

STATE OF NEW YORK

S. 1507--C

A. 2007--C

SENATE - ASSEMBLY

January 18, 2019

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

AN ACT intentionally omitted (Part A); 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 (Part B); to amend the social services law, in relation to extension of the National Diabetes Prevention Program (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 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,

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

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amending the social 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-

ity 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 fiscal intermediary services for the consumer directed personal assistance program; to amend the public health law, in relation to payments to home care aides; to establish a residential health care facilities case mix adjustment workgroup; and to repeal certain provisions of the social services 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); intentionally omitted (Part I); to amend the insurance law and the public health law, in relation to guaranteed availability and pre-existing conditions; 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 prescription drug coverage (Subpart C); and to amend the insurance law, in relation to discrimination based on sex and gender identity (Subpart D) (Part J); to amend the public health law, in relation to the medical indemnity fund; 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; and to amend the state finance law, in relation to the New York state medical indemnity fund account (Part K); to amend the insurance law, in relation to in-vitro fertilization (Part L); to amend the insurance law, in relation to requiring medical, major medical, or similar comprehensive type coverage health insurance policies to include certain reproductive health coverage; and clarifying the definition of voluntary sterilization procedures and over-the-counter contraceptive products (Part M); intentionally omitted (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); intentionally omitted (Part R); intentionally omitted (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); intentionally omitted (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); intentionally omitted (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); intentionally omitted (Subpart C); to amend the social services law, in relation to court ordered substance use disorder treatment (Subpart D); and intentionally omitted (Subpart E)(Part BB); intentionally omitted (Part CC); intentionally omitted (Part DD); to amend the public health law, in relation to direct observation and evaluation of certain temporary employees (Part EE); to amend chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness thereof (Part FF); to provide funding to programs providing opioid treatment, recovery and prevention and education services operated by the New York state office of alcoholism and substance abuse services or certain agencies (Part GG); to amend the elder law, in relation to grants awarded for classic NORC programs (Part HH); to amend chapter 141 of the laws of 1994, amending the legislative law and the state finance law relating to the operation and administration of the legislature, in relation to extending such provisions (Part II); to amend the public health law, in relation to authorizing the dormitory authority to transfer certain funds repaid by borrowers relating to restructuring pool loans (Part JJ); and directing the department of health to conduct a study in relation to staffing enhancement and patient safety (Part KK)

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 KK. 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,
7 including the effective date of the Part, which makes reference to a
8 section "of this act", when used in connection with that particular
9 component, shall be deemed to mean and refer to the corresponding
10 section of the Part in which it is found. Section three of this act sets
11 forth the general effective date of this act.

12 PART A

13 Intentionally Omitted

14 PART B

15 Section 1. Intentionally omitted.

16 § 2. Intentionally omitted.

17 § 3. Intentionally omitted.

18 § 4. Intentionally omitted.

19 § 5. Paragraphs (b) and (c) of subdivision 2 of section 280 of the
20 public health law, paragraph (b) as amended and paragraph (c) as added

1 by section 8 of part D of chapter 57 of the laws of 2018, are amended
2 and a new paragraph (d) is added to read as follows:

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

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

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

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

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

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

52 (b) If the department intends to refer a drug to the drug utilization
53 review board pursuant to paragraph (a) of this subdivision, the depart-
54 ment shall notify the manufacturer of such drug and shall attempt to
55 reach agreement with the manufacturer on a rebate for the drug prior to
56 referring the drug to the drug utilization review board for review.

Such rebate may be based on evidence-based research, including, but not limited to, such research operated or conducted by or for other state governments, the federal government, the governments of other nations, and third party payers or multi-state coalitions, provided however that the department shall account for the effectiveness of the drug in treating the conditions for which it is prescribed or in improving a patient's health, quality of life, or overall health outcomes, and the likelihood that use of the drug will reduce the need for other medical care, including hospitalization.

(c) In the event that the commissioner and the manufacturer have previously agreed to a supplemental rebate for a drug pursuant to paragraph (b) of this subdivision or paragraph (e) of subdivision seven of section three hundred sixty-seven-a of the social services law, the drug shall not be referred to the drug utilization review board for any further supplemental rebate for the duration of the previous rebate agreement, provided however, the commissioner may refer a drug to the drug utilization review board if the commissioner determines there are significant and substantiated utilization or market changes, new evidence-based research, or statutory or federal regulatory changes that warrant additional rebates. In such cases, the department shall notify the manufacturer and provide evidence of the changes or research that would warrant additional rebates, and shall attempt to reach agreement with the manufacturer on a rebate for the drug prior to referring the drug to the drug utilization review board for review.

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

(e) The commissioner shall be authorized to take the actions described in this section only so long as total Medicaid drug expenditures are projected to exceed the annual growth limitation imposed by subdivision two of this section.

§ 6-a. Subparagraph (iii) of paragraph (e) of subdivision 5 of section 280 of the public health law, as amended by section 8 of part D of chapter 57 of the laws of 2018, is amended to read as follows:

(iii) information relating to value-based pricing provided, however, if the department directly invites any third party to provide cost-effectiveness analysis or research related to value-based pricing, and the department receives and considers such analysis or research for use by the board, such third party shall disclose any funding sources. The department shall, if reasonably possible, make publicly available the following documents in its possession that it relies upon to provide cost effectiveness analyses or research related to value-based pricing: (A) descriptions of underlying methodologies; (B) assumptions and limitations of research findings; and (C) if available, data that presents results in a way that reflects different outcomes for affected subpopulations;

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

(a) If the drug utilization review board recommends a target rebate amount on a drug referred by the commissioner, the [~~commissioner shall require~~] department shall negotiate with the drug's manufacturer for a supplemental rebate to be paid by the [~~drug's~~] manufacturer in an amount

1 not to exceed such target rebate amount. [~~With respect to a~~] A rebate
2 [~~required in state fiscal year two thousand seventeen two thousand~~
3 ~~eighteen, the rebate~~] requirement shall apply beginning with the [~~month~~
4 ~~of April, two thousand seventeen,~~] first day of the state fiscal year
5 during which the rebate was required without regard to the date the
6 department enters into the rebate agreement with the manufacturer.

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

10 (a) If, after taking into account all rebates and supplemental rebates
11 received by the department, including rebates received to date pursuant
12 to this section, total Medicaid drug expenditures are still projected to
13 exceed the annual growth limitation imposed by subdivision two of this
14 section, the commissioner may: subject any drug of a manufacturer
15 referred to the drug utilization review board under this section to
16 prior approval in accordance with existing processes and procedures when
17 such manufacturer has not entered into a supplemental rebate agreement
18 as required by this section; [~~directing~~] direct managed care plans to
19 remove from their Medicaid formularies those drugs that the drug utili-
20 zation review board recommends a target rebate amount for and the
21 manufacturer has failed to enter into a rebate agreement required by
22 this section; [~~promoting~~] promote the use of cost effective and clin-
23 ically appropriate drugs other than those of a manufacturer who has a
24 drug that the drug utilization review board recommends a target rebate
25 amount and the manufacturer has failed to enter into a rebate agreement
26 required by this section; [~~allowing~~] allow manufacturers to accelerate
27 rebate payments under existing rebate contracts; and such other actions
28 as authorized by law. The commissioner shall provide written notice to
29 the legislature thirty days prior to taking action pursuant to this
30 paragraph, unless action is necessary in the fourth quarter of a fiscal
31 year to prevent total Medicaid drug expenditures from exceeding the
32 limitation imposed by subdivision two of this section, in which case
33 such notice to the legislature may be less than thirty days.

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

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

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

46 10. (a) Any contract or other arrangement entered into by a health
47 care plan for the provision and administration of pharmacy benefit
48 management services on behalf of individuals enrolled in a managed care
49 provider, as defined in section three hundred sixty-four-j of the social
50 services law, shall be based on a pass-through pricing model and include
51 the following requirements:

52 (i) Payment to the pharmacy benefit manager for pharmacy benefit
53 management services shall be limited to the actual ingredient costs,
54 dispensing fees paid to pharmacies, and an administrative fee that
55 covers the cost of providing pharmacy benefit management services pursu-

1 ant to a contract described in this paragraph. The department may estab-
2 lish a maximum administrative fee;

3 (ii) The pharmacy benefit manager shall identify all sources and
4 amounts of income, payments, and financial benefits to the pharmacy
5 benefit manager related to the provision and administration of pharmacy
6 benefit management services on behalf of the health care plan, includ-
7 ing, but not limited to, any pricing discounts, rebates of any kind,
8 inflationary payments, credits, clawbacks, fees, grants, chargebacks,
9 reimbursements, or other benefits and shall ensure that any portion of
10 such income, payments, and financial benefits is passed through to the
11 health care plan in full to reduce the reportable ingredient cost;

12 (iii) The pharmacy benefit manager shall fully disclose to the depart-
13 ment and to the health care plan the sources and amounts of all income,
14 payments, and financial benefits referred to in subparagraph (ii) of
15 this paragraph received by the pharmacy benefit manager;

16 (iv) The pharmacy benefit manager shall identify all ingredient costs
17 and dispensing fees or similar payments made by the pharmacy benefit
18 manager to any pharmacy in connection with the contract or other
19 arrangement;

20 (v) The pharmacy benefit manager shall not utilize any form of spread
21 pricing in any contract or other arrangement with health care plans. For
22 purposes of this subdivision "spread pricing" means any amount charged
23 or claimed by the pharmacy benefit manager in excess of the amount paid
24 to pharmacies on behalf of the health care plan less an administrative
25 fee as described in this paragraph. Any such excess amount shall be
26 remitted to the health care plan on a quarterly basis;

27 (vi) Pharmacy benefit managers shall make their payment model for
28 administrative fees available to the health care plan and to the depart-
29 ment. The health care plan shall, if so directed by the department,
30 make changes to the payment model and resubmit an amended contract or
31 contracts to the department for review and approval.

32 (b) Any changes to premiums resulting from such contracts shall be
33 subject to certification by the state's actuary as actuarially appropri-
34 ate.

35 (c) Contracts or other arrangements subject to this subdivision shall
36 be submitted to the department for review and approval as required by
37 and in accordance with state law and the regulations of the department.
38 Contracts or other arrangements subject to this subdivision existing
39 and in force at the time of enactment of this subdivision shall be
40 submitted to the department for review and approval on or before July
41 first, two thousand nineteen.

42 § 10-a. Section 364-j of the social services law is amended by adding
43 a new subdivision 37 to read as follows:

44 37. Managed care providers shall report to the department all sources
45 and amounts of income, payments, and financial benefits related to the
46 provision of pharmacy benefits, including, but not limited to, any pric-
47 ing discounts, rebates of any kind, inflationary payments, credits,
48 clawbacks, fees, grants, chargebacks, reimbursements, or other benefits
49 whether such income, payments, or financial benefits are received
50 directly by the managed care provider or passed through from a pharmacy
51 benefit manager or other entity. Managed care providers shall also
52 report to the department the amounts of any administrative fees paid to
53 cover the cost of providing pharmacy benefit management services. The
54 reporting required in this subdivision shall be supplemental to and
55 included with other existing reporting requirements, including but not
56 limited to any quarterly reporting requirements.

§ 11. 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, further that the amendments to section 364-j of the social services law made by section 10-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART C

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

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

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. This act shall take effect July 1, 2019.

PART D

Section 1. Subdivision 1 of section 92 of part H of 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, as amended by section 2 of part K of chapter 57 of the laws of 2018, is amended to read as follows:

1. For state fiscal years 2011-12 through [~~2019-20~~] 2020-2021, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner, and if the director of the budget determines that such expenditures are expected to cause medicaid disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, minimum wage increases, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund and state costs or savings from the basic health plan. Such projections may be adjusted by the director of the budget to account for increased or expected department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

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

PART E

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

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

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

13 p. the amendments [~~made~~] to subparagraph [~~(7)~~] 7 of paragraph (b) of
14 subdivision 1 of section 366 of the social services law made by section
15 one of this act shall expire and be deemed repealed October 1, [~~2019~~]
16 2024.

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

22 § 11. This act shall take effect immediately and:

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

24 (b) sections four through ten shall expire on June 30, [~~2019~~] 2021,
25 and

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

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

34 § 3. This act shall take effect immediately, provided, however, that
35 subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of
36 1973, as added by section one of this act, shall expire and be deemed
37 repealed June 30, [~~2019~~] 2023; and provided further, however, that the
38 expiration and repeal of such subdivision 15-a shall not affect or
39 impair in any manner any health facilities bonds issued, or any lease or
40 purchase of a health facility executed, pursuant to such subdivision
41 15-a prior to its expiration and repeal and that, with respect to any
42 such bonds issued and outstanding as of June 30, [~~2019~~] 2023, the
43 provisions of such subdivision 15-a as they existed immediately prior to
44 such expiration and repeal shall continue to apply through the latest
45 maturity date of any such bonds, or their earlier retirement or redemp-
46 tion, for the sole purpose of authorizing the issuance of refunding
47 bonds to refund bonds previously issued pursuant thereto.

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

52 (a) sections two, three, three-a, three-b, three-c, three-d, three-e
53 and twenty-one of this act shall take effect July 1, 2010; sections
54 fifteen, sixteen, seventeen, eighteen and nineteen of this act shall
55 take effect January 1, 2011; and provided further that section twenty of
56 this act shall be deemed repealed [~~eight~~] ten years after the date the

1 contract entered into pursuant to section 365-h of the social services
2 law, as amended by section twenty of this act, is executed; provided
3 that the commissioner of health shall notify the legislative bill draft-
4 ing commission upon the execution of the contract entered into pursuant
5 to section 367-h of the social services law in order that the commission
6 may maintain an accurate and timely effective data base of the official
7 text of the laws of the state of New York in furtherance of effectuating
8 the provisions of section 44 of the legislative law and section 70-b of
9 the public officers law;

10 § 6. Subdivision (f) of section 129 of part C of chapter 58 of the
11 laws of 2009, amending the public health law relating to payment by
12 governmental agencies for general hospital inpatient services, as
13 amended by section 4 of part D of chapter 59 of the laws of 2016, is
14 amended to read as follows:

15 (f) section twenty-five of this act shall expire and be deemed
16 repealed April 1, [~~2019~~] 2022;

17 § 7. Subdivision (c) of section 122 of part E of chapter 56 of the
18 laws of 2013 amending the public health law relating to the general
19 public health work program, as amended by section 5 of part D of chapter
20 59 of the laws of 2016, is amended to read as follows:

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

23 § 8. Subdivision (i) of section 111 of part H of chapter 59 of the
24 laws of 2011, amending the public health law and other laws relating to
25 known and projected department of health state fund medical expendi-
26 tures, as amended by section 19 of part D of chapter 57 of the laws of
27 2015, is amended to read as follows:

28 (i) the amendments to paragraph (b) and subparagraph (i) of paragraph
29 (g) of subdivision 7 of section 4403-f of the public health law made by
30 section forty-one-b of this act shall expire and be repealed April 1,
31 [~~2019~~] 2023;

32 § 9. Subparagraph (vi) of paragraph (b) of subdivision 2 of section
33 2807-d of the public health law, as amended by section 3 of part I of
34 chapter 57 of the laws of 2017, is amended to read as follows:

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

assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-one such assessment shall be six percent.

