

# STATE OF NEW YORK

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S. 1507--A

A. 2007--A

## SENATE - ASSEMBLY

January 18, 2019

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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.

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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, including  
7 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:

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

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

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

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

16 3. The department and the division of the budget shall assess on a  
17 quarterly basis the projected total amount to be expended in the year on  
18 a cash basis by the Medicaid program for each drug, and the projected  
19 annual amount of state funds Medicaid drug expenditures on a cash basis  
20 for all drugs, which shall be a component of the projected department of  
21 health state funds Medicaid expenditures calculated for purposes of  
22 sections ninety-one and ninety-two of part H of chapter fifty-nine of  
23 the laws of two thousand eleven. For purposes of this section, state  
24 funds Medicaid drug expenditures include amounts expended for drugs in  
25 both the Medicaid fee-for-service program and Medicaid managed care  
26 programs, minus the amount of any drug rebates or supplemental drug  
27 rebates received by the department, including rebates pursuant to subdivi-  
28 sion five of this section with respect to rebate targets. ~~[The depart-~~  
29 ~~ment and the division of the budget shall report quarterly to the drug~~  
30 ~~utilization review board the projected state funds Medicaid drug expend-~~  
31 ~~itures including the amounts, in aggregate thereof, attributable to the~~  
32 ~~net cost of: changes in the utilization of drugs by Medicaid recipients,~~  
33 ~~changes in the number of Medicaid recipients, changes to the cost of~~  
34 ~~brand name drugs and changes to the cost of generic drugs. The informa-~~  
35 ~~tion contained in the report shall not be publicly released in a manner~~  
36 ~~that allows for the identification of an individual drug or manufacturer~~  
37 ~~or that is likely to compromise the financial competitive, or proprie-~~  
38 ~~tary nature of the information.]~~

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

49 (b) If the department intends to refer a drug to the drug utilization  
50 review board pursuant to paragraph (a) of this subdivision, the depart-  
51 ment shall notify the manufacturer of such drug and shall attempt to  
52 reach agreement with the manufacturer on a rebate for the drug prior to  
53 referring the drug to the drug utilization review board for review.  
54 Such rebate may be based on evidence-based research, including, but not  
55 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 (e)]~~ 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 certifi-  
56 cation 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

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

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

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

29 (C) No facility shall experience a reduction in indigent care pool  
30 payments pursuant to this subdivision that: for the calendar year begin-  
31 ning January first, two thousand thirteen, is greater than two and one-  
32 half percent; for the calendar year beginning January first, two thou-  
33 sand fourteen, is greater than five percent; and, for the calendar year  
34 beginning on January first, two thousand fifteen; is greater than seven  
35 and one-half percent, and for the calendar year beginning on January  
36 first, two thousand sixteen, is greater than ten percent; and for the  
37 calendar year beginning on January first, two thousand seventeen, is  
38 greater than twelve and one-half percent; and for the calendar year  
39 beginning on January first, two thousand eighteen, is greater than  
40 fifteen percent; and for the calendar year beginning on January first,  
41 two thousand nineteen, is greater than seventeen and one-half percent.

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

52 (c) The commissioner shall annually report to the governor and the  
53 legislature on the distribution of funds under this subdivision includ-  
54 ing, but not limited to:

55 (i) the impact on safety net providers, including community providers,  
56 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 29PHARMACY BENEFIT MANAGERSSection 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) if the superintendent determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other registrants or licensees, or the registrant or licensee proposing employment or appointment of such person; or

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

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

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

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

§ 2913. Assessments. Pharmacy benefit managers that file a registration with the department or are licensed by the department shall be assessed by the superintendent for the operating expenses of the department that are solely attributable to regulating such pharmacy benefit managers in such proportions as the superintendent shall deem just and reasonable.

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

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two, section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two thousand one hundred two, two thousand one hundred seventeen, two thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, two thousand nine hundred two, two thousand nine hundred five, three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four thousand two hundred twenty-four, four thousand two hundred twenty-five, four thousand two hundred twenty-six, seven thousand eight hundred nine, 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  
8 PART J

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

22  
23 SUBPART A

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

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

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

35 § 2. Paragraph 1 of subsection (g) of section 3231 of the insurance  
36 law, as amended by section 70 of part D of chapter 56 of the laws of  
37 2013, is amended to read as follows:

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

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

52 § 4. Subsections (f) and (g) of section 3232 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, 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[~~r~~  
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

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 seven-teen-i of this article by another insurer, corporation or health maintenance organization within the insurer's same holding company system, as defined in article fifteen of this chapter.

