to complete a course of
11 treatment; and restrictions based on geographic location, facility type,
12 provider specialty, and other criteria that limit the scope or duration
13 of benefits for services provided under the contract; and

14 (D) "mental health condition" means any mental health disorder as
15 defined in the most recent edition of the diagnostic and statistical
16 manual of mental disorders or the most recent edition of another gener-
17 ally recognized independent standard of current medical practice such as
18 the international classification of diseases.

19 (7) A corporation shall provide coverage under this paragraph, at a
20 minimum, consistent with the federal Paul Wellstone and Pete Domenici
21 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
22 1185a).

23 (8) This subparagraph shall apply to hospitals in this state that are
24 licensed by the office of mental health that are participating in the
25 corporation's provider network. Where the contract provides coverage for
26 inpatient hospital care, benefits for inpatient hospital care in a
27 hospital as defined by subdivision ten of section 1.03 of the mental
28 hygiene law provided to individuals who have not attained the age of
29 eighteen shall not be subject to preauthorization. Coverage provided
30 under this paragraph shall also not be subject to concurrent utiliza-
31 tion review during the first fourteen days of the inpatient admission,
32 provided the facility notifies the corporation of both the admission and
33 the initial treatment plan within two business days of the admission,
34 performs daily clinical review of the patient, and participates in peri-
35 odic consultation with the corporation to ensure that the facility is
36 using the evidence-based and peer reviewed clinical review criteria
37 utilized by the corporation which is approved by the office of mental
38 health and appropriate to the age of the patient, to ensure that the
39 inpatient care is medically necessary for the patient. All treatment
40 provided under this subparagraph may be reviewed retrospectively. Where
41 care is denied retrospectively, an insured shall not have any financial
42 obligation to the facility for any treatment under this subparagraph
43 other than any copayment, coinsurance, or deductible otherwise required
44 under the contract.

45 § 24. Subsection (h) of section 4303 of the insurance law is REPEALED.

46 § 25. Subsection (i) of section 4303 of the insurance law, as amended
47 by chapter 230 of the laws of 2004, is amended to read as follows:

48 (i) A medical expense indemnity corporation or health service corpo-
49 ration ~~[which]~~ that provides coverage for physicians, psychiatrists or
50 psychologists for psychiatric or psychological services or for the diag-
51 nosis and treatment of ~~[mental, nervous or emotional disorders and~~
52 ~~ailments]~~ mental health conditions, however defined in such contract,
53 ~~[must]~~ shall make available and if requested by all persons holding
54 individual contracts in a group whose premiums are paid by a remitting
55 agent or by the contract holder in the case of a group contract issued
56 pursuant to section four thousand three hundred five of this article,

1 provide the same coverage for such services when performed by a licensed
2 clinical social worker, within the lawful scope of his or her practice,
3 who is licensed pursuant to article one hundred fifty-four of the educa-
4 tion law. The state board for social work shall maintain a list of all
5 licensed clinical social workers qualified for reimbursement under this
6 subsection. Such coverage shall be made available at the inception of
7 all new contracts and, with respect to all other contracts, at any anni-
8 versary date subject to evidence of insurability. Written notice of the
9 availability of such coverage shall be delivered to the group remitting
10 agent or group contract holder prior to inception of such contract and
11 annually thereafter, except that this notice shall not be required where
12 a ~~[policy]~~ contract covers two hundred or more employees or where the
13 benefit structure was the subject of collective bargaining affecting
14 persons who are employed in more than one state.

15 § 26. Subsection (k) of section 4303 of the insurance law, as amended
16 by section 3 of part B of chapter 71 of the laws of 2016, is amended to
17 read as follows:

18 (k)(1) Every contract that provides hospital, major medical or similar
19 comprehensive coverage ~~[must]~~ shall provide inpatient coverage for the
20 diagnosis and treatment of substance use disorder, including detoxifica-
21 tion and rehabilitation services. Such inpatient coverage shall include
22 unlimited medically necessary treatment for substance use disorder
23 treatment services provided in residential settings ~~[as required by the~~
24 ~~Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §~~
25 ~~1185a)]~~. Further, such inpatient coverage shall not apply financial
26 requirements or treatment limitations, including utilization review
27 requirements, to inpatient substance use disorder benefits that are more
28 restrictive than the predominant financial requirements and treatment
29 limitations applied to substantially all medical and surgical benefits
30 covered by the contract. ~~[Further, such coverage shall be provided~~
31 ~~consistent with the federal Paul Wellstone and Pete Domenici Mental~~
32 ~~Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]~~

33 (2) Coverage provided under this subsection may be limited to facili-
34 ties in New York state ~~[which are certified]~~ that are licensed, certi-
35 fied or otherwise authorized by the office of alcoholism and substance
36 abuse services and, in other states, to those which are accredited by
37 the joint commission as alcoholism, substance abuse, or chemical depend-
38 ence treatment programs and are similarly licensed, certified or other-
39 wise authorized in the state in which the facility is located.

40 (3) Coverage provided under this subsection may be subject to annual
41 deductibles and co-insurance as deemed appropriate by the superintendent
42 and that are consistent with those imposed on other benefits within a
43 given contract.