§ 10. Subdivision 1 of section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 4 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

§ 11. Subdivision 1 of section 89-a of part C of 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, as amended by section 5 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2021 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US

1 Department of Labor, Bureau of Labor Statistics less twenty-five
2 hundredths of a percentage point.

3 § 12. Subdivision 5-a of section 246 of chapter 81 of the laws of
4 1995, amending the public health law and other laws relating to medical
5 reimbursement and welfare reform, as amended by section 6 of part I of
6 chapter 57 of the laws of 2017, is amended to read as follows:

7 5-a. Section sixty-four-a of this act shall be deemed to have been in
8 full force and effect on and after April 1, 1995 through March 31, 1999
9 and on and after July 1, 1999 through March 31, 2000 and on and after
10 April 1, 2000 through March 31, 2003 and on and after April 1, 2003
11 through March 31, 2007, and on and after April 1, 2007 through March 31,
12 2009, and on and after April 1, 2009 through March 31, 2011, and on and
13 after April 1, 2011 through March 31, 2013, and on and after April 1,
14 2013 through March 31, 2015, and on and after April 1, 2015 through
15 March 31, 2017 and on and after April 1, 2017 through March 31, 2019,
16 and on and after April 1, 2019 through March 31, 2021;

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

21 § 64-b. Notwithstanding any inconsistent provision of law, the
22 provisions of subdivision 7 of section 3614 of the public health law, as
23 amended, shall remain and be in full force and effect on April 1, 1995
24 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on
25 and after April 1, 2000 through March 31, 2003 and on and after April 1,
26 2003 through March 31, 2007, and on and after April 1, 2007 through
27 March 31, 2009, and on and after April 1, 2009 through March 31, 2011,
28 and on and after April 1, 2011 through March 31, 2013, and on and after
29 April 1, 2013 through March 31, 2015, and on and after April 1, 2015
30 through March 31, 2017 and on and after April 1, 2017 through March 31,
31 2019, and on and after April 1, 2019 through March 31, 2021.

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

37 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section
38 2807-c of the public health law, section 21 of chapter 1 of the laws of
39 1999, or any other contrary provision of law, in determining rates of
40 payments by state governmental agencies effective for services provided
41 on and after January 1, 2017 through March 31, ~~2019~~ 2021, for inpa-
42 tient and outpatient services provided by general hospitals, for inpa-
43 tient services and adult day health care outpatient services provided by
44 residential health care facilities pursuant to article 28 of the public
45 health law, except for residential health care facilities or units of
46 such facilities providing services primarily to children under twenty-
47 one years of age, for home health care services provided pursuant to
48 article 36 of the public health law by certified home health agencies,
49 long term home health care programs and AIDS home care programs, and for
50 personal care services provided pursuant to section 365-a of the social
51 services law, the commissioner of health shall apply no greater than
52 zero trend factors attributable to the 2017, 2018, ~~and~~ 2019, 2020, and
53 2021 calendar years in accordance with paragraph (c) of subdivision 10
54 of section 2807-c of the public health law, provided, however, that such
55 no greater than zero trend factors attributable to such 2017, 2018,
56 ~~and~~ 2019, 2020, and 2021 calendar years shall also be applied to rates

1 of payment provided on and after January 1, 2017 through March 31,
2 [~~2019~~] 2021 for personal care services provided in those local social
3 services districts, including New York city, whose rates of payment for
4 such services are established by such local social services districts
5 pursuant to a rate-setting exemption issued by the commissioner of
6 health to such local social services districts in accordance with appli-
7 cable regulations; and provided further, however, that for rates of
8 payment for assisted living program services provided on and after Janu-
9 ary 1, 2017 through March 31, [~~2019~~] 2021, such trend factors attribut-
10 able to the 2017, 2018, [~~and~~] 2019, 2020, and 2021 calendar years shall
11 be established at no greater than zero percent.

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

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

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

49 (a) Notwithstanding any inconsistent provision of law or regulation
50 and subject to the availability of federal financial participation,
51 effective April first, two thousand twelve through March thirty-first,
52 two thousand [~~nineteen~~] twenty-three, payments by government agencies
53 for services provided by certified home health agencies, except for such
54 services provided to children under eighteen years of age and other
55 discreet groups as may be determined by the commissioner pursuant to
56 regulations, shall be based on episodic payments. In establishing such

1 payments, a statewide base price shall be established for each sixty day
2 episode of care and adjusted by a regional wage index factor and an
3 individual patient case mix index. Such episodic payments may be further
4 adjusted for low utilization cases and to reflect a percentage limita-
5 tion of the cost for high-utilization cases that exceed outlier thresh-
6 olds of such payments.

7 § 17. Subdivision 2 of section 246 of chapter 81 of the laws of 1995,
8 amending the public health law and other laws relating to medical
9 reimbursement and welfare reform, as amended by section 18 of part I of
10 chapter 57 of the laws of 2017, is amended to read as follows:

11 2. Sections five, seven through nine, twelve through fourteen, and
12 eighteen of this act shall be deemed to have been in full force and
13 effect on and after April 1, 1995 through March 31, 1999 and on and
14 after July 1, 1999 through March 31, 2000 and on and after April 1, 2000
15 through March 31, 2003 and on and after April 1, 2003 through March 31,
16 2006 and on and after April 1, 2006 through March 31, 2007 and on and
17 after April 1, 2007 through March 31, 2009 and on and after April 1,
18 2009 through March 31, 2011 and sections twelve, thirteen and fourteen
19 of this act shall be deemed to be in full force and effect on and after
20 April 1, 2011 through March 31, 2015 and on and after April 1, 2015
21 through March 31, 2017 and on and after April 1, 2017 through March 31,
22 2019, and on and after April 1, 2019 through March 31, 2021;

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

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

1 of such ambulatory behavioral health fees to providers available under
2 this section shall be for all rate periods on and after the effective
3 date of section ~~[29]~~ 1 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of
4 ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2023 for patients in the city of
5 New York, for all rate periods on and after the effective date of
6 section ~~[29]~~ 1 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~
7 2017 through ~~[March 31, 2020]~~ March 31, 2023 for patients outside the
8 city of New York, and for all rate periods on and after the effective
9 date of such chapter through ~~[March 31, 2020]~~ March 31, 2023 for all
10 services provided to persons under the age of twenty-one; provided,
11 however, the commissioner of health, in consultation with the commis-
12 sioner of alcoholism and substance abuse services and the commissioner
13 of mental health, may require, as a condition of approval of such ambu-
14 latory behavioral health fees, that aggregate managed care expenditures
15 to eligible providers meet the alternative payment methodology require-
16 ments as set forth in attachment I of the New York state medicaid
17 section one thousand one hundred fifteen medicaid redesign team waiver
18 as approved by the centers for medicare and medicaid services. The
19 commissioner of health shall, in consultation with the commissioner of
20 alcoholism and substance abuse services and the commissioner of mental
21 health, waive such conditions if a sufficient number of providers, as
22 determined by the commissioner, suffer a financial hardship as a conse-
23 quence of such alternative payment methodology requirements, or if he or
24 she shall determine that such alternative payment methodologies signif-
25 icantly threaten individuals access to ambulatory behavioral health
26 services. Such waiver may be applied on a provider specific or industry
27 wide basis. Further, such conditions may be waived, as the commissioner
28 determines necessary, to comply with federal rules or regulations
29 governing these payment methodologies. Nothing in this section shall
30 prohibit managed care organizations and providers from negotiating
31 different rates and methods of payment during such periods described
32 above, subject to the approval of the department of health. The depart-
33 ment of health shall consult with the office of alcoholism and substance
34 abuse services and the office of mental health in determining whether
35 such alternative rates shall be approved. The commissioner of health
36 may, in consultation with the commissioner of alcoholism and substance
37 abuse services and the commissioner of the office of mental health,
38 promulgate regulations, including emergency regulations promulgated
39 prior to October 1, 2015 to establish rates for ambulatory behavioral
40 health services, as are necessary to implement the provisions of this
41 section. Rates promulgated under this section shall be included in the
42 report required under section 45-c of part A of this chapter.

43 2. Notwithstanding any contrary provision of law, the fees paid by
44 managed care organizations licensed under article 44 of the public
45 health law or under article 43 of the insurance law, to providers
46 licensed pursuant to article 28 of the public health law or article 31
47 or 32 of the mental hygiene law, for ambulatory behavioral health
48 services provided to patients enrolled in the child health insurance
49 program pursuant to title ~~[one-A]~~ 1-A of article 25 of the public health
50 law, shall be in the form of fees for such services which are equivalent
51 to the payments established for such services under the ambulatory
52 patient group (APG) rate-setting methodology or any such other fees
53 established pursuant to the Medicaid state plan. The commissioner of
54 health shall consult with the commissioner of alcoholism and substance
55 abuse services and the commissioner of the office of mental health in
56 determining such services and establishing such fees. Such ambulatory

behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through ~~March 31, 2020~~ March 31, 2023, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title ~~one-A~~ 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

§ 19. Section 1 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, as amended by section 2 of part P of chapter 57 of the laws of 2017, is amended to read as follows:

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section ~~[30]~~ 2 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2023 for patients in the city of New York, for all rate periods on and after the effective date of section ~~[30]~~ 2 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2023 for patients outside the city of New York, and for all rate periods on and after the effective date of section ~~[30]~~ 2 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2023 for all services provided to persons

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

34 b. Notwithstanding any contrary provision of law, the fees paid by
35 managed care organizations licensed under article 44 of the public
36 health law or under article 43 of the insurance law, to providers
37 licensed pursuant to article 28 of the public health law or article 31
38 or 32 of the mental hygiene law, for ambulatory behavioral health
39 services provided to patients enrolled in the child health insurance
40 program pursuant to title ~~[one-A]~~ 1-A of article 25 of the public health
41 law, shall be in the form of fees for such services which are equivalent
42 to the payments established for such services under the ambulatory
43 patient group (APG) rate-setting methodology. The commissioner of health
44 shall consult with the commissioner of alcoholism and substance abuse
45 services and the commissioner of the office of mental health in deter-
46 mining such services and establishing such fees. Such ambulatory behav-
47 ioral health fees to providers available under this section shall be for
48 all rate periods on and after the effective date of this chapter through
49 March 31, ~~[2020]~~ 2023, provided, however, that managed care organiza-
50 tions and providers may negotiate different rates and methods of payment
51 during such periods described above, subject to the approval of the
52 department of health. The department of health shall consult with the
53 office of alcoholism and substance abuse services and the office of
54 mental health in determining whether such alternative rates shall be
55 approved. The report required under section 16-a of part C of chapter
56 60 of the laws of 2014 shall also include the population of patients

1 enrolled in the child health insurance program pursuant to title [~~one-A~~]
2 1-A of article 25 of the public health law in its examination on the
3 transition of behavioral health services into managed care.

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

9 § 2. This act shall take effect immediately and shall be deemed to
10 have been in full force and effect on and after April 1, 2010, and shall
11 expire on [~~January 1, 2018~~] March 31, 2023.

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

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

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

34 (a) Notwithstanding any inconsistent provision of law or regulation to
35 the contrary, effective beginning August 1, 1996, for the period April
36 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,
37 1998 through March 31, 1999, August 1, 1999, for the period April 1,
38 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000
39 through March 31, 2001, April 1, 2001, for the period April 1, 2001
40 through March 31, 2002, April 1, 2002, for the period April 1, 2002
41 through March 31, 2003, and for the state fiscal year beginning April 1,
42 2005 through March 31, 2006, and for the state fiscal year beginning
43 April 1, 2006 through March 31, 2007, and for the state fiscal year
44 beginning April 1, 2007 through March 31, 2008, and for the state fiscal
45 year beginning April 1, 2008 through March 31, 2009, and for the state
46 fiscal year beginning April 1, 2009 through March 31, 2010, and for the
47 state fiscal year beginning April 1, 2010 through March 31, 2016, and
48 for the state fiscal year beginning April 1, 2016 through March 31,
49 2019, and for the state fiscal year beginning April 1, 2019 through
50 March 31, 2022, the department of health is authorized to pay public
51 general hospitals, as defined in subdivision 10 of section 2801 of the
52 public health law, operated by the state of New York or by the state
53 university of New York or by a county, which shall not include a city
54 with a population of over one million, of the state of New York, and
55 those public general hospitals located in the county of Westchester, the
56 county of Erie or the county of Nassau, additional payments for inpa-

1 tient hospital services as medical assistance payments pursuant to title
2 11 of article 5 of the social services law for patients eligible for
3 federal financial participation under title XIX of the federal social
4 security act in medical assistance pursuant to the federal laws and
5 regulations governing disproportionate share payments to hospitals up to
6 one hundred percent of each such public general hospital's medical
7 assistance and uninsured patient losses after all other medical assist-
8 ance, including disproportionate share payments to such public general
9 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on
10 reported 1994 reconciled data as further reconciled to actual reported
11 1996 reconciled data, and for 1997 based initially on reported 1995
12 reconciled data as further reconciled to actual reported 1997 reconciled
13 data, for 1998 based initially on reported 1995 reconciled data as
14 further reconciled to actual reported 1998 reconciled data, for 1999
15 based initially on reported 1995 reconciled data as further reconciled
16 to actual reported 1999 reconciled data, for 2000 based initially on
17 reported 1995 reconciled data as further reconciled to actual reported
18 2000 data, for 2001 based initially on reported 1995 reconciled data as
19 further reconciled to actual reported 2001 data, for 2002 based initial-
20 ly on reported 2000 reconciled data as further reconciled to actual
21 reported 2002 data, and for state fiscal years beginning on April 1,
22 2005, based initially on reported 2000 reconciled data as further recon-
23 ciled to actual reported data for 2005, and for state fiscal years
24 beginning on April 1, 2006, based initially on reported 2000 reconciled
25 data as further reconciled to actual reported data for 2006, for state
26 fiscal years beginning on and after April 1, 2007 through March 31,
27 2009, based initially on reported 2000 reconciled data as further recon-
28 ciled to actual reported data for 2007 and 2008, respectively, for state
29 fiscal years beginning on and after April 1, 2009, based initially on
30 reported 2007 reconciled data, adjusted for authorized Medicaid rate
31 changes applicable to the state fiscal year, and as further reconciled
32 to actual reported data for 2009, for state fiscal years beginning on
33 and after April 1, 2010, based initially on reported reconciled data
34 from the base year two years prior to the payment year, adjusted for
35 authorized Medicaid rate changes applicable to the state fiscal year,
36 and further reconciled to actual reported data from such payment year,
37 and to actual reported data for each respective succeeding year. The
38 payments may be added to rates of payment or made as aggregate payments
39 to an eligible public general hospital.