§ 3. Items (i) and (ii) of subparagraph (D) of paragraph 11 of subsection (i) of section 3216 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.

§ 4. Items (i) and (ii) of subparagraph (D) of paragraph 15 of subsection (i) of section 3216 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.

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

§ 6. Paragraph 21 of subsection (i) of section 3216 of the insurance law, as amended by chapter 469 of the laws of 2018, is amended to read 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 seventeen-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 (1) 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 (1) 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.

1 ~~[Catastrophic health insurance policies issued pursuant to section~~  
2 ~~1302(e) of the affordable care act, 42 U.S.C. § 18022(e), shall be clas-~~  
3 ~~sified in a distinct community rating pool.]~~

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

7 (d) A student accident and health insurance policy or contract shall  
8 provide coverage for essential health benefits as defined in subsection  
9 (a) of section [1302(b) of the affordable care act, 42 U.S.C. §  
10 18022(b)] three thousand two hundred seventeen-i or subsection (a) of  
11 section four thousand three hundred six-h of this chapter, as  
12 applicable.

13 § 22. Subparagraph (A) of paragraph 3 of subsection (d) of section  
14 4235 of the insurance law, as added by section 60 of part D of chapter  
15 56 of the laws of 2013, is amended to read as follows:

16 (A) "employee" shall have the meaning set forth in ~~[section 2791 of~~  
17 ~~the public health service act, 42 U.S.C. § 300gg-91(d)(5) or any regu-~~  
18 ~~lations promulgated thereunder]~~ the Employee Retirement Income Security  
19 Act of 1974, 29 U.S.C. § 1002(6); and

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

24 (C) with respect to children, including infants and adolescents,  
25 evidence-informed preventive care and screenings provided for in compre-  
26 hensive guidelines supported by the health resources and services admin-  
27 istration; ~~[and]~~

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

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

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

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

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

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

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

(A) 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~~

(B) with respect to women, such additional preventive care and screenings for cervical cytology 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.

§ 26. 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]~~ defined in subsection (a) of section ~~[2707(a) of the public health services act 42 U.S.C. 300 gg 6(a)]~~ four thousand three hundred six-h of this article.

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

(y) Every contract ~~[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~~].

§ 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(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~].

(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 6 4328 of the insurance law, as added by chapter 11 of the laws of 2016, 7 is amended to read as follows:

8 (A) The individual enrollee direct payment contract offered pursuant 9 to this section shall have the same enrollment periods, including 10 special enrollment periods, as required for an individual direct payment 11 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 15 section 46 of part D of chapter 56 of the laws of 2013, is amended to 16 read as follows:

17 (c) In addition to or in lieu of the individual enrollee direct 18 payment contracts required under this section, all health maintenance 19 organizations issued a certificate of authority under article forty-four 20 of the public health law or licensed under this article may offer indi- 21 vidual enrollee direct payment contracts within the health benefit 22 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 bene- 25 fit exchange. If a health maintenance organization satisfies the 26 requirements of subsection (a) of this section by offering individual 27 enrollee direct payment contracts, only within the health benefit 28 exchange, the health maintenance organization, not including a holder of 29 a special purpose certificate of authority issued pursuant to section 30 four thousand four hundred three-a of the public health law, shall also 31 offer at least one individual enrollee direct payment contract at each 32 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 34 six-h of this article, outside the health benefit exchange.

35 § 42. This act shall take effect on the first of January next succeed- 36 ing the date on which it shall have become a law and shall apply to all 37 policies and contracts issued, renewed, modified, altered or amended on 38 or after such date.