44 (4) This paragraph shall apply to facilities in this state ~~[certified]~~
45 that are licensed, certified or otherwise authorized by the office of
46 alcoholism and substance abuse services that are participating in the
47 corporation's provider network. Coverage provided under this subsection
48 shall not be subject to preauthorization. Coverage provided under this
49 subsection shall also not be subject to concurrent utilization review
50 during the first ~~[fourteen]~~ twenty-one days of the inpatient admission
51 provided that the facility notifies the corporation of both the admis-
52 sion and the initial treatment plan within ~~[forty-eight hours]~~ two busi-
53 ness days of the admission. The facility shall perform daily clinical
54 review of the patient, including the periodic consultation with the
55 corporation to ensure that the facility is using the evidence-based and
56 peer reviewed clinical review tool utilized by the corporation which is

1 designated by the office of alcoholism and substance abuse services and
2 appropriate to the age of the patient, to ensure that the inpatient
3 treatment is medically necessary for the patient. Any utilization review
4 of treatment provided under this paragraph may include a review of all
5 services provided during such inpatient treatment, including all
6 services provided during the first ~~fourteen~~ twenty-one days of such
7 inpatient treatment. Provided, however, the corporation shall only deny
8 coverage for any portion of the initial ~~fourteen~~ twenty-one day inpa-
9 tient treatment on the basis that such treatment was not medically
10 necessary if such inpatient treatment was contrary to the evidence-based
11 and peer reviewed clinical review tool utilized by the corporation which
12 is designated by the office of alcoholism and substance abuse services.
13 An insured shall not have any financial obligation to the facility for
14 any treatment under this paragraph other than any copayment, coinsu-
15 rance, or deductible otherwise required under the contract.

16 (5) The criteria for medical necessity determinations under the
17 contract with respect to inpatient substance use disorder benefits
18 shall be made available by the corporation to any insured, prospective
19 insured or in-network provider upon request.

20 (6) For purposes of this subsection:

21 (A) "financial requirement" means deductible, copayments, coinsurance
22 and out-of-pocket expenses;

23 (B) "predominant" means that a financial requirement or treatment
24 limitation is the most common or frequent of such type of limit or
25 requirement;

26 (C) "treatment limitation" means limits on the frequency of treatment,
27 number of visits, days of coverage, or other similar limits on the
28 scope or duration of treatment and includes nonquantitative treatment
29 limitations such as: medical management standards limiting or excluding
30 benefits based on medical necessity, or based on whether the treatment
31 is experimental or investigational; formulary design for prescription
32 drugs; network tier design; standards for provider admission to partic-
33 ipate in a network, including reimbursement rates; methods for deter-
34 mining usual, customary, and reasonable charges; fail-first or step
35 therapy protocols; exclusions based on failure to complete a course of
36 treatment; and restrictions based on geographic location, facility type,
37 provider specialty, and other criteria that limit the scope or duration
38 of benefits for services provided under the contract; and

39 (D) "substance use disorder" shall have the meaning set forth in the
40 most recent edition of the diagnostic and statistical manual of mental
41 disorders or the most recent edition of another generally recognized
42 independent standard of current medical practice such as the interna-
43 tional classification of diseases.

44 (7) A corporation shall provide coverage under this paragraph, at a
45 minimum, consistent with the federal Paul Wellstone and Pete Domenici
46 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
47 1185a).

48 § 27. Paragraphs 1 and 2 of subsection (1) of section 4303 of the
49 insurance law, as amended by chapter 41 of the laws of 2014, are amended
50 and a new paragraph 3-a is added to read as follows:

51 (1) Every contract that provides medical, major medical or similar
52 comprehensive-type coverage ~~must~~ shall provide outpatient coverage for
53 the diagnosis and treatment of substance use disorder, including detoxi-
54 fication and rehabilitation services. Such coverage shall not apply
55 financial requirements or treatment limitations to outpatient substance
56 use disorder benefits that are more restrictive than the predominant

1 financial requirements and treatment limitations applied to substantial-
2 ly all medical and surgical benefits covered by the contract. [~~Further,~~
3 ~~such coverage shall be provided consistent with the federal Paul Well-~~
4 ~~stone and Pete Domenici Mental Health Parity and Addiction Equity Act of~~
5 ~~2008 (29 U.S.C. § 1185a).~~]

6 (2) Coverage under this subsection may be limited to facilities in New
7 York state that are licensed, certified or otherwise authorized by the
8 office of alcoholism and substance abuse services [~~or licensed by such~~
9 ~~office as outpatient clinics or medically supervised ambulatory]~~ to
10 provide outpatient substance [abuse programs] use disorder services and,
11 in other states, to those which are accredited by the joint commission
12 as alcoholism or chemical dependence substance abuse treatment programs
13 and are similarly licensed, certified or otherwise authorized in the
14 state in which the facility is located.

15 (3-a) A contract that provides large group coverage that provides
16 coverage for outpatient substance use disorder services under this
17 subsection may not impose copayments or coinsurance for outpatient
18 substance use disorder services that exceed the copayment or coinsurance
19 imposed for a primary care office visit. Provided that only one such
20 copayment may be imposed for all services provided in a single day by a
21 facility licensed, certified or otherwise authorized by the office of
22 alcoholism and substance abuse services to provide outpatient substance
23 use disorder services.