40 § 23. This act shall take effect immediately and shall be deemed to
41 have been in full force and effect on and after April 1, 2019; provided
42 that the amendments to section 1 of part H of chapter 111 of the laws of
43 2010 made by section nineteen of this act shall not affect the expira-
44 tion of such section and shall expire therewith; and provided further
45 that section twenty of this act shall be deemed to have been in full
46 force and effect on and after January 1, 2018.

47 PART F

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

53 (a) The superintendent of financial services and the commissioner of
54 health or their designee shall, from funds available in the hospital

1 excess liability pool created pursuant to subdivision 5 of this section,
2 purchase a policy or policies for excess insurance coverage, as author-
3 ized by paragraph 1 of subsection (e) of section 5502 of the insurance
4 law; or from an insurer, other than an insurer described in section 5502
5 of the insurance law, duly authorized to write such coverage and actual-
6 ly writing medical malpractice insurance in this state; or shall
7 purchase equivalent excess coverage in a form previously approved by the
8 superintendent of financial services for purposes of providing equiv-
9 alent excess coverage in accordance with section 19 of chapter 294 of
10 the laws of 1985, for medical or dental malpractice occurrences between
11 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,
12 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June
13 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991
14 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July
15 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,
16 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June
17 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998
18 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July
19 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,
20 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June
21 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005
22 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July
23 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,
24 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June
25 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012
26 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July
27 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016,
28 between July 1, 2016 and June 30, 2017, between July 1, 2017 and June
29 30, 2018, [~~and~~] between July 1, 2018 and June 30, 2019, and between July
30 1, 2019 and June 30, 2020 or reimburse the hospital where the hospital
31 purchases equivalent excess coverage as defined in subparagraph (i) of
32 paragraph (a) of subdivision 1-a of this section for medical or dental
33 malpractice occurrences between July 1, 1987 and June 30, 1988, between
34 July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990,
35 between July 1, 1990 and June 30, 1991, between July 1, 1991 and June
36 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993
37 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July
38 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997,
39 between July 1, 1997 and June 30, 1998, between July 1, 1998 and June
40 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000
41 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July
42 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004,
43 between July 1, 2004 and June 30, 2005, between July 1, 2005 and June
44 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007
45 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July
46 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011,
47 between July 1, 2011 and June 30, 2012, between July 1, 2012 and June
48 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014
49 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July
50 1, 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 for physicians or dentists certified as eligible for each
53 such period or periods pursuant to subdivision 2 of this section by a
54 general hospital licensed pursuant to article 28 of the public health
55 law; provided that no single insurer shall write more than fifty percent
56 of the total excess premium for a given policy year; and provided,

1 however, that such eligible physicians or dentists must have in force an
2 individual policy, from an insurer licensed in this state of primary
3 malpractice insurance coverage in amounts of no less than one million
4 three hundred thousand dollars for each claimant and three million nine
5 hundred thousand dollars for all claimants under that policy during the
6 period of such excess coverage for such occurrences or be endorsed as
7 additional insureds under a hospital professional liability policy which
8 is offered through a voluntary attending physician ("channeling")
9 program previously permitted by the superintendent of financial services
10 during the period of such excess coverage for such occurrences. During
11 such period, such policy for excess coverage or such equivalent excess
12 coverage shall, when combined with the physician's or dentist's primary
13 malpractice insurance coverage or coverage provided through a voluntary
14 attending physician ("channeling") program, total an aggregate level of
15 two million three hundred thousand dollars for each claimant and six
16 million nine hundred thousand dollars for all claimants from all such
17 policies with respect to occurrences in each of such years provided,
18 however, if the cost of primary malpractice insurance coverage in excess
19 of one million dollars, but below the excess medical malpractice insur-
20 ance coverage provided pursuant to this act, exceeds the rate of nine
21 percent per annum, then the required level of primary malpractice insur-
22 ance coverage in excess of one million dollars for each claimant shall
23 be in an amount of not less than the dollar amount of such coverage
24 available at nine percent per annum; the required level of such coverage
25 for all claimants under that policy shall be in an amount not less than
26 three times the dollar amount of coverage for each claimant; and excess
27 coverage, when combined with such primary malpractice insurance cover-
28 age, shall increase the aggregate level for each claimant by one million
29 dollars and three million dollars for all claimants; and provided
30 further, that, with respect to policies of primary medical malpractice
31 coverage that include occurrences between April 1, 2002 and June 30,
32 2002, such requirement that coverage be in amounts no less than one
33 million three hundred thousand dollars for each claimant and three
34 million nine hundred thousand dollars for all claimants for such occur-
35 rences shall be effective April 1, 2002.

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

40 (3)(a) The superintendent of financial services shall determine and
41 certify to each general hospital and to the commissioner of health the
42 cost of excess malpractice insurance for medical or dental malpractice
43 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988
44 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July
45 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,
46 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June
47 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995
48 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July
49 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,
50 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June
51 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002
52 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July
53 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,
54 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June
55 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009
56 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July

1 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and
2 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June
3 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1,
4 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and]
5 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and
6 June 30, 2020 allocable to each general hospital for physicians or
7 dentists certified as eligible for purchase of a policy for excess
8 insurance coverage by such general hospital in accordance with subdivi-
9 sion 2 of this section, and may amend such determination and certif-
10 ication as necessary.

11 (b) The superintendent of financial services shall determine and
12 certify to each general hospital and to the commissioner of health the
13 cost of excess malpractice insurance or equivalent excess coverage for
14 medical or dental malpractice occurrences between July 1, 1987 and June
15 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989
16 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July
17 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,
18 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June
19 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996
20 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July
21 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,
22 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June
23 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003
24 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July
25 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,
26 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June
27 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010
28 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July
29 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,
30 between July 1, 2014 and June 30, 2015, between July 1, 2015 and June
31 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017
32 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019, and
33 between July 1, 2019 and June 30, 2020 allocable to each general hospi-
34 tal for physicians or dentists certified as eligible for purchase of a
35 policy for excess insurance coverage or equivalent excess coverage by
36 such general hospital in accordance with subdivision 2 of this section,
37 and may amend such determination and certification as necessary. The
38 superintendent of financial services shall determine and certify to each
39 general hospital and to the commissioner of health the ratable share of
40 such cost allocable to the period July 1, 1987 to December 31, 1987, to
41 the period January 1, 1988 to June 30, 1988, to the period July 1, 1988
42 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to
43 the period July 1, 1989 to December 31, 1989, to the period January 1,
44 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990,
45 to the period January 1, 1991 to June 30, 1991, to the period July 1,
46 1991 to December 31, 1991, to the period January 1, 1992 to June 30,
47 1992, to the period July 1, 1992 to December 31, 1992, to the period
48 January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December
49 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period
50 July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June
51 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period
52 January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December
53 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period
54 July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June
55 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period
56 January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December

1 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period
2 July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June
3 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period
4 July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30,
5 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1,
6 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to
7 the period July 1, 2007 and June 30, 2008, to the period July 1, 2008
8 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the
9 period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and
10 June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the
11 period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and
12 June 30, 2015, to the period July 1, 2015 and June 30, 2016, [~~and~~
13 ~~between~~] to the period July 1, 2016 and June 30, 2017, [~~and~~ to the
14 period July 1, 2017 to June 30, 2018, [~~and~~ to the period July 1, 2018
15 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020.

16 § 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section
17 18 of chapter 266 of the laws of 1986, amending the civil practice law
18 and rules and other laws relating to malpractice and professional
19 medical conduct, as amended by section 3 of part M of chapter 57 of the
20 laws of 2018, are amended to read as follows:

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

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020 determined in accordance with paragraph (a) of this subdivision fails, refuses or

1 neglects to make payment to the provider of excess insurance coverage or
2 equivalent excess coverage in such time and manner as determined by the
3 superintendent of financial services pursuant to paragraph (b) of this
4 subdivision, excess insurance coverage or equivalent excess coverage
5 purchased for such physician or dentist in accordance with this section
6 for such coverage period shall be cancelled and shall be null and void
7 as of the first day on or after the commencement of a policy period
8 where the liability for payment pursuant to this subdivision has not
9 been met.

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

40 (e) A provider of excess insurance coverage or equivalent excess
41 coverage shall refund to the hospital excess liability pool any amount
42 allocable to the period July 1, 1992 to June 30, 1993, and to the period
43 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June
44 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the
45 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to
46 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to
47 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000
48 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,
49 and to the period April 1, 2002 to June 30, 2002, and to the period July
50 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,
51 2004, and to the period July 1, 2004 to June 30, 2005, and to the period
52 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June
53 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the
54 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to
55 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to
56 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012

1 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and
2 to the period July 1, 2014 to June 30, 2015, and to the period July 1,
3 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and
4 to the period July 1, 2017 to June 30, 2018, and to the period July 1,
5 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020
6 received from the hospital excess liability pool for purchase of excess
7 insurance coverage or equivalent excess coverage covering the period
8 July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to
9 June 30, 1994, and covering the period July 1, 1994 to June 30, 1995,
10 and covering the period July 1, 1995 to June 30, 1996, and covering the
11 period July 1, 1996 to June 30, 1997, and covering the period July 1,
12 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30,
13 1999, and covering the period July 1, 1999 to June 30, 2000, and cover-
14 ing the period July 1, 2000 to June 30, 2001, and covering the period
15 July 1, 2001 to October 29, 2001, and covering the period April 1, 2002
16 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003,
17 and covering the period July 1, 2003 to June 30, 2004, and covering the
18 period July 1, 2004 to June 30, 2005, and covering the period July 1,
19 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30,
20 2007, and covering the period July 1, 2007 to June 30, 2008, and cover-
21 ing the period July 1, 2008 to June 30, 2009, and covering the period
22 July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to
23 June 30, 2011, and covering the period July 1, 2011 to June 30, 2012,
24 and covering the period July 1, 2012 to June 30, 2013, and covering the
25 period July 1, 2013 to June 30, 2014, and covering the period July 1,
26 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,
27 2016, and covering the period July 1, 2016 to June 30, 2017, and cover-
28 ing the period July 1, 2017 to June 30, 2018, and covering the period
29 July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to
30 June 30, 2020 for a physician or dentist where such excess insurance
31 coverage or equivalent excess coverage is cancelled in accordance with
32 paragraph (c) of this subdivision.

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

37 § 40. The superintendent of financial services shall establish rates
38 for policies providing coverage for physicians and surgeons medical
39 malpractice for the periods commencing July 1, 1985 and ending June 30,
40 ~~[2019,]~~ 2020; provided, however, that notwithstanding any other
41 provision of law, the superintendent shall not establish or approve any
42 increase in rates for the period commencing July 1, 2009 and ending June
43 30, 2010. The superintendent shall direct insurers to establish segre-
44 gated accounts for premiums, payments, reserves and investment income
45 attributable to such premium periods and shall require periodic reports
46 by the insurers regarding claims and expenses attributable to such peri-
47 ods to monitor whether such accounts will be sufficient to meet incurred
48 claims and expenses. On or after July 1, 1989, the superintendent shall
49 impose a surcharge on premiums to satisfy a projected deficiency that is
50 attributable to the premium levels established pursuant to this section
51 for such periods; provided, however, that such annual surcharge shall
52 not exceed eight percent of the established rate until July 1, ~~[2019,]~~
53 2020, at which time and thereafter such surcharge shall not exceed twen-
54 ty-five percent of the approved adequate rate, and that such annual
55 surcharges shall continue for such period of time as shall be sufficient
56 to satisfy such deficiency. The superintendent shall not impose such

1 surcharge during the period commencing July 1, 2009 and ending June 30,
2 2010. On and after July 1, 1989, the surcharge prescribed by this
3 section shall be retained by insurers to the extent that they insured
4 physicians and surgeons during the July 1, 1985 through June 30, [2019]
5 2020 policy periods; in the event and to the extent physicians and
6 surgeons were insured by another insurer during such periods, all or a
7 pro rata share of the surcharge, as the case may be, shall be remitted
8 to such other insurer in accordance with rules and regulations to be
9 promulgated by the superintendent. Surcharges collected from physicians
10 and surgeons who were not insured during such policy periods shall be
11 apportioned among all insurers in proportion to the premium written by
12 each insurer during such policy periods; if a physician or surgeon was
13 insured by an insurer subject to rates established by the superintendent
14 during such policy periods, and at any time thereafter a hospital,
15 health maintenance organization, employer or institution is responsible
16 for responding in damages for liability arising out of such physician's
17 or surgeon's practice of medicine, such responsible entity shall also
18 remit to such prior insurer the equivalent amount that would then be
19 collected as a surcharge if the physician or surgeon had continued to
20 remain insured by such prior insurer. In the event any insurer that
21 provided coverage during such policy periods is in liquidation, the
22 property/casualty insurance security fund shall receive the portion of
23 surcharges to which the insurer in liquidation would have been entitled.
24 The surcharges authorized herein shall be deemed to be income earned for
25 the purposes of section 2303 of the insurance law. The superintendent,
26 in establishing adequate rates and in determining any projected defi-
27 ciency pursuant to the requirements of this section and the insurance
28 law, shall give substantial weight, determined in his discretion and
29 judgment, to the prospective anticipated effect of any regulations
30 promulgated and laws enacted and the public benefit of stabilizing
31 malpractice rates and minimizing rate level fluctuation during the peri-
32 od of time necessary for the development of more reliable statistical
33 experience as to the efficacy of such laws and regulations affecting
34 medical, dental or podiatric malpractice enacted or promulgated in 1985,
35 1986, by this act and at any other time. Notwithstanding any provision
36 of the insurance law, rates already established and to be established by
37 the superintendent pursuant to this section are deemed adequate if such
38 rates would be adequate when taken together with the maximum authorized
39 annual surcharges to be imposed for a reasonable period of time whether
40 or not any such annual surcharge has been actually imposed as of the
41 establishment of such rates.