39 SUBPART C

40 Section 1. Subsection (i) of section 3216 of the insurance law is 41 amended by adding a new paragraph 35 to read as follows:

42 (35) No policy delivered or issued for delivery in this state that 43 provides hospital, surgical, or medical expense coverage shall limit or 44 exclude coverage for abortions that are medically necessary. Coverage 45 for abortions that are medically necessary shall not be subject to annu- 46 al deductibles or coinsurance, including co-payments, unless the policy 47 is a high deductible health plan as defined in section 223(c)(2) of the 48 internal revenue code of 1986; in which case coverage for medically 49 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 51 adding a new paragraph 21 to read as follows:

52 (21) (A) No policy delivered or issued for delivery in this state that 53 provides hospital, surgical, or medical expense coverage shall limit or 54 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.

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

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

(B) An external appeal agent shall make a determination on the external appeal and notify the corporation, the insured or the insured's designee, and the insured's prescribing health care provider by telephone of its determination no later than seventy-two hours following the external appeal agent's receipt of the request, if the original request was a standard exception request under paragraph two of this subsection. The external appeal agent shall notify the corporation, the insured or the insured's designee and the insured's prescribing health care provider in writing of the external appeal determination within two business days of rendering such determination.

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

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

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

§ 3. 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 E

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

§ 2607. Discrimination because of sex or marital status. (a) No individual or entity shall refuse to issue any policy of insurance, or cancel or decline to renew ~~such~~ the policy because of the sex or marital status of the applicant or policyholder or engage in sexual stereotyping.

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

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

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

(1) make any distinction or discrimination between persons as to the premiums or rates charged for the policy or in any other manner whatever;

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

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

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

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

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

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

(8) engage in sexual stereotyping.

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

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

§ 4330. Discrimination because of sex or marital status in hospital, surgical or medical expense insurance. (a) With regard to a contract issued by a corporation subject to the provisions of this article that 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 [~~(i)~~] ~~(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 ~~(i)~~] 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 O

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;

1 (ii) provides at least a bronze level of coverage as defined by state  
2 law, unless the plan is certified as a qualified catastrophic plan, as  
3 defined in section 1302(e) of the federal act and the insurance law, and  
4 shall only be offered to individuals eligible for catastrophic coverage;

5 (iii) has cost-sharing requirements, including deductibles, which do  
6 not exceed the limits established under section 1302(c) of the federal  
7 act, state law and any requirements of the Marketplace;

8 (iv) complies with regulations promulgated by the secretary pursuant  
9 to section 1311(c) of the federal act and applicable state law, which  
10 include minimum standards in the areas of marketing practices, network  
11 adequacy, essential community providers in underserved areas, accredi-  
12 tation, quality improvement, uniform enrollment forms and descriptions  
13 of coverage and information on quality measures for health benefit plan  
14 performance;

15 (v) meets standards specified and determined by the Marketplace,  
16 provided that the standards do not conflict with or prevent the applica-  
17 tion of federal requirements; and

18 (vi) complies with the insurance law and this chapter requirements  
19 applicable to health insurance issued in this state and any regulations  
20 promulgated pursuant thereto that do not conflict with or prevent the  
21 application of federal requirements; and

22 (c) The Marketplace determines that making the health plan available  
23 through the Marketplace is in the interest of qualified individuals in  
24 this state.

25 2. The Marketplace shall not exclude a health plan:

26 (a) on the basis that the health plan is a fee-for-service plan;

27 (b) through the imposition of premium price controls by the Market-  
28 place; or

29 (c) on the basis that the health plan provides treatments necessary to  
30 prevent patients' deaths in circumstances the Marketplace determines are  
31 inappropriate or too costly.

32 3. The Marketplace shall require each insurer certified or seeking  
33 certification of a health plan as a qualified health plan or plan  
34 approved for sale by the department of financial services or the depart-  
35 ment to:

36 (a) submit a justification for any premium increase pursuant to appli-  
37 cable law prior to implementation of such increase. The insurer shall  
38 prominently post the information on its internet website. Such rate  
39 increases shall be subject to the prior approval of the superintendent  
40 pursuant to the insurance law;

41 (b)(i) make available to the public and submit to the Marketplace, the  
42 secretary and the superintendent, accurate and timely disclosure of:

43 (A) claims payment policies and practices;

44 (B) periodic financial disclosures;

45 (C) data on enrollment and disenrollment;

46 (D) data on the number of claims that are denied;

47 (E) data on rating practices;

48 (F) information on cost-sharing and payments with respect to any out-  
49 of-network coverage;

50 (G) information on enrollee and participant rights under title I of  
51 the federal act; and

52 (H) other information as determined appropriate by the secretary or  
53 otherwise required by the Marketplace;

54 (ii) the information shall be provided in plain language, as that term  
55 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.