24 § 28. Paragraph 5 of subsection (1) of section 4303 of the insurance
25 law, as added by section 5 of part MM of chapter 57 of the laws of 2018,
26 is amended and three new paragraphs 6, 7 and 8 are added to read as
27 follows:

28 (5) This paragraph shall apply to facilities in this state [~~certified~~
29 that are licensed, certified or otherwise authorized by the office of
30 alcoholism and substance abuse services for the provision of outpatient,
31 intensive outpatient, outpatient rehabilitation and opioid treatment
32 that are participating in the corporation's provider network. Coverage
33 provided under this subsection shall not be subject to preauthorization.
34 Coverage provided under this subsection shall not be subject to concur-
35 rent review for the first [~~two~~] three weeks of continuous treatment, not
36 to exceed [~~fourteen~~] twenty-one visits, provided the facility notifies
37 the corporation of both the start of treatment and the initial treatment
38 plan within [~~forty-eight hours~~] two business days. The facility shall
39 perform clinical assessment of the patient at each visit, including the
40 periodic consultation with the corporation to ensure that the facility
41 is using the evidence-based and peer reviewed clinical review tool
42 utilized by the corporation which is designated by the office of alco-
43 holism and substance abuse services and appropriate to the age of the
44 patient, to ensure that the outpatient treatment is medically necessary
45 for the patient. Any utilization review of the treatment provided under
46 this paragraph may include a review of all services provided during such
47 outpatient treatment, including all services provided during the first
48 [~~two~~] three weeks of continuous treatment, not to exceed [~~fourteen~~]
49 twenty-one visits, of such outpatient treatment. Provided, however, the
50 corporation shall only deny coverage for any portion of the initial
51 [~~two~~] three weeks of continuous treatment, not to exceed [~~fourteen~~]
52 twenty-one visits, for outpatient treatment on the basis that such
53 treatment was not medically necessary if such outpatient treatment was
54 contrary to the evidence-based and peer reviewed clinical review tool
55 utilized by the corporation which is designated by the office of alco-
56 holism and substance abuse services. A subscriber shall not have any

1 financial obligation to the facility for any treatment under this para-
2 graph other than any copayment, coinsurance, or deductible otherwise
3 required under the contract.

4 (6) The criteria for medical necessity determinations under the
5 contract with respect to outpatient substance use disorder benefits
6 shall be made available by the corporation to any insured, prospective
7 insured, or in-network provider upon request.

8 (7) For purposes of this subsection:

9 (A) "financial requirement" means deductible, copayments, coinsurance
10 and out-of-pocket expenses;

11 (B) "predominant" means that a financial requirement or treatment
12 limitation is the most common or frequent of such type of limit or
13 requirement.

14 (C) "treatment limitation" means limits on the frequency of treatment,
15 number of visits, days of coverage, or other similar limits on the scope
16 or duration of treatment and includes nonquantitative treatment limita-
17 tions such as: medical management standards limiting or excluding bene-
18 fits based on medical necessity, or based on whether the treatment is
19 experimental or investigational; formulary design for prescription
20 drugs; network tier design; standards for provider admission to partic-
21 ipate in a network, including reimbursement rates; methods for determin-
22 ing usual, customary, and reasonable charges; fail-first or step therapy
23 protocols; exclusions based on failure to complete a course of treat-
24 ment; and restrictions based on geographic location, facility type,
25 provider specialty, and other criteria that limit the scope or duration
26 of benefits for services provided under the contract; and

27 (D) "substance use disorder" shall have the meaning set forth in the
28 most recent edition of the diagnostic and statistical manual of mental
29 disorders or the most recent edition of another generally recognized
30 independent standard of current medical practice such as the interna-
31 tional classification of diseases.

32 (8) A corporation shall provide coverage under this paragraph, at a
33 minimum, consistent with the federal Paul Wellstone and Pete Domenici
34 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
35 1185a).

36 § 29. Subsection (1-2) of section 4303 of the insurance law, as added
37 by section 3 of part B of chapter 69 of the laws of 2016, is amended to
38 read as follows:

39 (1-2) ~~(1)~~ Every contract that provides medical, major medical or
40 similar comprehensive-type coverage and provides coverage for
41 prescription drugs for medication for the treatment of a substance use
42 disorder shall include immediate access, without prior authorization, to
43 ~~[a five-day emergency supply]~~ the formulary forms of prescribed medica-
44 tions covered under the contract for the treatment of substance use
45 disorder ~~[where an emergency condition exists]~~, including a prescribed
46 drug or medication associated with the management of opioid withdrawal
47 and/or stabilization, except where otherwise prohibited by law. Further,
48 coverage ~~[of an emergency supply]~~ without prior authorization shall
49 include formulary forms of medication for opioid overdose reversal
50 otherwise covered under the contract prescribed or dispensed to an indi-
51 vidual covered by the contract.

