

STATE OF NEW YORK

1090

2019-2020 Regular Sessions

IN SENATE

January 10, 2019

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

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relation to providing health insurance protection to New Yorkers in the event that the federal Affordable Care Act is repealed

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

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

3 § 3217-i. Essential health benefits package. (a) Coverage required.
4 No insurer subject to this article shall decline to provide an essential
5 health benefits package as required by this section.

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

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

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

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

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

9 (B) not make coverage decisions, determine reimbursement rates, estab-
10 lish incentive programs, or design benefits in ways that discriminate
11 against individuals because of their age, disability, or expected length
12 of life;

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

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

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

24 (i) coverage for emergency department services will be provided with-
25 out imposing any requirement under the plan for prior authorization of
26 services or any limitation on coverage where the provider of services
27 does not have a contractual relationship with the plan for the providing
28 of services that is more restrictive than the requirements or limita-
29 tions that apply to emergency department services received from provid-
30 ers who do have such a contractual relationship with the plan; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (3) For purposes of clause (i) of subparagraph (B) of paragraph one of
24 this subsection, the premium adjustment percentage for any calendar year
25 is the percentage, if any, by which the average per capita premium for
26 health insurance coverage in the United States for the preceding calen-
27 dar year exceeds such average per capita premium for the year two thou-
28 sand thirteen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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