42 § 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of
43 chapter 63 of the laws of 2001, amending chapter 266 of the laws of
44 1986, amending the civil practice law and rules and other laws relating
45 to malpractice and professional medical conduct, relating to the effec-
46 tiveness of certain provisions of such chapter, as amended by section 5
47 of part M of chapter 57 of the laws of 2018, are amended to read as
48 follows:

49 § 5. The superintendent of financial services and the commissioner of
50 health shall determine, no later than June 15, 2002, June 15, 2003, June
51 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,
52 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,
53 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June
54 15, 2018, [and] June 15, 2019, and June 15, 2020 the amount of funds
55 available in the hospital excess liability pool, created pursuant to
56 section 18 of chapter 266 of the laws of 1986, and whether such funds

1 are sufficient for purposes of purchasing excess insurance coverage for
2 eligible participating physicians and dentists during the period July 1,
3 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003
4 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to
5 June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June
6 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30,
7 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30,
8 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
9 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
10 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,
11 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
12 as applicable.

13 (a) This section shall be effective only upon a determination, pursu-
14 ant to section five of this act, by the superintendent of financial
15 services and the commissioner of health, and a certification of such
16 determination to the state director of the budget, the chair of the
17 senate committee on finance and the chair of the assembly committee on
18 ways and means, that the amount of funds in the hospital excess liabil-
19 ity pool, created pursuant to section 18 of chapter 266 of the laws of
20 1986, is insufficient for purposes of purchasing excess insurance cover-
21 age for eligible participating physicians and dentists during the period
22 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July
23 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,
24 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007
25 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to
26 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June
27 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
28 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
29 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,
30 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
31 as applicable.

32 (e) The commissioner of health shall transfer for deposit to the
33 hospital excess liability pool created pursuant to section 18 of chapter
34 266 of the laws of 1986 such amounts as directed by the superintendent
35 of financial services for the purchase of excess liability insurance
36 coverage for eligible participating physicians and dentists for the
37 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,
38 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,
39 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,
40 2007, as applicable, and the cost of administering the hospital excess
41 liability pool for such applicable policy year, pursuant to the program
42 established in chapter 266 of the laws of 1986, as amended, no later
43 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June
44 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,
45 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,
46 2015, June 15, 2016, June 15, 2017, June 15, 2018, [~~and~~] June 15, 2019,
47 and June 15, 2020 as applicable.

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

52 § 20. Notwithstanding any law, rule or regulation to the contrary,
53 only physicians or dentists who were eligible, and for whom the super-
54 intendent of financial services and the commissioner of health, or their
55 designee, purchased, with funds available in the hospital excess liabil-
56 ity pool, a full or partial policy for excess coverage or equivalent

1 excess coverage for the coverage period ending the thirtieth of June,
2 two thousand [~~eighteen,~~ nineteen, shall be eligible to apply for such
3 coverage for the coverage period beginning the first of July, two thou-
4 sand [~~eighteen,~~ nineteen; provided, however, if the total number of
5 physicians or dentists for whom such excess coverage or equivalent
6 excess coverage was purchased for the policy year ending the thirtieth
7 of June, two thousand [~~eighteen~~ nineteen exceeds the total number of
8 physicians or dentists certified as eligible for the coverage period
9 beginning the first of July, two thousand [~~eighteen,~~ nineteen, then the
10 general hospitals may certify additional eligible physicians or dentists
11 in a number equal to such general hospital's proportional share of the
12 total number of physicians or dentists for whom excess coverage or
13 equivalent excess coverage was purchased with funds available in the
14 hospital excess liability pool as of the thirtieth of June, two thousand
15 [~~eighteen,~~ nineteen, as applied to the difference between the number of
16 eligible physicians or dentists for whom a policy for excess coverage or
17 equivalent excess coverage was purchased for the coverage period ending
18 the thirtieth of June, two thousand [~~eighteen~~ nineteen and the number
19 of such eligible physicians or dentists who have applied for excess
20 coverage or equivalent excess coverage for the coverage period beginning
21 the first of July, two thousand [~~eighteen~~ nineteen.

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

24 PART G

25 Section 1. Intentionally omitted.

26 § 2. Paragraphs (c), (d), (e), (f), (g) and (h) of subdivision 4-a and
27 subdivision 4-c of section 365-f of the social services law are
28 REPEALED, and paragraph (i) of subdivision 4-a is relettered paragraph
29 (c).

30 § 3. Subparagraphs (i) and (ii) of paragraph (a) of subdivision 4-a of
31 section 365-f of the social services law, as added by section 1 of part
32 E of chapter 57 of the laws of 2017, are amended to read as follows:

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

35 ~~(A) a local department of social services,~~

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

38 ~~(C) an accountable care organization certified under article twenty-~~
39 ~~nine-E of the public health law or an integrated delivery system~~
40 ~~composed primarily of health care providers recognized by the department~~
41 ~~as a performing provider system under the delivery system reform incen-~~
42 ~~tive payment program] the department of health and is selected through~~
43 ~~the procurement process described in paragraph (b) of this subdivision.~~
44 ~~Eligible applicants for contracts shall be entities that are capable of~~
45 ~~appropriately providing fiscal intermediary services, performing the~~
46 ~~responsibilities of a fiscal intermediary, and complying with this~~
47 ~~section, including but not limited to entities that:~~

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

50 ~~(B) have been established as fiscal intermediaries prior to January~~
51 ~~first, two thousand twelve and have been continuously providing such~~
52 ~~services for eligible individuals under this section.~~

(ii) Fiscal intermediary services shall include the following services, performed on behalf of the consumer to facilitate his or her role as the employer:

(A) wage and benefit processing for consumer directed personal assistants;

(B) processing all income tax and other required wage withholdings;

(C) complying with workers' compensation, disability and unemployment requirements;

(D) maintaining personnel records for each consumer directed personal assistant, including time ~~sheets~~ records and other documentation needed for wages and benefit processing and a copy of the medical documentation required pursuant to regulations established by the commissioner;

(E) ensuring that the health status of each consumer directed personal assistant is assessed prior to service delivery pursuant to regulations issued by the commissioner;

(F) maintaining records of service authorizations or reauthorizations;

(G) monitoring the consumer's or, if applicable, the designated representative's continuing ability to fulfill the consumer's responsibilities under the program and promptly notifying the authorizing entity of any circumstance that may affect the consumer's or, if applicable, the designated representative's ability to fulfill such responsibilities;

(H) complying with regulations established by the commissioner specifying the responsibilities of fiscal intermediaries providing services under this title; ~~and~~

(I) entering into a department approved memorandum of understanding with the consumer that describes the parties' responsibilities under this program; and

(J) other related responsibilities which may include, as determined by the commissioner, assisting consumers to perform the consumers' responsibilities under this section and department regulations in a manner that does not infringe upon the consumer's responsibilities and self-direction.

§ 4. Paragraph (b) of subdivision 4-a of section 365-f of the social services law, as added by section 1 of part E of chapter 57 of the laws of 2017, is amended to read 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 section one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law the commissioner shall enter into contracts under this subdivision with eligible contractors that submit an offer for a contract, provided, however, that:

(i) the department shall post on its website:

(A) a description of the proposed services to be provided pursuant to contracts in accordance with this subdivision;

(B) that the selection of contractors shall be based on criteria reasonably related to the contractors' ability to provide fiscal intermediary services including but not limited to: ability to appropriately serve individuals participating in the program, geographic distribution that would ensure access in rural and underserved areas, demonstrated cultural and language competencies specific to the population of consumers and those of the available workforce, ability to provide timely consumer assistance, experience serving individuals with disabilities, the availability of consumer peer support, and demonstrated compliance

1 with all applicable federal and state laws and regulations, including
2 but not limited to those relating to wages and labor;

3 (C) the manner by which prospective contractors may seek such
4 selection, which may include submission by electronic means;

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

8 (iii) the commissioner shall award such contracts to the contractors
9 that best meet the criteria for selection and are best suited to serve
10 the purposes of this section and the needs of consumers;

11 (iv) all entities providing fiscal intermediary services on or before
12 April first, two thousand nineteen, shall submit an offer for a contract
13 under this section within sixty days after the commissioner publishes
14 the initial offer on the department's website. Such entities shall be
15 deemed authorized to provide such services unless: (A) the entity fails
16 to submit an offer for a contract under this section within the sixty
17 days; or (B) the entity's offer for a contract under this section is
18 denied;

19 (v) all decisions made and approaches taken pursuant to this paragraph
20 shall be documented in a procurement record as defined in section one
21 hundred sixty-three of the state finance law; and

22 (vi) the commissioner is authorized to reoffer contracts under the
23 same terms of this subdivision, if determined necessary by the commis-
24 sioner.

25 § 5. Subparagraph (i) of paragraph (c) of subdivision 4-a of section
26 365-f of the social services law, as added by section 1-a of part K of
27 chapter 57 of the laws of 2018 and as relettered by section two of this
28 act, is amended to read as follows:

29 (i) The commissioner [~~may~~] shall require a fiscal intermediary to
30 report annually on the direct care and administrative costs of personal
31 assistance services as accounted for by the fiscal intermediary. The
32 department [~~may~~] shall specify the [~~frequency and~~] format of such
33 reports, determine the type and amount of information to be submitted,
34 and require the submission of supporting documentation, provided, howev-
35 er, that the department shall provide no less than ninety calendar days'
36 notice before such reports are due.

37 § 6. Section 365-f of the social services law is amended by adding a
38 new subdivision 4-c to read as follows:

39 4-c. The commissioner shall convene and chair a stakeholder workgroup
40 pertaining to fiscal intermediary services and the needs of consumers.
41 The workgroup shall consist of, at a minimum, representatives of service
42 centers for independent living; statewide associations of fiscal inter-
43 mediaries; representatives of managed care entities under article
44 forty-four of the public health law and local social service districts;
45 consumers; and representatives of advocacy groups representing consumers
46 of services under this section. The workgroup shall be established no
47 later than May fifteenth, two thousand nineteen. The workgroup shall
48 identify and develop best practices pertaining to the delivery of fiscal
49 intermediary services; inform the criteria for use by the department for
50 the selection of entities under subdivision four-a of this section;
51 identify whether services differ for certain consumers and under what
52 circumstances; inform criteria in relation to the development of quality
53 reporting requirements; and work with the department to develop transi-
54 tion plans for consumers that may need to transition to another fiscal
55 intermediary.

§ 7. Section 365-f of the social services law is amended by adding a new subdivision 4-d to read as follows:

4-d. Fiscal intermediaries ceasing operation. (a) Where a fiscal intermediary is ceasing operation or will no longer serve the consumer's area, the fiscal intermediary shall:

(i) deliver written notice forty-five calendar days in advance to the affected consumers, consumer representatives, personal assistants, the department, and any local social services districts or managed care plans with which the fiscal intermediary contracts. Within five business days of receipt of the notice, the local social services district or managed care plan shall acknowledge the notice and provide the affected consumers with a list of other fiscal intermediaries operating in the same county or managed care plan network as appropriate;

(ii) not take any action that would prevent a personal assistant from moving to a new fiscal intermediary of the consumer's choice, nor require the consumer or the personal assistant to switch to a personal care or home health care program not under this section; and

(iii) upon request and consent, promptly transfer all records relating to the individual's health and care authorizations, and personnel documents to the fiscal intermediary or personal care or home health care provider chosen by the consumer and assume all liability for omissions or errors in such records.

(b) Where a consumer is electing to transfer his or her services to a new fiscal intermediary or a personal care or home health care provider by the consumer's independent choice, the fiscal intermediary being discontinued shall comply with subparagraphs (ii) and (iii) of paragraph (a) of this subdivision.

(c) Where a fiscal intermediary is suspending or ceasing operation pursuant to an order under subdivision four-b of this section, or has failed to submit an offer for a contract, or has been denied a contract under this section, all the provisions of this subdivision shall apply except subparagraph (i) of paragraph (a) of this subdivision, notice of which to all parties shall be provided by the department as appropriate.

(d) The local social services district or managed care plan, as appropriate, shall supervise the transition of services and transfer of records and maintain provision of services by the personal assistant(s) chosen by the individual.

(e) Any transfer under this subdivision shall not diminish any of an individual's rights relating to continuity of care, utilization review or fair hearing appeals and aid continuing.

§ 8. Subdivision 4-b of section 365-f of the social services law, as added by section 1 of part E of chapter 57 of the laws of 2017, is amended to read as follows:

4-b. Actions involving the authorization of a fiscal intermediary.

~~(a) [A fiscal intermediary's authorization may be revoked, suspended, limited or annulled upon thirty day's written notice to the fiscal intermediary, if the commissioner finds that the fiscal intermediary has failed to comply with the provisions of this subdivision or regulations promulgated hereunder.]~~ The department may terminate a fiscal intermediary's contract under this section or suspend or limit the fiscal intermediary's rights and privileges under the contract upon thirty day's written notice to the fiscal intermediary, if the commissioner finds that the fiscal intermediary has failed to comply with the provisions of this section or regulations promulgated hereunder. The written notice shall include:

1 (i) A description of the conduct and the issues related thereto that
2 have been identified as failure of compliance; and
3 (ii) the time frame of the conduct that fails compliance.