52 ~~[(2) For purposes of this paragraph, an "emergency condition" means a~~
53 ~~substance use disorder condition that manifests itself by acute symptoms~~
54 ~~of sufficient severity, including severe pain or the expectation of~~
55 ~~severe pain, such that a prudent layperson, possessing an average know-~~

~~ledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:~~

~~(i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;~~

~~(ii) serious impairment to such person's bodily functions;~~

~~(iii) serious dysfunction of any bodily organ or part of such person;~~

~~(iv) serious disfigurement of such person; or~~

~~(v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.~~

~~(3) Coverage provided under this subsection may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the contract; provided, however, no contract shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This paragraph shall not preclude the imposition of a copayment or coinsurance on the initial limited supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]~~

§ 30. Subsection (n) of section 4303 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(n) In addition to the requirements of subsection (i) of this section, every health service or medical expense indemnity corporation issuing a group contract pursuant to this section or a group remittance contract for delivery in this state which contract provides reimbursement to subscribers or physicians, psychiatrists or psychologists for psychiatric or psychological services or for the diagnosis and treatment of ~~[mental, nervous or emotional disorders and ailments,]~~ **mental health conditions**, however defined in such contract, must provide the same coverage to persons covered under the group contract for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either (i) three or more additional years experience in psychotherapy, which for the purposes of this subsection shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior which are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of ~~[mental, nervous or emotional disorders or ailments,]~~ **mental health conditions**, or (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection (i) of this section, or (iii) a combination of the experience specified in paragraphs (i) and (ii) totaling three years, satisfactory to the state board for social work. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection.

§ 31. Paragraph 2 of subsection (ee) of section 4303 of the insurance law, as amended by section 40 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(2) Every contract that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the contract because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. ~~[Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per contract or calendar year per covered individual.]~~ This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the contract, provided however that such contract shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as ~~[~~ case management~~]~~ and other managed care provisions.

§ 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of section 4303 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

(A) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders~~[, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS)].~~

(C) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided ~~[or supervised]~~ by a ~~[behavior analyst certified pursuant to the behavior analyst certification board]~~ person that is licensed, certified or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. ~~[Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this subsection shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.]~~

§ 33. Subsection (ee) of section 4303 of the insurance law is amended by adding four new paragraphs 8, 9, 10, and 11 to read as follows:

(8) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(9) The criteria for medical necessity determinations under the contract with respect to autism spectrum disorder benefits shall be made

1 available by the corporation to any insured, prospective insured, or
2 in-network provider upon request.

3 (10) For purposes of this subsection:

4 (A) "financial requirement" means deductible, copayments, coinsurance
5 and out-of-pocket expenses;

6 (B) "predominant" means that a financial requirement or treatment
7 limitation is the most common or frequent of such type of limit or
8 requirement; and

9 (C) "treatment limitation" means limits on the frequency of treatment,
10 number of visits, days of coverage, or other similar limits on the scope
11 or duration of treatment and includes nonquantitative treatment limita-
12 tions such as: medical management standards limiting or excluding bene-
13 fits based on medical necessity, or based on whether the treatment is
14 experimental or investigational; formulary design for prescription
15 drugs; network tier design; standards for provider admission to partic-
16 ipate in a network, including reimbursement rates; methods for determin-
17 ing usual, customary, and reasonable charges; fail-first or step therapy
18 protocols; exclusions based on failure to complete a course of treat-
19 ment; and restrictions based on geographic location, facility type,
20 provider specialty, and other criteria that limit the scope or duration
21 of benefits for services provided under the contract.

22 (11) A corporation shall provide coverage under this subsection, at a
23 minimum, consistent with the federal Paul Wellstone and Pete Domenici
24 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
25 1185a).

26 § 34. Paragraphs 17, 20 and 21 of subsection (a) of section 4324 of
27 the insurance law, paragraph 17 as amended and paragraphs 20 and 21 as
28 added by section 8 of part H of chapter 60 of the laws of 2014, are
29 amended and a new paragraph 22 is added to read as follows:

30 (17) where applicable, a listing by specialty, which may be in a sepa-
31 rate document that is updated annually, of the name, address, and tele-
32 phone number of all participating providers, including facilities, [~~and~~
33 ~~in addition,~~] and: (A) whether the provider is accepting new patients;
34 (B) in the case of mental health or substance use disorder services
35 providers, any affiliations with participating facilities certified or
36 authorized by the office of mental health or the office of alcoholism
37 and substance abuse services, and any restrictions regarding the avail-
38 ability of the individual provider's services; (C) in the case of physi-
39 cians, board certification, languages spoken and any affiliations with
40 participating hospitals. The listing shall also be posted on the corpo-
41 ration's website and the corporation shall update the website within
42 fifteen days of the addition or termination of a provider from the
43 corporation's network or a change in a physician's hospital affiliation;

44 (20) with respect to out-of-network coverage:

45 (A) a clear description of the methodology used by the corporation to
46 determine reimbursement for out-of-network health care services;

47 (B) a description of the amount that the corporation will reimburse
48 under the methodology for out-of-network health care services set forth
49 as a percentage of the usual and customary cost for out-of-network
50 health care services; and

51 (C) examples of anticipated out-of-pocket costs for frequently billed
52 out-of-network health care services; [~~and~~]

53 (21) information in writing and through an internet website that
54 reasonably permits a subscriber or prospective subscriber to estimate
55 the anticipated out-of-pocket cost for out-of-network health care
56 services in a geographical area or zip code based upon the difference

1 between what the corporation will reimburse for out-of-network health
2 care services and the usual and customary cost for out-of-network health
3 care services[~~-~~]; and

4 (22) the most recent comparative analysis performed by the corporation
5 to assess the provision of its covered services in accordance with the
6 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
7 Equity Act of 2008, 42 U.S.C. 18031 (j), and any amendments to, and
8 federal guidance or regulations issued under, those Acts.