1 § 2. Section 364-j of the social services law is amended by adding a  
2 new subdivision 34 read as follows:

3 34. Any payment made pursuant to the state's managed care program,  
4 including payments made by managed long term care plans, shall be deemed  
5 a payment by the state's medical assistance program.

6 § 3. Section 364-j of the social services law is amended by adding a  
7 new subdivision 36 to read as follows:

8 36. Medicaid Program Integrity Reviews. (a) For purposes of this  
9 subdivision, managed care provider shall also include managed long term  
10 care plans.

11 (b) The Medicaid inspector general shall conduct periodic reviews of  
12 the contractual performance of each managed care provider as it relates  
13 to the managed care provider's program integrity obligations under its  
14 contract with the department. The Medicaid inspector general, in consul-  
15 tation with the commissioner, shall publish a list of those contractual  
16 obligations which may be subject to review and how they shall be evalu-  
17 ated, including benchmarks, prior to commencing any review.

18 (c) If, as a result of his or her review, the Medicaid inspector  
19 general determines that a managed care provider is not meeting its  
20 program integrity obligations, the Medicaid inspector general may  
21 recover from the managed care provider up to two percent of the Medicaid  
22 premiums paid to the managed care provider for the period under review.  
23 Any premium recovery under this subdivision shall be a percentage of the  
24 administrative component of the Medicaid premium calculated by the  
25 department and may be recovered by the department in the same manner it  
26 recovers overpayments.

27 (d) The managed care provider shall be entitled to receive a draft  
28 audit report and final audit report containing the results of the Medi-  
29 caid inspector general's review. If the Medicaid inspector general  
30 determines to recover a percentage of the premium as described in para-  
31 graph (c) of this subdivision, the managed care provider shall have an  
32 opportunity to be heard in accordance with section twenty-two of this  
33 chapter.

34 § 4. Subdivision 3 of section 363-d of the social services law, as  
35 amended by section 44 of part C of chapter 58 of the laws of 2007, is  
36 amended to read as follows:

37 3. Upon enrollment in the medical assistance program, a provider shall  
38 certify to the department that the provider satisfactorily meets the  
39 requirements of this section. Additionally, the commissioner of health  
40 and Medicaid inspector general shall have the authority to determine at  
41 any time if a provider has a compliance program that satisfactorily  
42 meets the requirements of this section.

43 (a) A compliance program that is accepted by the federal department of  
44 health and human services office of inspector general and remains in  
45 compliance with the standards promulgated by such office shall be deemed  
46 in compliance with the provisions of this section, so long as such plans  
47 adequately address medical assistance program risk areas and compliance  
48 issues.

49 (b) A compliance program that meets Federal requirements for managed  
50 care provider compliance programs, as specified in the contract or  
51 contracts between the department and the Medicaid managed care provider  
52 shall be deemed in compliance with the provisions in this section, so  
53 long as such programs adequately address medical assistance program risk  
54 areas and compliance issues. For purposes of this section, a managed  
55 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 (NPPES).

§ 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  
2 follows:

3 3-b. Notwithstanding any inconsistent provision of law, beginning  
4 April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and  
5 ending March 31, ~~[2019]~~ 2020, the commissioners shall not include a COLA  
6 for the purpose of establishing rates of payments, contracts or any  
7 other form of reimbursement~~[, provided that the commissioners of the~~  
8 ~~office for people with developmental disabilities, the office of mental~~  
9 ~~health, and the office of alcoholism and substance abuse services shall~~  
10 ~~not include a COLA beginning April 1, 2017 and ending March 31, 2019]~~.