4 (b) Notwithstanding the foregoing, upon determining that the public
5 health or safety would be imminently endangered by the continued
6 ~~[authorization]~~ operation or actions of the fiscal intermediary, the
7 commissioner may ~~[revoke, suspend, limit or annul the fiscal interme-~~
8 ~~diary's authorization immediately.~~

9 ~~(b)]~~ terminate the fiscal intermediary's contract or suspend or limit
10 the fiscal intermediary's rights and privileges under the contract imme-
11 diately upon written notice.

12 (c) All orders or determinations under this subdivision shall be
13 subject to review as provided in article seventy-eight of the civil
14 practice law and rules.

15 § 9. Residential health care facilities case mix adjustment workgroup.
16 The commissioner of health or his or her designee shall convene and
17 chair a workgroup on the implementation of the change in case mix
18 adjustments to Medicaid rates of payment of residential health care
19 facilities that will take effect on July 1, 2019. The workgroup shall be
20 comprised of residential health care facilities or representatives from
21 such facilities, representatives from the statewide associations and
22 other such experts on case mix as required by the commissioner or his or
23 her designee. The workgroup shall review recent case mix data and
24 related analyses conducted by the department with respect to the depart-
25 ment's implementation of the July 1, 2019 change in methodology, the
26 department's minimum data set collection process, and case mix adjust-
27 ments authorized under subparagraph (ii) of paragraph (b) of subdivision
28 2-b of section 2808 of the public health law. Such review shall seek to
29 promote a higher degree of accuracy in the minimum data set data, and
30 target abuses. The workgroup may offer recommendations on how to improve
31 future practice regarding accuracy in the minimum data set collection
32 process and how to reduce or eliminate abusive practices. In developing
33 such recommendations, the workgroup shall ensure that the collection
34 process and case mix adjustment recognizes the appropriate acuity for
35 residential health care residents. The workgroup may provide recommenda-
36 tions regarding the proposed patient driven payment model and the admin-
37 istrative complexity in revising the minimum data set collection and
38 rate promulgation processes. The commissioner shall not modify the meth-
39 od used to determine the case mix adjustment for periods prior to June
40 30, 2019. Notwithstanding any changes in federal law or regulation
41 relating to nursing home acuity reimbursement, the workgroup shall
42 report its recommendations no later than June 30, 2019.

43 § 10. Subdivision 2 of section 3614-c of the public health law, as
44 amended by section 5 of part S of chapter 57 of the laws of 2017, is
45 amended to read as follows:

46 2. Notwithstanding any inconsistent provision of law, rule or regu-
47 lation, no payments by government agencies shall be made to certified
48 home health agencies, long term home health care programs, managed care
49 plans, ~~[or]~~ the consumer directed personal assistance program under
50 section three hundred sixty-five-f of the social services law, the nurs-
51 ing home transition and diversion waiver program under section three
52 hundred sixty-six of the social services law, or the traumatic brain
53 injury waiver program under section two thousand seven hundred forty of
54 this chapter for any episode of care furnished, in whole or in part, by
55 any home care aide who is compensated at amounts less than the applica-

1 ble minimum rate of home care aide total compensation established pursu-
2 ant to this section.

3 § 11. This act shall take effect immediately and shall be deemed to
4 have been in full force and effect on and after April 1, 2019; provided
5 however, that sections three, four, five, seven and eight of this act
6 shall take effect January 1, 2020; and provided further that effective
7 immediately, the commissioner of health is authorized to request offers
8 for contracts in accordance with section four of this act, to facilitate
9 execution of such contracts on and after January 1, 2020.

10 PART H

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

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

15 20-a. Notwithstanding any provision of law to the contrary, the
16 commissioners of the department of health, the office of mental health,
17 the office of people with developmental disabilities, and the office of
18 alcoholism and substance abuse services are authorized to waive any
19 regulatory requirements as are necessary, consistent with applicable
20 law, to allow providers that are involved in DSRIP projects or repli-
21 cation and scaling activities, as approved by the authorizing commis-
22 sioner, to avoid duplication of requirements and to allow the efficient
23 scaling and replication of DSRIP promising practices, as determined by
24 the authorizing commissioner; provided however, that regulations
25 pertaining to patient safety, patient autonomy, patient privacy, patient
26 rights, due process, scope of practice, professional licensure, envi-
27 ronmental protections, provider reimbursement methodologies, or occupa-
28 tional standards and employee rights may not be waived, nor shall any
29 regulations be waived if such waiver would risk patient safety. Any
30 regulatory action under this subdivision shall be published on the
31 applicable website of the authorizing commissioner and shall include a
32 description of each waiver, including a citation of each regulation
33 waived, and a description of the project of which such relief was
34 granted.

35 § 3. Subparagraph (i) of paragraph (e-1) of subdivision 4 of section
36 2807-c of the public health law, as amended by section 29 of part C of
37 chapter 60 of the laws of 2014, is amended to read as follows:

38 (i) For rate periods on ~~and~~ or after April first, two thousand ten,
39 the commissioner, in consultation with the commissioner of the office of
40 mental health, shall promulgate regulations, and may promulgate emergen-
41 cy regulations, establishing methodologies for determining the operating
42 cost components of rates of payments for services described in this
43 paragraph. ~~[Such regulations shall utilize two thousand five operating~~
44 ~~costs as submitted to the department prior to July first, two thousand~~
45 ~~nine and shall provide for methodologies establishing per diem inpatient~~
46 ~~rates that utilize case mix adjustment mechanisms. Such regulations~~
47 ~~shall contain criteria for adjustments based on length of stay and may~~
48 ~~also provide for a base year update, provided, however, that such base~~
49 ~~year update shall take effect no earlier than April first, two thousand~~
50 ~~fifteen, and provided further, however, that the]~~ The commissioner may
51 make such adjustments to ~~[such utilization and to]~~ the methodology for
52 computing such rates as is necessary to achieve no aggregate, net growth
53 in overall Medicaid expenditures related to such rates, as compared to
54 such aggregate expenditures from the prior year. In determining the

1 updated base year to be utilized pursuant to this subparagraph, the
2 commissioner shall take into account the base year determined in accord-
3 ance with paragraph (c) of subdivision thirty-five of this section.

4 Furthermore, the commissioner shall establish such rates in consulta-
5 tion with industry representatives to achieve an appropriate base year
6 update to the operating cost components of rates of payment for services
7 described in this paragraph and that takes into account facility cost,
8 mix of services, and patient specific conditions.

9 § 4. Intentionally omitted.

10 § 5. Intentionally omitted.

11 § 6. Subdivision 5-d of section 2807-k of the public health law, as
12 amended by section 2 of part A of chapter 57 of the laws of 2018, is
13 amended to read as follows:

14 5-d. (a) Notwithstanding any inconsistent provision of this section,
15 section twenty-eight hundred seven-w of this article or any other
16 contrary provision of law, and subject to the availability of federal
17 financial participation, for periods on and after January first, two
18 thousand thirteen, through March thirty-first, two thousand twenty, all
19 funds available for distribution pursuant to this section, except for
20 funds distributed pursuant to subparagraph (v) of paragraph (b) of
21 subdivision five-b of this section, and all funds available for distrib-
22 ution pursuant to section twenty-eight hundred seven-w of this article,
23 shall be reserved and set aside and distributed in accordance with the
24 provisions of this subdivision.

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

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

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

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

45 (B) nine hundred ninety-four million nine hundred thousand dollars as
46 Medicaid DSH payments to eligible general hospitals, other than major
47 public general hospitals.

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

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

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

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

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

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

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

§ 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019, provided, however, that section two of this act shall expire on April 1, 2020.

PART I

Intentionally Omitted

PART J

Section 1. This Part enacts into law major components of legislation which are necessary to protect health care consumers; increase access to more affordable quality health insurance coverage; and preserve and foster New York's health insurance markets. Each component is wholly contained within a Subpart identified as Subparts A through D. The effective date for each particular provision contained within such

Subpart is set forth in the last section of such Subpart. Any provision in any section contained within a Subpart, including the effective date of the Subpart, which makes a reference to a section "of this act," when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Subpart in which it is found. Section five of this Part sets forth the general effective date of this Part.

SUBPART A

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

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

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

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

(1) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five, 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 policies 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.

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

§ 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~~].

1 § 5. Intentionally omitted.

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

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

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

14 § 7. Paragraph 1 of subsection (d) of section 4317 of the insurance
15 law, as amended by section 72 of part D of chapter 56 of the laws of
16 2013, is amended to read as follows:

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

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

31 § 9. Subsections (f) and (g) of section 4318 of the insurance law, as
32 added by chapter 219 of the laws of 2011, are amended to read as
33 follows:

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

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

49 § 10. Subdivision 1 of section 4406 of the public health law, as
50 amended by section 46-a of part D of chapter 56 of the laws of 2013, is
51 amended to read as follows:

52 1. The contract between a health maintenance organization and an
53 enrollee shall be subject to regulation by the superintendent as if it
54 were a health insurance subscriber contract, and shall include, but not
55 be limited to, all mandated benefits required by article forty-three of
56 the insurance law. Such contract shall fully and clearly state the bene-

fits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of ~~[fifty]~~ one hundred or fewer employees or members, exclusive of spouses and dependents, or to any employee or member of the group, including dependents, applying for such contract at any time throughout the year~~7~~ ~~and may include a pre-existing condition provision as provided for in section four thousand three hundred eighteen of the insurance law, provided, however, that, the~~. An individual direct payment contract shall be issued only in accordance with section four thousand three hundred twenty-eight of the insurance law. The superintendent may, after giving consideration to the public interest, exempt a health maintenance organization from the requirements of this section provided that another health insurer or health maintenance organization within the health maintenance organization's same holding company system, as defined in article fifteen of the insurance law, including a health maintenance organization operated as a line of business of a health service corporation licensed under article forty-three of the insurance law, offers coverage that, at a minimum, complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to this chapter and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of this chapter. The requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of ~~[the public health law]~~ this chapter or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred ~~[twenty-two of this article]~~ twenty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. ~~[Subject to the creditable coverage requirements of subsection (a) of section four thousand three hundred eighteen of the insurance law, the organization may, as an alternative to the use of a pre-existing condition provision, elect to offer contracts without a pre-existing condition provision to such groups but may require that coverage shall not become effective until after a specified affiliation period of not more than sixty days after the application for coverage is submitted. The organization is not required to provide health care services or benefits during such period and no premium shall be charged for any coverage during the period. After January first, nineteen hundred ninety six, all individual direct payment contracts shall be issued only pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of the insurance law. Such contracts may not, with respect to an eligible individual (as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. § 300gg-41(b), impose any pre-existing condition exclusion.]~~

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

(1) sections one, three, four, 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 (b) 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 (b) 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)]~~ (e) of section ~~[four thousand three hundred twenty-eight of this chapter]~~ three thousand two hundred seventeen-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. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 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 (l) 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:

(l) ~~[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. §~~

1 ~~18031, or any regulations promulgated thereunder,~~ by this state also
2 shall meet any requirements established by the health benefit exchange.

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

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

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

19 § 3217-i. Essential health benefits package and limit on cost-sharing.
20 (a) (1) For purposes of this article, "essential health benefits" shall
21 mean the following categories of benefits:

22 (A) ambulatory patient services;
23 (B) emergency services;
24 (C) hospitalization;
25 (D) maternity and newborn care;
26 (E) mental health and substance use disorder services, including
27 behavioral health treatment;
28 (F) prescription drugs;
29 (G) rehabilitative and habilitative services and devices;
30 (H) laboratory services;
31 (I) preventive and wellness services and chronic disease management;
32 and
33 (J) pediatric services, including oral and vision care.

34 (2) An insurer shall not be required to provide coverage for pediatric
35 oral services as an essential health benefit if:

36 (A) for coverage offered through the exchange established by this
37 state, the exchange has determined sufficient coverage of the pediatric
38 oral benefit is available through stand-alone dental plans certified by
39 the exchange; or

40 (B) for coverage offered outside the exchange, the insurer obtains
41 reasonable written assurance that the individual or group has obtained a
42 stand-alone dental plan that has been approved by the superintendent as
43 meeting exchange certification standards.

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

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

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

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

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

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

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

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

26 (d) The superintendent may require the use of model language describ-
27 ing the coverage requirements for any accident and health insurance
28 policy form that is subject to the superintendent's approval pursuant to
29 section three thousand two hundred one of this article.

30 (e) For purposes of this section:

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

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

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

38 (A) provides for essential health benefits;

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

41 (C) provides one of the levels of coverage described in subsection (b)
42 of this section;

43 (4) "grandfathered health plan" means coverage provided by an insurer
44 in which an individual was enrolled on March twenty-third, two thousand
45 ten for as long as the coverage maintains grandfathered status in
46 accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. §
47 18011(e);

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

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

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

55 (g) For conversion purposes, an insurer shall offer to the employee or
56 member a policy at each level of coverage as defined in subsection (b)

1 ~~of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)]~~
2 three thousand two hundred seventeen-i of this article that contains the
3 essential health benefits package described in paragraph ~~[one]~~ three of
4 subsection ~~[(b)]~~ (e) of section ~~[four thousand three hundred twenty-~~
5 ~~eight of this chapter]~~ three thousand two hundred seventeen-i of this
6 article. Provided, however, the superintendent may, after giving due
7 consideration to the public interest, approve a request made by an
8 insurer for the insurer to satisfy the requirements of this subsection
9 and subsections (e) and (f) of this section through the offering of
10 policies that comply with this subsection by another insurer, corpo-
11 ration or health maintenance organization within the insurer's holding
12 company system, as defined in article fifteen of this chapter.