9 § 35. Subsection (b) of section 4325 of the insurance law, as added by
10 chapter 705 of the laws of 1996, is amended to read as follows:

11 (b) No corporation organized under this article shall by contract,
12 written policy [~~or~~], written procedure or practice prohibit or restrict
13 any health care provider from filing a complaint, making a report or
14 commenting to an appropriate governmental body regarding the policies or
15 practices of such corporation which the provider believes may negatively
16 impact upon the quality of or access to patient care. Nor shall a corpo-
17 ration organized under this article take any adverse action, including
18 but not limited to refusing to renew or execute a contract or agreement
19 with a health care provider as retaliation against a health care provid-
20 er for filing a complaint, making a report or commenting to an appropri-
21 ate governmental body regarding policies or practices of such corpo-
22 ration which may violate this chapter including subsection (g), (k),
23 (1), (1-1) or (1-2) of section forty-three hundred three of this arti-
24 cle.

25 § 36. Subparagraph (C) of paragraph 1 of subsection (b) of section
26 4900 of the insurance law, as added by chapter 41 of the laws of 2014,
27 is amended and a new subparagraph (D) is added to read as follows:

28 (C) for purposes of a determination involving substance use disorder
29 treatment:

30 (i) a physician who possesses a current and valid non-restricted
31 license to practice medicine and who specializes in behavioral health
32 and has experience in the delivery of substance use disorder courses of
33 treatment; or

34 (ii) a health care professional other than a licensed physician who
35 specializes in behavioral health and has experience in the delivery of
36 substance use disorder courses of treatment and, where applicable,
37 possesses a current and valid non-restricted license, certificate or
38 registration or, where no provision for a license, certificate or regis-
39 tration exists, is credentialed by the national accrediting body appro-
40 priate to the profession; [~~and~~] or

41 (D) for purposes of a determination involving treatment for a mental
42 health condition:

43 (i) a physician who possesses a current and valid non-restricted
44 license to practice medicine and who specializes in behavioral health
45 and has experience in the delivery of mental health courses or treat-
46 ment; or

47 (ii) a health care professional other than a licensed physician who
48 specializes in behavioral health and has experience in the delivery of
49 mental health courses of treatment and, where applicable, possesses a
50 current and valid non-restricted license, certificate, or registration
51 or, where no provision for a license, certificate or registration
52 exists, is credentialed by the national accrediting body appropriate to
53 the profession; and

54 § 37. Paragraph 9 of subsection (a) of section 4902 of the insurance
55 law, as amended by section 1 of part A of chapter 69 of the laws of
56 2016, is amended to read as follows:

(9) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review [tools designated by the office of alcoholism and substance abuse services that are appropriate to the age of the patient and consistent with the treatment service levels within the office of alcoholism and substance abuse services system] tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

§ 38. Subsection (a) of section 4902 of the insurance law is amended by adding a new paragraph 12 to read as follows:

(12) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

§ 39. Paragraph (b) of subsection 5 of section 4403 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) The following criteria shall be considered by the commissioner at the time of a review: (i) the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disability Act to assure access to health care for the enrollee population; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; ~~and~~ (iii) the availability of appropriate and timely care that is in compliance with the standards of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance and regulations issued under those Acts, which shall include an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services; and (iv) with the exception of initial licensure, the number of grievances filed by enrollees relating to waiting times for appointments, appropriateness of referrals and other indicators of plan capacity.

§ 40. Subdivision 3 of section 4406-c of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

3. No health care plan shall by contract, written policy ~~or~~, written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such health care plan which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall a health care plan take any adverse action, including but not limited to refusing to renew

1 or execute a contract or agreement with a health care provider as retal-
2 iation against a health care provider for filing a complaint, making a
3 report or commenting to an appropriate governmental body regarding poli-
4 cies or practices of such health care plan which may violate this chap-
5 ter or the insurance law including subsection (g), (k), (l), (1-1) or
6 (1-2) of section forty-three hundred three of the insurance law.

7 § 41. Paragraphs (r), (t) and (u) of subdivision 1 of section 4408 of
8 the public health law, paragraph (r) as amended and paragraphs (t) and
9 (u) as added by section 18 of part H of chapter 60 of the laws of 2014,
10 are amended and a new paragraph (v) is added to read as follows:

11 (r) a listing by specialty, which may be in a separate document that
12 is updated annually, of the name, address and telephone number of all
13 participating providers, including facilities, ~~[and, in addition,]~~ and:
14 (i) whether the provider is accepting new patients; (ii) in the case of
15 mental health or substance use disorder services providers, any affil-
16 iations with participating facilities certified or authorized by the
17 office of mental health or the office of alcoholism and substance abuse
18 services, and any restrictions regarding the availability of the indi-
19 vidual provider's services; and (iii) in the case of physicians, board
20 certification, languages spoken and any affiliations with participating
21 hospitals. The listing shall also be posted on the health maintenance
22 organization's website and the health maintenance organization shall
23 update the website within fifteen days of the addition or termination of
24 a provider from the health maintenance organization's network or a
25 change in a physician's hospital affiliation;