11 3-c. Notwithstanding any inconsistent provision of law, beginning  
12 April 1, ~~[2019]~~ 2020 and ending March 31, ~~[2022]~~ 2023, the commissioners  
13 shall develop the COLA under this section using the actual U.S. consumer  
14 price index for all urban consumers (CPI-U) published by the United  
15 States department of labor, bureau of labor statistics for the twelve  
16 month period ending in July of the budget year prior to such state  
17 fiscal year, for the purpose of establishing rates of payments,  
18 contracts or any other form of reimbursement.

19 § 2. This act shall take effect immediately and shall be deemed to  
20 have been in full force and effect on and after April 1, 2019; provided,  
21 however, that the amendments to section 1 of part C of chapter 57 of the  
22 laws of 2006 made by section one of this act shall not affect the repeal  
23 of such section and shall be deemed repealed therewith.

24 PART Z

25 Section 1. Subdivision 1 of section 2801 of the public health law, as  
26 amended by section 1 of subpart B of part S of chapter 57 of the laws of  
27 2018, is amended to read as follows:

28 1. "Hospital" means a facility or institution engaged principally in  
29 providing services by or under the supervision of a physician or, in the  
30 case of a dental clinic or dental dispensary, of a dentist, or, in the  
31 case of a midwifery birth center, of a midwife, for the prevention,  
32 diagnosis or treatment of human disease, pain, injury, deformity or  
33 physical condition, including, but not limited to, a general hospital,  
34 public health center, diagnostic center, treatment center, dental clinic,  
35 dental dispensary, rehabilitation center other than a facility used  
36 solely for vocational rehabilitation, nursing home, tuberculosis hospital,  
37 chronic disease hospital, maternity hospital, midwifery birth  
38 center, lying-in-asylum, out-patient department, out-patient lodge,  
39 dispensary and a laboratory or central service facility serving one or  
40 more such institutions, but the term hospital shall not include an  
41 institution, sanitarium or other facility engaged principally in providing  
42 services for the prevention, diagnosis or treatment of mental disability  
43 and which is subject to the powers of visitation, examination,  
44 inspection and investigation of the department of mental hygiene except  
45 for those distinct parts of such a facility which provide hospital  
46 service. The provisions of this article shall not apply to a facility or  
47 institution engaged principally in providing services by or under the  
48 supervision of the bona fide members and adherents of a recognized religious  
49 organization whose teachings include reliance on spiritual means  
50 through prayer alone for healing in the practice of the religion of such  
51 organization and where services are provided in accordance with those  
52 teachings. No provision of this article or any other provision of law  
53 shall be construed to: (a) limit the volume of mental health ~~[or],~~  
54 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.

1 (G) 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 § 6. Paragraph 31 of subsection (i) of section 3216 of the insurance  
5 law, as added by chapter 41 of the laws of 2014 and subparagraph (E) as  
6 added by section 3 of part MM of chapter 57 of the laws of 2018, is  
7 amended to read as follows:

8 (31) (A) Every policy that provides medical, major medical or similar  
9 comprehensive-type coverage ~~[must]~~ shall provide outpatient coverage for  
10 the diagnosis and treatment of substance use disorder, including detoxi-  
11 fication and rehabilitation services. Such coverage shall not apply  
12 financial requirements or treatment limitations to outpatient substance  
13 use disorder benefits that are more restrictive than the predominant  
14 financial requirements and treatment limitations applied to substantial-  
15 ly all medical and surgical benefits covered by the policy. ~~[Further,~~  
16 ~~such coverage shall be provided consistent with the federal Paul Well-~~  
17 ~~stone and Pete Domenici Mental Health Parity and Addiction Equity Act of~~  
18 ~~2008 (29 U.S.C. § 1185a).]~~

19 (B) Coverage under this paragraph may be limited to facilities in New  
20 York state ~~[certified]~~ that are licensed, certified or otherwise author-  
21 ized by the office of alcoholism and substance abuse services ~~[or~~  
22 ~~licensed by such office as outpatient clinics or medically supervised~~  
23 ~~ambulatory]~~ to provide outpatient substance ~~[abuse programs]~~ use disor-  
24 der services and, in other states, to those which are accredited by the  
25 joint commission as alcoholism or chemical dependence substance abuse  
26 treatment programs and are similarly licensed, certified, or otherwise  
27 authorized in the state in which the facility is located.