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

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

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

26 (2) "grandfathered health plan" means coverage provided by an insurer
27 in which an individual was enrolled on March twenty-third, two thousand
28 ten for as long as the coverage maintains grandfathered status in
29 accordance with section 1251(e) of the affordable care act, 42 U.S.C. §
30 18011(e);

31 (3) "small group" means a group of ~~[fifty or fewer employees or~~
32 ~~members exclusive of spouses and dependents, provided, however, that~~
33 ~~beginning January first, two thousand sixteen, "small group" means a~~
34 ~~group of]~~ one hundred or fewer employees or members exclusive of spouses
35 and dependents; and

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

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

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

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

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

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

55 (11) Every policy ~~[which]~~ that provides coverage for prescription
56 drugs shall include coverage for the cost of enteral formulas for home

1 use, whether administered orally or via tube feeding, for which a physi-
2 cian or other licensed health care provider legally authorized to
3 prescribe under title eight of the education law has issued a written
4 order. Such written order shall state that the enteral formula is clear-
5 ly medically necessary and has been proven effective as a disease-spe-
6 cific treatment regimen. Specific diseases and disorders for which
7 enteral formulas have been proven effective shall include, but are not
8 limited to, inherited diseases of amino-acid or organic acid metabolism;
9 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
10 motility such as chronic intestinal pseudo-obstruction; and multiple,
11 severe food allergies including, but not limited to immunoglobulin E and
12 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
13 food protein induced enterocolitis syndrome; eosinophilic disorders and
14 impaired absorption of nutrients caused by disorders affecting the
15 absorptive surface, function, length, and motility of the gastrointesti-
16 nal tract. Enteral formulas ~~[which]~~ that are medically necessary and
17 taken under written order from a physician for the treatment of specific
18 diseases shall be distinguished from nutritional supplements taken elec-
19 tively. Coverage for certain inherited diseases of amino acid and organ-
20 ic acid metabolism as well as severe protein allergic conditions shall
21 include modified solid food products that are low protein ~~[or which]~~,
22 contain modified protein, or are amino acid based ~~[which]~~ that are
23 medically necessary~~[, and such coverage for such modified solid food~~
24 ~~products for any calendar year or for any continuous period of twelve~~
25 ~~months for any insured individual shall not exceed two thousand five~~
26 ~~hundred dollars]~~.

27 § 15. Intentionally omitted.

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

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

46 § 17. Intentionally omitted.

47 § 18. Intentionally omitted.

48 § 19. Intentionally omitted.

49 § 20. Paragraph 4 of subsection (a) of section 3231 of the insurance
50 law, as amended by section 69 of part D of chapter 56 of the laws of
51 2013, is amended to read as follows:

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

1 individuals or small groups covered by medicare supplemental insurance.
2 For medicare supplemental insurance coverage, "community rated" means a
3 rating methodology in which the premiums for all persons covered by a
4 policy or contract form is the same based on the experience of the
5 entire pool of risks covered by that policy or contract form without
6 regard to age, sex, health status, tobacco usage or occupation.

7 ~~[Catastrophic health insurance policies issued pursuant to section~~
8 ~~1302(e) of the affordable care act, 42 U.S.C. § 18022(e), shall be clas-~~
9 ~~sified in a distinct community rating pool.]~~

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

13 (d) A student accident and health insurance policy or contract shall
14 provide coverage for essential health benefits as defined in subsection
15 (a) of section [1302(b) of the affordable care act, 42 U.S.C. §
16 18022(b)] three thousand two hundred seventeen-i or subsection (a) of
17 section four thousand three hundred six-h of this chapter, as
18 applicable.

19 § 22. Subparagraph (A) of paragraph 3 of subsection (d) of section
20 4235 of the insurance law, as added by section 60 of part D of chapter
21 56 of the laws of 2013, is amended to read as follows:

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

26 § 23. Intentionally omitted.

27 § 24. Intentionally omitted.

28 § 25. Intentionally omitted.

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

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

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

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

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

20 § 28. Intentionally omitted.

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

24 (ll) Every small group contract or association group contract ~~[deliv-~~
25 ~~ered or issued for delivery in this state]~~ issued by a corporation
26 subject to the provisions of this article that provides coverage for
27 hospital, medical or surgical expense insurance and is not a grandfa-
28 thered health plan shall provide coverage for the essential health
29 ~~[benefit]~~ benefits package ~~[as required in section 2707(a) of the public~~
30 ~~health service act, 42 U.S.C. § 300gg-6(a)]~~. For purposes of this
31 subsection:

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

36 (2) "grandfathered health plan" means coverage provided by a corpo-
37 ration in which an individual was enrolled on March twenty-third, two
38 thousand ten for as long as the coverage maintains grandfathered status
39 in accordance with section 1251(e) of the affordable care act, 42 U.S.C.
40 § 18011(e); and

41 (3) "small group" means a group of ~~[fifty or fewer employees or~~
42 ~~members exclusive of spouses and dependents. Beginning January first,~~
43 ~~two thousand sixteen, "small group" means a group of]~~ one hundred or
44 fewer employees or members exclusive of spouses and dependents; and

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

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

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

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

54 (mm) A corporation shall not be required to offer the contract holder
55 any benefits that must be made available pursuant to this section if
56 such benefits must be covered pursuant to subsection (kk) of this

1 section. For any contract issued within the health benefit exchange
2 established [~~pursuant to section 1311 of the affordable care act, 42~~
3 ~~U.S.C. § 18031~~] by this state, a corporation shall not be required to
4 offer the contract holder any benefits that must be made available
5 pursuant to this section.

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

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

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

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

55 (B) The corporation shall offer one contract at each level of coverage
56 as defined in subsection (b) of section [1302(d) of the affordable care

1 ~~aet, 42 U.S.C. § 18022(d)]~~ four thousand three hundred six-h of this
2 article. The individual may choose any such contract offered by the
3 corporation. Provided, however, the superintendent may, after giving due
4 consideration to the public interest, approve a request made by a corpo-
5 ration for the corporation to satisfy the requirements of this paragraph
6 through the offering of contracts that comply with this paragraph by
7 another corporation, insurer or health maintenance organization within
8 the corporation's same holding company system, as defined in article
9 fifteen of this chapter.

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

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

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

30 § 34. Subparagraph (A) of paragraph 1 of subsection (d) of section
31 4305 of the insurance law, as amended by chapter 388 of the laws of
32 2014, is amended to read as follows:

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

1 another corporation, insurer or health maintenance organization within
2 the corporation's same holding company system, as defined in article
3 fifteen of this chapter.

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

6 § 4306-h. Essential health benefits package and limit on cost-sharing.

7 (a) (1) For purposes of this article, "essential health benefits" shall
8 mean the following categories of benefits:

9 (A) ambulatory patient services;

10 (B) emergency services;

11 (C) hospitalization;

12 (D) maternity and newborn care;

13 (E) mental health and substance use disorder services, including
14 behavioral health treatment;

15 (F) prescription drugs;

16 (G) rehabilitative and habilitative services and devices;

17 (H) laboratory services;

18 (I) preventive and wellness services and chronic disease management;
19 and

20 (J) pediatric services, including oral and vision care.

21 (2) A corporation shall not be required to provide coverage for pedia-
22 tric oral services as an essential health benefit if:

23 (A) for coverage offered through the exchange established by this
24 state, the exchange has determined sufficient coverage of the pediatric
25 oral benefit is available through stand-alone dental plans certified by
26 the exchange; or

27 (B) for coverage offered outside the exchange, the corporation obtains
28 reasonable written assurance that the individual or group has obtained a
29 stand-alone dental plan that has been approved by the superintendent as
30 meeting exchange certification standards.

31 (b) (1) Every individual and small group contract that provides hospi-
32 tal, surgical, or medical expense coverage and is not a grandfathered
33 health plan shall provide coverage that meets the actuarial requirements
34 of one of the following levels of coverage:

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

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

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

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

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

54 (3) Every student accident and health insurance contract shall provide
55 coverage that meets at least sixty percent of the full actuarial value
56 of the benefits provided under the contract. The contract's schedule of

1 benefits shall include the level as described in paragraph one of this
2 subsection nearest to, but below the actual actuarial value.

3 (c) Every individual or group contract that provides hospital, surgi-
4 cal, or medical expense coverage and is not a grandfathered health plan,
5 and every student accident and health insurance contract shall limit the
6 insured's cost-sharing for in-network services in a contract year to not
7 more than the maximum out-of-pocket amount determined by the superinten-
8 dent for all contracts subject to this section. Such amount shall not
9 exceed any annual out-of-pocket limit on cost-sharing set by the United
10 States secretary of health and human services, if available.

11 (d) The superintendent may require the use of model language describ-
12 ing the coverage requirements for any form that is subject to the
13 approval of the superintendent pursuant to section four thousand three
14 hundred eight of this article.

15 (e) For purposes of this section:

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

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

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

23 (A) provides for essential health benefits;

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

26 (C) provides one of the levels of coverage described in subsection (b)
27 of this section;

28 (4) "grandfathered health plan" means coverage provided by a corpo-
29 ration in which an individual was enrolled on March twenty-third, two
30 thousand ten for as long as the coverage maintains grandfathered status
31 in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C.
32 § 18011(e);

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

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

38 § 36. Paragraph 4 of subsection (a) of section 4317 of the insurance
39 law, as amended by section 72 of part D of chapter 56 of the laws of
40 2013, is amended to read as follows:

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

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

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

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

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

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

§ 41. Subsection (c) of section 4328 of the insurance law, as added by section 46 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

SUBPART C

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 cover-

1 age, publish an up-to-date, accurate, and complete list of all covered
2 prescription drugs on its formulary drug list, including any tiering
3 structure that it has adopted and any restrictions on the manner in
4 which a prescription drug may be obtained, in a manner that is easily
5 accessible to insureds and prospective insureds. The formulary drug list
6 shall clearly identify the preventive prescription drugs that are avail-
7 able without annual deductibles or coinsurance, including co-payments.

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

17 (2) (A) An insurer shall have a process for an insured, the insured's
18 designee, or the insured's prescribing health care provider to request a
19 standard review that is not based on exigent circumstances of a formu-
20 lary exception for a prescription drug that is not covered by the poli-
21 cy.

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

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

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

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

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

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

48 (4) An insurer that denies an exception request under paragraph two or
49 three of this subsection shall provide written notice of its determi-
50 nation to the insured or the insured's designee and the insured's
51 prescribing health care provider within three business days of receipt
52 of the exception request. The written notice shall be considered a final
53 adverse determination under section four thousand nine hundred four of
54 this chapter or section four thousand nine hundred four of the public
55 health law. Written notice shall also include the name or names of clin-

1 ically appropriate prescription drugs covered by the insurer to treat
2 the insured.

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

10 (B) An external appeal agent shall make a determination on the
11 external appeal and notify the insurer, the insured or the insured's
12 designee, and the insured's prescribing health care provider by tele-
13 phone of its determination no later than seventy-two hours following the
14 external appeal agent's receipt of the request, if the original request
15 was a standard exception request under paragraph two of this subsection.
16 The external appeal agent shall notify the insurer, the insured or the
17 insured's designee, and the insured's prescribing health care provider
18 in writing of the external appeal determination within two business days
19 of rendering such determination.

20 (C) An external appeal agent shall make a determination on the
21 external appeal and notify the insurer, the insured or the insured's
22 designee, and the insured's prescribing health care provider by tele-
23 phone of its determination no later than twenty-four hours following the
24 external appeal agent's receipt of the request, if the original request
25 was an expedited exception request under paragraph three of this
26 subsection and the insured's prescribing health care provider attests
27 that exigent circumstances exist. The external appeal agent shall notify
28 the insurer, the insured or the insured's designee, and the insured's
29 prescribing health care provider in writing of the external appeal
30 determination within seventy-two hours of the external appeal agent's
31 receipt of the external appeal.

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

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

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

51 § 4329. Prescription drug coverage. (a) Every corporation subject to
52 the provisions of this article that issues a contract that provides
53 coverage for prescription drugs shall, with respect to the prescription
54 drug coverage, publish an up-to-date, accurate, and complete list of all
55 covered prescription drugs on its formulary drug list, including any
56 tiering structure that it has adopted and any restrictions on the manner

1 in which a prescription drug may be obtained, in a manner that is easily
2 accessible to insureds and prospective insureds. The formulary drug list
3 shall clearly identify the preventive prescription drugs that are avail-
4 able without annual deductibles or coinsurance, including co-payments.

5 (b) (1) Every contract issued by a corporation subject to the
6 provisions of this article that provides coverage for prescription drugs
7 shall include in the contract a process that allows an insured, the
8 insured's designee, or the insured's prescribing health care provider to
9 request a formulary exception. With respect to the process for such a
10 formulary exception, a corporation shall follow the process and proce-
11 dures specified in article forty-nine of this chapter and article
12 forty-nine of the public health law, except as otherwise provided in
13 paragraphs two, three, four and five of this subsection.

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

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

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

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

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

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

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

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

55 (5) (A) If a corporation denies a request for an exception under para-
56 graph two or three of this subsection, the insured, the insured's desig-

1 nee, or the insured's prescribing health care provider shall have the
2 right to request that such denial be reviewed by an external appeal
3 agent certified by the superintendent pursuant to section four thousand
4 nine hundred eleven of this chapter in accordance with article forty-
5 nine of this chapter and article forty-nine of the public health law.

6 (B) An external appeal agent shall make a determination on the
7 external appeal and notify the corporation, the insured or the insured's
8 designee, and the insured's prescribing health care provider by tele-
9 phone of its determination no later than seventy-two hours following the
10 external appeal agent's receipt of the request, if the original request
11 was a standard exception request under paragraph two of this subsection.
12 The external appeal agent shall notify the corporation, the insured or
13 the insured's designee and the insured's prescribing health care provid-
14 er in writing of the external appeal determination within two business
15 days of rendering such determination.

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

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

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

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

49 SUBPART D

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

52 § 2607. Discrimination because of sex or marital status. (a) No indi-
53 vidual or entity shall refuse to issue any policy of insurance, or
54 cancel or decline to renew ~~such~~ the policy because of the sex or mari-

tal 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 of student accident and health insurance, as defined in subsection (a) of section three thousand two hundred forty of this chapter, no corporation 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 contract 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 contract;

(4) insert in the contract 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 contract 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 contract issued or sold by it;

(6) cancel or refuse to issue, renew or sell such contract 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 contract; or

(8) engage in sexual stereotyping.

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

§ 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.

§ 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. Intentionally omitted.