26 (t) with respect to out-of-network coverage:

27 (i) a clear description of the methodology used by the health mainte-
28 nance organization to determine reimbursement for out-of-network health
29 care services;

30 (ii) the amount that the health maintenance organization will reim-
31 burse under the methodology for out-of-network health care services set
32 forth as a percentage of the usual and customary cost for out-of-network
33 health care services;

34 (iii) examples of anticipated out-of-pocket costs for frequently
35 billed out-of-network health care services; ~~[and]~~

36 (u) information in writing and through an internet website that
37 reasonably permits an enrollee or prospective enrollee to estimate the
38 anticipated out-of-pocket cost for out-of-network health care services
39 in a geographical area or zip code based upon the difference between
40 what the health maintenance organization will reimburse for out-of-net-
41 work health care services and the usual and customary cost for out-of-
42 network health care services~~[-]~~; and

43 (v) the most recent comparative analysis performed by the health main-
44 tenance organization to assess the provision of its covered services in
45 accordance with the Paul Wellstone and Pete Dominici Mental Health Pari-
46 ty and Addiction Equity Act of 2008, 42 U.S.C. 18031(j) and any amend-
47 ments to, and federal guidance and regulations issued under, those Acts.

48 § 42. Subparagraph (iii) of paragraph (a) of subdivision 2 of section
49 4900 of the public health law, as added by chapter 41 of the laws of
50 2014, is amended and a new subparagraph (iv) is added to read as
51 follows:

52 (iii) for purposes of a determination involving substance use disorder
53 treatment:

54 (A) a physician who possesses a current and valid non-restricted
55 license to practice medicine and who specializes in behavioral health

1 and has experience in the delivery of substance use disorder courses of
2 treatment; or

3 (B) a health care professional other than a licensed physician who
4 specializes in behavioral health and has experience in the delivery of
5 substance use disorder courses of treatment and, where applicable,
6 possesses a current and valid non-restricted license, certificate or
7 registration or, where no provision for a license, certificate or regis-
8 tration exists, is credentialed by the national accrediting body appro-
9 priate to the profession; ~~[and]~~ or

10 (iv) for purposes of a determination involving treatment for a mental
11 health condition:

12 (A) a physician who possesses a current and valid non-restricted
13 license to practice medicine and who specializes in behavioral health
14 and has experience in the delivery of mental health courses of treat-
15 ment; or

16 (B) a health care professional other than a licensed physician who
17 specializes in behavioral health and has experience in the delivery of a
18 mental health courses of treatment and, where applicable, possesses a
19 current and valid non-restricted license, certificate, or registration
20 or, where no provision for a license, certificate or registration
21 exists, is credentialed by the national accrediting body appropriate to
22 the profession; and

23 § 43. Paragraph (i) of subdivision 1 of section 4902 of the public
24 health law, as amended by section 2 of part A of chapter 69 of the laws
25 of 2016, is amended and a new paragraph (j) is added to read as follows:

26 (i) When conducting utilization review for purposes of determining
27 health care coverage for substance use disorder treatment, a utilization
28 review agent shall utilize an evidence-based and peer reviewed clinical
29 review ~~[tools designated by the office of alcoholism and substance abuse~~
30 ~~services that are appropriate to the age of the patient and consistent~~
31 ~~with the treatment service levels within the office of alcoholism and~~
32 ~~substance abuse services system]~~ tool that is appropriate to the age of
33 the patient. When conducting such utilization review for treatment
34 provided in this state, a utilization review agent shall utilize an
35 evidence-based and peer reviewed clinical tool designated by the office
36 of alcoholism and substance abuse services that is consistent with the
37 treatment service levels within the office of alcoholism and substance
38 abuse services system. All approved tools shall have inter rater reli-
39 ability testing completed by December thirty-first, two thousand
40 sixteen.

41 (j) When conducting utilization review for purposes of determining
42 health care coverage for a mental health condition, a utilization review
43 agent shall utilize evidence-based and peer reviewed clinical review
44 criteria that is appropriate to the age of the patient. The utilization
45 review agent shall use clinical review criteria deemed appropriate and
46 approved for such use by the commissioner of the office of mental
47 health, in consultation with the commissioner and the superintendent of
48 financial services. Approved clinical review criteria shall have inter
49 rater reliability testing completed by December thirty-first, two thou-
50 sand nineteen.

51 § 44. This act shall take effect on the first of January next succeed-
52 ing the date on which it shall have become a law and shall apply to all
53 policies and contracts issued, renewed, modified, altered or amended on
54 or after such date; provided, however, notwithstanding any provision of
55 law to the contrary, nothing in this act shall limit the rights accruing
56 to employees pursuant to a collective bargaining agreement with any

1 state or local government employer for the unexpired term of such agree-
2 ment where such agreement is in effect on the effective date of this act
3 and so long as such agreement remains in effect thereafter or the eligi-
4 bility of any member of an employee organization to join a health insur-
5 ance plan open to him or her pursuant to such a collectively negotiated
6 agreement.