28 (C) Coverage provided under this paragraph may be subject to annual  
29 deductibles and co-insurance as deemed appropriate by the superintendent  
30 and that are consistent with those imposed on other benefits within a  
31 given policy.

32 (D) A policy providing coverage for substance use disorder services  
33 pursuant to this paragraph shall provide up to twenty outpatient visits  
34 per policy or calendar year to an individual who identifies him or  
35 herself as a family member of a person suffering from substance use  
36 disorder and who seeks treatment as a family member who is otherwise  
37 covered by the applicable policy pursuant to this paragraph. The cover-  
38 age required by this paragraph shall include treatment as a family  
39 member pursuant to such family member's own policy provided such family  
40 member:

41 (i) does not exceed the allowable number of family visits provided by  
42 the applicable policy pursuant to this paragraph; and

43 (ii) is otherwise entitled to coverage pursuant to this paragraph and  
44 such family member's applicable policy.

45 (E) This subparagraph shall apply to facilities in this state that are  
46 licensed, certified or otherwise authorized by the office of alcoholism  
47 and substance abuse services for the provision of outpatient, intensive  
48 outpatient, outpatient rehabilitation and opioid treatment that are  
49 participating in the insurer's provider network. Coverage provided under  
50 this paragraph shall not be subject to preauthorization. Coverage  
51 provided under this paragraph shall not be subject to concurrent review  
52 for the first ~~[two]~~ three weeks of continuous treatment, not to exceed  
53 ~~[fourteen]~~ twenty-one visits, provided the facility notifies the insurer  
54 of both the start of treatment and the initial treatment plan within  
55 ~~[forty-eight hours]~~ two business days. The facility shall perform clin-  
56 ical 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 (l) of section thirty-two hundred twenty-one of this article.

§ 11. Subparagraph (A) of paragraph 4 of subsection (l) 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 (l) 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 disorder.  
53 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 (1) 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 (1) 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;

(C) "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 contract; and

(D) "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.

(7) A corporation 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).

(8) This subparagraph shall apply to hospitals in this state that are licensed by the office of mental health that are participating in the corporation's provider network. Where the contract provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law provided to individuals who have not attained the age of eighteen shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first fourteen days of the inpatient admission, provided the facility notifies the corporation of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the patient, and participates in periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the corporation 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 contract.

§ 24. Subsection (h) of section 4303 of the insurance law is REPEALED.

§ 25. Subsection (i) of section 4303 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(i) A medical expense indemnity corporation or health service corporation ~~[which]~~ that provides coverage for 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]~~ shall make available and if requested by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contract holder in the case of a group contract issued 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 1967(c)(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 ~~[7]~~ case management~~[7]~~ 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 [~~ex~~], 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), (l-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

social services law made by section one of this act shall not affect the repeal of such section and shall be deemed to be repealed therewith.

## SUBPART E

Section 1. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding nineteen new paragraphs 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75 and 76 to read as follows:

(58) N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide. Other name: Butyryl Fentanyl.

(59) N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-N-phenylpropionamide. Other name: Beta-Hydroxythiofentanyl.

(60) N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide. Other name: Furanyl Fentanyl.

(61) 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide. Other name: U-47700.

(62) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide. Other names: Acryl Fentanyl or Acryloylfentanyl.

(63) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl.

(64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

(65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide. Other name: tetrahydrofuranyl fentanyl.

(66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other name: methoxyacetyl fentanyl.

(67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide. Other name: cyclopropyl fentanyl.

(68) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide. Other name: Valeryl fentanyl.

(69) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-fluorobutyrylfentanyl.

(70) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-methoxybutyryl fentanyl.

(71) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other name: para-chloroisobutyryl fentanyl.

(72) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide. Other name: isobutyryl fentanyl.

(73) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide. Other name: cyclopentyl fentanyl.

(74) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide. Other name: Ocfentanil.

(75) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine. Other name: MT-45.

(76) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers, esters and ethers.

(i) Fentanyl-related substance means any substance not otherwise listed in this section, that is structurally related to fentanyl by one or more of the following modifications:

(A) Replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(B) Substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino or nitro groups;

(C) Substitution in or on the piperidine ring with alkyl, alkenyl, 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.