§ 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.

§ 5. This act shall take effect immediately provided, however, that the applicable effective date of Subparts A through D 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 section 29 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

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

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

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

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

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

(d) The department ~~[of financial services and the department]~~ shall post on ~~[their websites]~~ its website information about the fund~~[, eligibility for enrollment in the fund,]~~ and the process for enrollment in the fund.

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

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

5. For the state fiscal year beginning April first, two thousand eleven and ending March thirty-first, two thousand twelve, the state fiscal year beginning April first, two thousand twelve and ending March thirty-first, two thousand thirteen, and the state fiscal year beginning April first, two thousand thirteen and ending March thirty-first, two thousand fourteen, the superintendent of financial services shall cause to be deposited into the fund for each such fiscal year the amount appropriated for such purpose. Beginning April first, two thousand fourteen and annually thereafter, the superintendent of financial services or the commissioner, whoever is administering the fund for the applica-

1 ble period shall cause to be deposited into the fund, subject to avail-
2 able appropriations, an amount equal to the difference between the
3 amount appropriated to the fund in the preceding fiscal year, as
4 increased by the adjustment factor defined in subdivision seven of this
5 section, and the assets of the fund at the conclusion of that fiscal
6 year.

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

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

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

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

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

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

54 2. The provision of qualifying health care costs to qualified plain-
55 tiffs shall not be subject to prior authorization, except as described
56 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[~~7~~] 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 shall be provided for persons whose ages range from~~
26 ~~twenty-one through forty-four years, provided that nothing herein shall~~
27 ~~preclude the provision of coverage to persons whose age is below or~~
28 ~~above such range.~~

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

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

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

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

52 [~~(vi)]~~ (iv) The superintendent, in consultation with the commissioner
53 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;~~

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

12 [~~(III)]~~ (II) The identification of the required training, experience
13 and other standards for health care providers for the provision of
14 procedures and treatments for the diagnosis and treatment of infertility
15 determined in accordance with the standards and guidelines established
16 and adopted by the American College of Obstetricians and Gynecologists
17 and the American Society for Reproductive Medicine; and

18 [~~(IV)]~~ (III) The determination of appropriate medical candidates by
19 the treating physician in accordance with the standards and guidelines
20 established and adopted by the American College of Obstetricians and
21 Gynecologists and/or the American Society for Reproductive Medicine.

22 (v)(I) For the purposes of this paragraph, "infertility" means a
23 disease or condition characterized by the incapacity to impregnate
24 another person or to conceive, defined by the failure to establish a
25 clinical pregnancy after twelve months of regular, unprotected sexual
26 intercourse or therapeutic donor insemination, or after six months of
27 regular, unprotected sexual intercourse or therapeutic donor insemi-
28 nation for a female thirty-five years of age or older. Earlier evaluation
29 and treatment may be warranted based on an individual's medical history
30 or physical findings.

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

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

40 (vii) Every large group policy delivered or issued for delivery in
41 this state that provides medical, major medical or similar comprehen-
42 sive-type coverage shall provide coverage for three cycles of in-vitro
43 fertilization used in the treatment of infertility. Coverage may be
44 subject to annual deductibles and coinsurance, including copayments, as
45 may be deemed appropriate by the superintendent and as are consistent
46 with those established for other benefits within a given policy. For
47 purposes of this item, a "cycle" is defined as either all treatment that
48 starts when: preparatory medications are administered for ovarian stim-
49 ulation for oocyte retrieval with the intent of undergoing in-vitro
50 fertilization using a fresh embryo transfer; or medications are adminis-
51 tered for endometrial preparation with the intent of undergoing in-vitro
52 fertilization using a frozen embryo transfer.

53 (viii) No insurer providing coverage under this paragraph shall
54 discriminate based on an insured's expected length of life, present of
55 predicted disability, degree of medical dependency, perceived quality of
56 life, or other health conditions, nor based on personal characteristics,

1 including age, sex, sexual orientation, marital status or gender identi-
2 ty.

3 § 2. Paragraph 3 of subsection (s) of section 4303 of the insurance
4 law, as amended by section 2 of part K of chapter 82 of the laws of
5 2002, is amended to read as follows:

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

10 (A) [~~Coverage shall be provided for persons whose ages range from~~
11 ~~twenty-one through forty-four years, provided that nothing herein shall~~
12 ~~preclude the provision of coverage to persons whose age is below or~~
13 ~~above such range.~~

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

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

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

28 (E) Coverage (C) Except as provided in subparagraphs (F) and (G) of
29 this paragraph, coverage shall not be required to include the diagnosis
30 and treatment of infertility in connection with: (i) in vitro fertiliza-
31 tion, gamete intrafallopian tube transfers or zygote intrafallopian tube
32 transfers; (ii) the reversal of elective sterilizations; (iii) sex
33 change procedures; (iv) cloning; or (v) medical or surgical services or
34 procedures that are deemed to be experimental in accordance with clin-
35 ical guidelines referenced in subparagraph (D) of this paragraph.

36 (F) (D) The superintendent, in consultation with the commissioner of
37 health, shall promulgate regulations which shall stipulate the guide-
38 lines and standards which shall be used in carrying out the provisions
39 of this paragraph, which shall include:

40 (i) [~~The determination of "infertility" in accordance with the stand-~~
41 ~~ards and guidelines established and adopted by the American College of~~
42 ~~Obstetricians and Gynecologists and the American Society for Reproduc-~~
43 ~~tive Medicine;~~

44 (ii) The identification of experimental procedures and treatments not
45 covered for the diagnosis and treatment of infertility determined in
46 accordance with the standards and guidelines established and adopted by
47 the American College of Obstetricians and Gynecologists and the American
48 Society for Reproductive Medicine;

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

55 (iv) (iii) The determination of appropriate medical candidates by
56 the treating physician in accordance with the standards and guidelines

1 established and adopted by the American College of Obstetricians and
2 Gynecologists and/or the American Society for Reproductive Medicine.

3 (E)(i) For the purposes of this subsection, "infertility" means a
4 disease or condition characterized by the incapacity to impregnate
5 another person or to conceive, defined by the failure to establish a
6 clinical pregnancy after twelve months of regular, unprotected sexual
7 intercourse or therapeutic donor insemination, or after six months of
8 regular, unprotected sexual intercourse or therapeutic donor insemina-
9 tion for a female thirty-five years of age or older. Earlier evaluation
10 and treatment may be warranted based on an individual's medical history
11 or physical findings.

12 (ii) For purposes of this subsection, "iatrogenic infertility" means
13 an impairment of fertility by surgery, radiation, chemotherapy or other
14 medical treatment affecting reproductive organs or processes.

15 (F) Coverage shall also include standard fertility preservation
16 services when a medical treatment may directly or indirectly cause
17 iatrogenic infertility to an insured. Coverage may be subject to annual
18 deductibles and coinsurance, including copayments, as may be deemed
19 appropriate by the superintendent and as are consistent with those
20 established for other benefits within a given contract.

21 (G) Every large group contract that provides medical, major medical or
22 similar comprehensive-type coverage shall provide coverage for three
23 cycles of in-vitro fertilization used in the treatment of infertility.
24 Coverage may be subject to annual deductibles and coinsurance, including
25 copayments, as may be deemed appropriate by the superintendent and as
26 are consistent with those established for other benefits within a given
27 contract. For purposes of this subparagraph, a "cycle" is defined as
28 either all treatment that starts when: preparatory medications are
29 administered for ovarian stimulation for oocyte retrieval with the
30 intent of undergoing in-vitro fertilization using a fresh embryo trans-
31 fer; or medications are administered for endometrial preparation with
32 the intent of undergoing in-vitro fertilization using a frozen embryo
33 transfer.

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

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

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

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

52 (ii) No insurer providing coverage under this paragraph shall discrim-
53 inate based on an insured's expected length of life, present or
54 predicted disability, degree of medical dependency, perceived quality of
55 life, or other health conditions, nor based on personal characteristics,

1 including age, sex, sexual orientation, marital status or gender identi-
2 ty.

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

6 PART M

7 Section 1. Subparagraph (A) of paragraph 16 of subsection (1) of
8 section 3221 of the insurance law, as amended by a chapter of the laws
9 of 2019, amending the insurance law and the social services law relating
10 to requiring health insurance policies to include coverage of all
11 FDA-approved contraceptive drugs, devices, and products, as well as
12 voluntary sterilization procedures, contraceptive education and coun-
13 seling, and related follow up services and prohibiting a health insur-
14 ance policy from imposing any cost-sharing requirements or other
15 restrictions or delays with respect to this coverage, as proposed in
16 legislative bills numbers S. 659-a and A. 585-a, is amended and a new
17 subparagraph (H) is added to read as follows:

18 (A) Every group or blanket policy that provides medical, major
19 medical, or similar comprehensive type coverage that is issued, amended,
20 renewed, effective or delivered on or after January first, two thousand
21 twenty, shall provide coverage for all of the following services and
22 contraceptive methods:

23 (1) All FDA-approved contraceptive drugs, devices, and other products.
24 This includes all FDA-approved over-the-counter contraceptive drugs,
25 devices, and products as prescribed or as otherwise authorized under
26 state or federal law. The following applies to this coverage:

27 (a) where the FDA has approved one or more therapeutic and pharmaceu-
28 tical equivalent, as defined by the FDA, versions of a contraceptive
29 drug, device, or product, a group or blanket policy is not required to
30 include all such therapeutic and pharmaceutical equivalent versions in
31 its formulary, so long as at least one is included and covered without
32 cost-sharing and in accordance with this paragraph;

33 (b) if the covered therapeutic and pharmaceutical equivalent versions
34 of a drug, device, or product are not available or are deemed medically
35 inadvisable a group or blanket policy shall provide coverage for an
36 alternate therapeutic and pharmaceutical equivalent version of the
37 contraceptive drug, device, or product without cost-sharing. If the
38 attending health care provider, in his or her reasonable professional
39 judgment, determines that the use of a non-covered therapeutic or phar-
40 maceutical equivalent of a drug, device, or product is warranted, the
41 health care provider's determination shall be final. The superintendent
42 shall promulgate regulations establishing a process, including time-
43 frames, for an insured, an insured's designee or an insured's health
44 care provider to request coverage of a non-covered contraceptive drug,
45 device, or product. Such regulations shall include a requirement that
46 insurers use an exception form that shall meet criteria established by
47 the superintendent;

48 (c) this coverage shall include emergency contraception without cost-
49 sharing when provided pursuant to a prescription or order under section
50 sixty-eight hundred thirty-one of the education law or when lawfully
51 provided over the counter; and

52 (d) this coverage must allow for the dispensing of up to twelve months
53 worth of a contraceptive at one time;

(2) Voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and identified in the comprehensive guidelines supported by the health resources and services administration and thereby incorporated in the essential health benefits benchmark plan;

(3) Patient education and counseling on contraception; and

(4) 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.

(H) For the purposes of this paragraph, "over-the-counter contraceptive products" shall mean those products provided for in comprehensive guidelines supported by the health resources and services administration as of January twenty-first, two thousand nineteen.

§ 2. Paragraph 1 of subsection (cc) of section 4303 of the insurance law, as amended by a chapter of the laws of 2019, amending the insurance law and the social services law relating 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, as proposed in legislative bills numbers S. 659-a and A. 585-a, is amended and a new paragraph 8 is added to read as follows:

(1) Every contract that provides medical, major medical, or similar comprehensive type coverage that is issued, amended, renewed, effective or delivered on or after January first, two thousand twenty, shall provide coverage for all of the following services and contraceptive methods:

(A) 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. 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, a contract 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 subsection;

(ii) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable a contract shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. If the attending health care provider, in his or her reasonable professional judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final. The superintendent shall promulgate regulations establishing a process, including timeframes, for an insured, an insured's designee or an insured's health care provider to request coverage of a non-covered contraceptive drug, device, or product. Such regulations shall include a requirement that insurers use an exception form that shall meet criteria established by the superintendent;

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

1 (iv) this coverage must allow for the dispensing of up to twelve
2 months worth of a contraceptive at one time;

3 (B) Voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and
4 identified in the comprehensive guidelines supported by the health
5 resources and services administration and thereby incorporated in the
6 essential health benefits benchmark plan;

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

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

12 (8) For the purposes of this paragraph, "over-the-counter contracep-
13 tive products" shall mean those products provided for in comprehensive
14 guidelines supported by the health resources and services administration
15 as of January twenty-first, two thousand nineteen.

16 § 3. Clause (v) of subparagraph (E) of paragraph 17 of subsection (i)
17 of section 3216 of the insurance law, as added by a chapter of the laws
18 of 2019, amending the insurance law and the social services law relating
19 to requiring health insurance policies to include coverage of all
20 FDA-approved contraceptive drugs, devices, and products, as well as
21 voluntary sterilization procedures, contraceptive education and coun-
22 seling, and related follow up services and prohibiting a health insur-
23 ance policy from imposing any cost-sharing requirements or other
24 restrictions or delays with respect to this coverage, as proposed in
25 legislative bills numbers S. 659-a and A. 585-a, is amended to read as
26 follows:

27 (v) all FDA-approved contraceptive drugs, devices, and other products,
28 including all over-the-counter contraceptive drugs, devices, and
29 products as prescribed or as otherwise authorized under state or federal
30 law; voluntary sterilization procedures pursuant to 42 U.S.C. 18022 and
31 identified in the comprehensive guidelines supported by the health
32 resources and services administration and thereby incorporated in the
33 essential health benefits benchmark plan; patient education and coun-
34 seling on contraception; and follow-up services related to the drugs,
35 devices, products, and procedures covered under this clause, including,
36 but not limited to, management of side effects, counseling for continued
37 adherence, and device insertion and removal. Except as otherwise author-
38 ized under this clause, a contract shall not impose any restrictions or
39 delays on the coverage required under this clause. However, where the
40 FDA has approved one or more therapeutic and pharmaceutical equivalent,
41 as defined by the FDA, versions of a contraceptive drug, device, or
42 product, a contract is not required to include all such therapeutic and
43 pharmaceutical equivalent versions in its formulary, so long as at least
44 one is included and covered without cost-sharing and in accordance with
45 this clause. If the covered therapeutic and pharmaceutical equivalent
46 versions of a drug, device, or product are not available or are deemed
47 medically inadvisable a contract shall provide coverage for an alternate
48 therapeutic and pharmaceutical equivalent version of the contraceptive
49 drug, device, or product without cost-sharing. (a) This coverage shall
50 include emergency contraception without cost sharing when provided
51 pursuant to a prescription, or order under section sixty-eight hundred
52 thirty-one of the education law or when lawfully provided over-the-coun-
53 ter. (b) If the attending health care provider, in his or her reason-
54 able professional judgment, determines that the use of a non-covered
55 therapeutic or pharmaceutical equivalent of a drug, device, or product
56 is warranted, the health care provider's determination shall be final.