7 SUBPART B

8 Section 1. Subdivision 1 of section 2803-u of the public health law,
9 as added by section 1 of part C of chapter 70 of the laws of 2016, is
10 amended to read as follows:

11 1. The office of alcoholism and substance abuse services, in consulta-
12 tion with the department, shall develop or utilize existing educational
13 materials to be provided to general hospitals to disseminate to individ-
14 uals with a documented substance use disorder or who appear to have or
15 be at risk for a substance use disorder during discharge planning pursu-
16 ant to section twenty-eight hundred three-i of this [~~chapter~~] article.
17 Such materials shall include information regarding the various types of
18 treatment and recovery services, including but not limited to: inpa-
19 tient, outpatient, and medication-assisted treatment; how to recognize
20 the need for treatment services; information for individuals to deter-
21 mine what type and level of treatment is most appropriate and what
22 resources are available to them; and any other information the commis-
23 sioner deems appropriate. General hospitals shall include in their poli-
24 cies and procedures treatment protocols, consistent with medical stand-
25 ards, to be utilized by the emergency departments in general hospitals
26 for the appropriate use of medication-assisted treatment, including
27 buprenorphine, prior to discharge, or referral protocols for evaluation
28 of medication-assisted treatment when initiation in an emergency depart-
29 ment of a general hospital is not feasible.

30 § 2. This act shall take effect immediately.

31 SUBPART C

32 Section 1. Subparagraph (v) of paragraph (a) of subdivision 2 of
33 section 3343-a of the public health law is REPEALED and subparagraphs
34 (vi), (vii), (viii), (ix) and (x) are renumbered subparagraphs (v),
35 (vi), (vii), (viii) and (ix).

36 § 2. This act shall take effect immediately.

37 SUBPART D

38 Section 1. Paragraph (r) of subdivision 4 of section 364-j of the
39 social services law, as amended by section 39 of part A of chapter 56 of
40 the laws of 2013, is amended to read as follows:

41 (r) A managed care provider shall provide services to participants
42 pursuant to an order of a court of competent jurisdiction, provided
43 however, that such services shall be within such provider's or plan's
44 benefit package and are reimbursable under title xix of the federal
45 social security act, provided that services for a substance use disorder
46 shall be provided by a program licensed, certified or otherwise author-
47 ized by the office of alcoholism and substance abuse services.

48 § 2. This act shall take effect immediately; provided, however that
49 the amendments to paragraph (r) of subdivision 4 of section 364-j of the

1 social services law made by section one of this act shall not affect the
2 repeal of such section and shall be deemed to be repealed therewith.

3 SUBPART E

4 Section 1. Subdivision (b) of schedule I of section 3306 of the public
5 health law is amended by adding nineteen new paragraphs 58, 59, 60, 61,
6 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75 and 76 to read as
7 follows:

8 (58) N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide. Other name:
9 Butyryl Fentanyl.

10 (59) N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-N-phenylpro-
11 pionamide. Other name: Beta-Hydroxythiofentanyl.

12 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide. Other
13 name: Furanyl Fentanyl.

14 (61) 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide.
15 Other name: U-47700.

16 (62) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide. Other names:
17 Acryl Fentanyl or Acryloylfentanyl.

18 (63) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide.
19 Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fenta-
20 nyl.

21 (64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide.
22 Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

23 (65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide.
24 Other name: tetrahydrofuranyl fentanyl.

25 (66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other
26 name: methoxyacetyl fentanyl.

27 (67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide.
28 Other name: cyclopropyl fentanyl.

29 (68) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide. Other name:
30 Valeryl fentanyl.

31 (69) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other
32 name: para-fluorobutyrylfentanyl.

33 (70) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide.
34 Other name: para-methoxybutyryl fentanyl.

35 (71) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide.
36 Other name: para-chloroisobutyryl fentanyl.

37 (72) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide. Other name:
38 isobutyryl fentanyl.

39 (73) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide.
40 Other name: cyclopentyl fentanyl.

41 (74) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)
42 acetamide. Other name: Ocfentanyl.

43 (75) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine. Other name: MT-45.

44 (76) Fentanyl-related substances, their isomers, esters, ethers, salts
45 and salts of isomers, esters and ethers.

46 (i) Fentanyl-related substance means any substance not otherwise list-
47 ed in this section, that is structurally related to fentanyl by one or
48 more of the following modifications:

49 (A) Replacement of the phenyl portion of the phenethyl group by any
50 monocycle, whether or not further substituted in or on the monocycle;

51 (B) Substitution in or on the phenethyl group with alkyl, alkenyl,
52 alkoxyl, hydroxyl, halo, haloalkyl, amino or nitro groups;

53 (C) Substitution in or on the piperidine ring with alkyl, alkenyl,
54 alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino or nitro groups;

1 (D) Replacement of the aniline ring with any aromatic monocycle wheth-
2 er or not further substituted in or on the aromatic monocycle; and/or
3 (E) Replacement of the N-propionyl group by another acyl group.

4 § 2. Section 3308 of the public health law is amended by adding a new
5 subdivision 7 to read as follows:

6 7. The commissioner may, by regulation, classify as a Schedule I
7 controlled substance in section three thousand three hundred six of this
8 article any substance listed in Schedule I of the federal schedules of
9 controlled substances in 21 USC §812 or 21 CFR §1308.11.

10 § 3. This act shall take effect on the ninetieth day after it shall
11 have become a law.

12 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-
13 sion, section or part of this act shall be adjudged by any court of
14 competent jurisdiction to be invalid, such judgment shall not affect,
15 impair, or invalidate the remainder thereof, but shall be confined in
16 its operation to the clause, sentence, paragraph, subdivision, section
17 or part thereof directly involved in the controversy in which such judg-
18 ment shall have been rendered. It has hereby declared to be the intent
19 of the legislature that this act would have been enacted even if such
20 invalid provisions had not been included herein.

21 § 3. This act shall take effect immediately provided, however, that
22 the applicable effective date of Subparts A through E of this act shall
23 be as specifically set forth in the last section of such Subparts.

24 PART CC

25 Section 1. The public health law is amended by adding a new section
26 280-d to read as follows:

27 § 280-d. Prescriber assistance. 1. Unlicensed assistants may be
28 employed in licensed pharmacies for purposes other than the practice of
29 pharmacy, including at least two unlicensed persons per pharmacist to
30 assist in the dispensing of drugs, provided, however, that a pharmacist
31 may obtain the assistance of up to four additional unlicensed persons
32 where such additional unlicensed persons are certified as pharmacy tech-
33 nicians by a nationally accredited pharmacy technician certification
34 program. Proof of certification for such individuals employed by a phar-
35 macy shall be maintained by the pharmacy and provided to state agencies
36 upon request. The department and state board of pharmacy shall consider
37 and may establish regulations permitting a pharmacist to obtain the
38 assistance of a greater number of unlicensed persons.

39 2. (a) The compounding, preparation, labeling, or dispensing of drugs,
40 in accordance with article one hundred thirty-seven of the education
41 law, in facilities licensed in accordance with article twenty-eight of
42 this chapter shall be performed by: (i) a licensed pharmacist, as
43 defined in article one hundred thirty-seven of the education law; (ii) a
44 pharmacy intern, under the direct supervision of a licensed pharmacist
45 as defined in article one hundred thirty-seven of the education law; or
46 (iii) under the direct supervision of a licensed pharmacist an individ-
47 ual who has received certification from a nationally accredited pharmacy
48 technician certification program may assist in the preparation and
49 dispensing of drugs including weighing, mixing, and measuring when prop-
50 erly trained. Proof of certification and training for such individuals
51 employed by a facility shall be maintained by the facility and provided
52 to state agencies upon request.

53 (b) A person employed in a facility licensed in accordance with arti-
54 cle twenty-eight of this chapter who directly assists licensed pharma-

cists to dispense prescriptions in such facility on the effective date of this section shall be exempt from the certification requirement in paragraph (a) of this subdivision if he or she submits evidence to, and verified by, his or her employer, of a minimum of five (5) years of employment in good standing in a pharmacy within the previous eight (8) years, including eighteen consecutive months with a single employer. Such evidence and verification shall be documented and maintained by the facility and provided to state agencies upon request. Such individual shall not be permitted to assist in the compounding of medications.

§ 2. This act shall take effect immediately.

PART DD

Section 1. (a) Notwithstanding any other provision of law to the contrary, for the state fiscal years beginning April 1, 2019 and ending on March 31, 2021, all Medicaid payments made for services provided on and after April 1, 2019, shall, except as hereinafter provided, be subject to a uniform reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of the commissioner of health and the director of the budget based upon consultation with the health care industry including but not limited to, a uniform reduction in Medicaid rates of payments or other reductions provided that any method selected achieves up to \$190,200,000 in Medicaid state share savings in state fiscal year 2019-2020 and up to \$190,200,000 in state fiscal year 2020-2021, except as hereinafter provided, for services provided on and after April 1, 2019 through March 31, 2021. Any alternative methods to achieve the reduction must be provided in writing and shall be filed with the senate finance committee and the assembly ways and means committee not less than thirty days before the date on which implementation is expected to begin. Nothing in this section shall be deemed to prevent all or part of such alternative reduction plan from taking effect retroactively, to the extent permitted by the federal centers for medicare and Medicaid services.

(b) The following types of appropriations shall be exempt from reductions pursuant to this section:

(i) any reductions that would violate federal law including, but not limited to, payments required pursuant to the federal medicare program;

(ii) any reductions related to direct payments pursuant to article 32, article 31 and article 16 of the mental hygiene law;

(iii) payments the state is obligated to make pursuant to court orders or judgments;

(iv) payments for which the non-federal share does not reflect any state funding; and

(v) at the discretion of the commissioner of health and the director of the budget, payments with regard to which it is determined by the commissioner of health and the director of the budget that application of reductions pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

(c) Reductions to Medicaid payments or Medicaid rates of payments made pursuant to this section shall be subject to the receipt of all necessary federal approvals.

§ 2. This act shall take effect immediately.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of

1 competent jurisdiction to be invalid, such judgment shall not affect,
2 impair, or invalidate the remainder thereof, but shall be confined in
3 its operation to the clause, sentence, paragraph, subdivision, section
4 or part thereof directly involved in the controversy in which such judg-
5 ment shall have been rendered. It is hereby declared to be the intent of
6 the legislature that this act would have been enacted even if such
7 invalid provisions had not been included herein.

8 § 3. This act shall take effect immediately provided, however, that
9 the applicable effective date of Parts A through DD of this act shall be
10 as specifically set forth in the last section of such Parts.