1 The superintendent shall promulgate regulations establishing a process,
2 including timeframes, for an insured, an insured's designee or an
3 insured's health care provider to request coverage of a non-covered
4 contraceptive drug, device, or product. Such regulations shall include a
5 requirement that insurers use an exception form that shall meet criteria
6 established by the superintendent. (c) This coverage must allow for the
7 dispensing of up to twelve months worth of a contraceptive at one time.

8 (d) For the purposes of this clause, "over-the-counter contraceptive
9 products" shall mean those products provided for in comprehensive guide-
10 lines supported by the health resources and services administration as
11 of January twenty-first, two thousand nineteen.

12 § 4. This act shall take effect on the same date and in the same
13 manner as a chapter of the laws of 2019, amending the insurance law and
14 the social services law relating to requiring health insurance policies
15 to include coverage of all FDA-approved contraceptive drugs, devices,
16 and products, as well as voluntary sterilization procedures, contracep-
17 tive education and counseling, and related follow up services and
18 prohibiting a health insurance policy from imposing any cost-sharing
19 requirements or other restrictions or delays with respect to this cover-
20 age, as proposed in legislative bills numbers S. 659-a and A. 585-a,
21 takes effect.

22 PART N

23 Intentionally Omitted

24 PART O

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

28 2. State aid reimbursement for public health services provided by a
29 municipality under this title, shall be made if the municipality is
30 providing some or all of the core public health services identified in
31 section six hundred two of this title, pursuant to an approved applica-
32 tion for state aid, at a rate of no less than thirty-six per centum,
33 except for the city of New York which shall receive no less than twenty
34 per centum, of the difference between the amount of moneys expended by
35 the municipality for public health services required by section six
36 hundred two of this title during the fiscal year and the base grant
37 provided pursuant to subdivision one of this section. No such reimburse-
38 ment shall be provided for services that are not eligible for state aid
39 pursuant to this article.

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

43 1. The total amount of state aid provided pursuant to this article
44 shall be limited to the amount of the annual appropriation made by the
45 legislature. In no event, however, shall such state aid be less than an
46 amount to provide the full base grant and, as otherwise provided by
47 ~~[paragraph (a) of]~~ subdivision two of section six hundred five of this
48 article, ~~[at least]~~ no less than thirty-six per centum, except for the
49 city of New York which shall receive no less than twenty per centum, of
50 the difference between the amount of moneys expended by the municipality
51 for eligible public health services pursuant to an approved application

1 for state aid during the fiscal year and the base grant provided pursu-
2 ant to subdivision one of section six hundred five of this article.

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

4 PART P

5 Section 1. Subdivision 6 of section 1370 of the public health law, as
6 amended by chapter 485 of the laws of 1992, is amended to read as
7 follows:

8 6. "Elevated lead levels" means a blood lead level greater than or
9 equal to ~~ten~~ five micrograms of lead per deciliter of whole blood or
10 such lower blood lead level as may be established by the department
11 pursuant to rule or regulation.

12 § 1-a. (a) Within 180 days after the date on which this act takes
13 effect, the department of health shall adopt all necessary regulations
14 to define "elevated lead levels" to mean a blood lead level greater than
15 or equal to 5 micrograms per deciliter of whole blood, or such lower
16 blood lead level as the department may establish, to be utilized in its
17 lead poisoning prevention program.

18 (b) Within 6 months after the date on which the federal department of
19 health and human services has published guidance recommending a lower
20 concentration of lead in blood than the concentration established pursu-
21 ant to subdivision 6 of section 1370 of the public health law as the
22 reference level for conducting an environmental intervention, the
23 department of health shall, in consultation with the New York state
24 advisory council on lead poisoning prevention, make recommendations to
25 the governor and the legislature recommending actions the state should
26 take in response to such guidance.

27 § 2. Section 1151 of the public health law is amended by adding a new
28 subdivision 9 to read as follows:

29 9. General information regarding lead pipes reasonably known to be
30 located within the water system, as that term is defined in subdivision
31 twenty-six of section two of the public service law.

32 § 3. This act shall take effect immediately.

33 PART Q

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

36 4-a. Notwithstanding subdivision two of this section or any inconsist-
37 ent provision of law to the contrary, and upon approval of the director
38 of the budget, the commissioner may, subject to the availability of
39 lawful appropriation, award up to three hundred million dollars of the
40 funds made available pursuant to this section for unfunded project
41 applications submitted in response to the request for applications
42 number 17648 issued by the department on January eighth, two thousand
43 eighteen pursuant to section twenty-eight hundred twenty-five-e of this
44 article, provided however that the provisions of subdivisions three and
45 four of this section shall apply.

46 4-b. Authorized amounts to be awarded pursuant to applications submit-
47 ted in response to the request for application number 17648 shall be
48 awarded no later than May first, two thousand nineteen.

49 § 2. This act shall take effect immediately.

50 PART R

Intentionally Omitted

PART S

Intentionally Omitted

PART T

Section 1. This act shall be known and may be cited as the "NY State of Health, The Official Health Plan Marketplace Act".

§ 2. Article 2 of the public health law is amended by adding a new title VII to read as follows:

TITLE VII

NY STATE OF HEALTH

Section 268. Statement of policy and purposes.

268-a. Definitions.

268-b. Establishment of NY State of Health, The Official Health Plan Marketplace.

268-c. Functions of the Marketplace.

268-d. Special functions of the Marketplace related to health plan certification and qualified health plan oversight.

268-e. Appeals and appeal hearings; judicial review.

268-f. Marketplace advisory committee.

268-g. Funding of the Marketplace.

268-h. Construction.

§ 268. Statement of policy and purposes. The purpose of this title is to codify the establishment of the health benefit exchange in New York, known as NY State of Health, The Official Health Plan Marketplace (Marketplace), in conformance with Executive Order 42 (Cuomo) issued April 12, 2012. The Marketplace shall continue to perform eligibility determinations for federal and state insurance affordability programs including medical assistance in accordance with section three hundred sixty-six of the social services law, child health plus in accordance with section twenty-five hundred eleven of this chapter, the basic health program in accordance with section three hundred sixty-nine-gg of the social services law, and premium tax credits and cost-sharing reductions, together with performing eligibility determinations for qualified health plans and such other health insurance programs as determined by the commissioner. The Marketplace shall also facilitate enrollment in insurance affordability programs, qualified health plans and other health insurance programs as determined by the commissioner, the purchase and sale of qualified health plans and/or other or additional health plans certified by the Marketplace pursuant to this title, and shall continue to have the authority to operate a small business health options program ("SHOP") to assist eligible small employers in selecting qualified health plans and/or other or additional health plans certified by the Marketplace and to determine small employer eligibility for purposes of small employer tax credits. It is the intent of the legislature, by codifying the Marketplace in state statute, to continue to promote quality and affordable health coverage and care, reduce the number of uninsured persons, provide a transparent marketplace, educate consumers and assist individuals with access to coverage, premium assistance tax credits and cost-sharing reductions. In addition, the legislature declares the intent that the Marketplace continue to be properly integrated with insurance affordability programs, including

1 Medicaid, child health plus and the basic health program, and such other
2 health insurance programs as determined by the commissioner.

3 § 268-a. Definitions. For purposes of this title, the following defi-
4 nitions shall apply:

5 1. "Commissioner" means the commissioner of health of the state of New
6 York.

7 2. "Marketplace" means the "NY State of Health, The official health
8 plan Marketplace" or "Marketplace" established as a health benefit
9 exchange or "marketplace" within the department of health pursuant to
10 Executive Order 42 (Cuomo) issued April 12, 2012 and this title.

11 3. "Federal act" means the patient protection and affordable care act,
12 public law 111-148, as amended by the health care and education recon-
13 ciliation act of 2010, public law 111-152, and any regulations or guid-
14 ance issued thereunder.

15 4. "Health plan" means a policy, contract or certificate, offered or
16 issued by an insurer to provide, deliver, arrange for, pay for or reim-
17 burse any of the costs of health care services. Health plan shall not
18 include the following:

19 (a) accident insurance or disability income insurance, or any combina-
20 tion thereof;

21 (b) coverage issued as a supplement to liability insurance;

22 (c) liability insurance, including general liability insurance and
23 automobile liability insurance;

24 (d) workers' compensation or similar insurance;

25 (e) automobile no-fault insurance;

26 (f) credit insurance;

27 (g) other similar insurance coverage, as specified in federal regu-
28 lations, under which benefits for medical care are secondary or inci-
29 dental to other insurance benefits;

30 (h) limited scope dental or vision benefits, benefits for long-term
31 care insurance, nursing home insurance, home care insurance, or any
32 combination thereof, or such other similar, limited benefits health
33 insurance as specified in federal regulations, if the benefits are
34 provided under a separate policy, certificate or contract of insurance
35 or are otherwise not an integral part of the plan;

36 (i) coverage only for a specified disease or illness, hospital indem-
37 nity, or other fixed indemnity coverage;

38 (j) Medicare supplemental insurance as defined in section 1882(g)(1)
39 of the federal social security act, coverage supplemental to the cover-
40 age provided under chapter 55 of title 10 of the United States Code, or
41 similar supplemental coverage provided under a group health plan if it
42 is offered as a separate policy, certificate or contract of insurance;
43 or

44 (k) the New York state medical indemnity fund established pursuant to
45 title four of article twenty-nine-D of the public health law.

46 5. "Insurer" means an insurance company subject to article forty-two
47 or a corporation subject to article forty-three of the insurance law, or
48 a health maintenance organization certified pursuant to article forty-
49 four of the public health law that contracts or offers to contract to
50 provide, deliver, arrange, pay or reimburse any of the costs of health
51 care services.

52 6. "Stand-Alone dental plan" means a dental services plan that has
53 been issued pursuant to applicable law and certified by the Marketplace
54 in accordance with section two hundred sixty-eight-d of this title.

55 7. "Qualified health plan" means a health plan that is issued pursuant
56 to applicable law and certified by the Marketplace in accordance with

1 section two hundred sixty-eight-d of this title, including a stand-alone
2 dental plan.

3 8. "Insurance affordability program" means Medicaid, child health
4 plus, the basic health program and any other health insurance subsidy
5 program designated as such by the commissioner.

6 9. "Eligible individual" means an individual, including a minor, who
7 is eligible to enroll in an insurance affordability program or other
8 health insurance program as determined by the commissioner.

9 10. "Qualified individual" means, with respect to qualified health
10 plans, an individual, including a minor, who:

11 (a) is eligible to enroll in a qualified health plan offered to indi-
12 viduals through the Marketplace;

13 (b) resides in this state;

14 (c) at the time of enrollment, is not incarcerated, other than incar-
15 ceration pending the disposition of charges; and

16 (d) is, and is reasonably expected to be, for the entire period for
17 which enrollment is sought, a citizen or national of the United States
18 or an alien lawfully present in the United States.

19 11. "Secretary" means the secretary of the United States department of
20 health and human services.

21 12. "SHOP" means the small business health options program operated by
22 the Marketplace to assist eligible small employers in this state in
23 selecting qualified health plans and/or other or additional health plans
24 certified by the Marketplace and to determine small employer eligibility
25 for purposes of small employer tax credits in accordance with applicable
26 federal and state laws and regulations.

27 13. "Small employer" means an employer which offers coverage where the
28 coverage such employer offers would be considered small group coverage
29 under the insurance law and regulations promulgated thereunder, provided
30 that it is not otherwise prohibited under the federal act.

31 14. "Small group market" means the health insurance market under which
32 individuals receive health insurance coverage on behalf of themselves
33 and their dependents through a group health plan maintained by a small
34 employer.

35 15. "Superintendent" means the superintendent of financial services.

36 16. "Essential health benefits" shall mean the categories of benefits
37 defined in subsection (a) of section three thousand two hundred seven-
38 teen-i and subsection (a) of section four thousand three hundred six-h
39 of the insurance law.

40 § 268-b. Establishment of NY State of Health, The Official Health Plan
41 Marketplace. 1. There is hereby established an office within the depart-
42 ment of health to be known as the "NY State of Health, The official
43 health plan Marketplace".

44 2. The purpose of the Marketplace is to facilitate enrollment in
45 health coverage and the purchase and sale of qualified health plans and
46 other health plans certified by the Marketplace; enroll individuals in
47 coverage for which they are eligible in accordance with federal and
48 state law; enable eligible individuals to receive premium tax credits,
49 cost-sharing reductions, and to access insurance affordability programs
50 and other health insurance programs as determined by the commissioner;
51 assist eligible small employers in selecting qualified health plans
52 and/or other, or additional health plans certified by the Marketplace
53 and to qualify for small employer tax credits in accordance with appli-
54 cable law; and to carry out other functions set forth in this title.

55 § 268-c. Functions of the Marketplace. The Marketplace shall:

1 1. (a) Perform eligibility determinations for federal and state insur-
2 ance affordability programs including medical assistance in accordance
3 with section three hundred sixty-six of the social services law, child
4 health plus in accordance with section twenty-five hundred eleven of
5 this chapter, the basic health program in accordance with section three
6 hundred sixty-nine-gg of the social services law, premium tax credits
7 and cost-sharing reductions and qualified health plans in accordance
8 with applicable law and other health insurance programs as determined by
9 the commissioner;

10 (b) certify and make available to qualified individuals, qualified
11 health plans, including dental plans, certified by the Marketplace
12 pursuant to applicable law, provided that coverage under such plans
13 shall not become effective prior to certification by the Marketplace;
14 and

15 (c) certify and/or make available to eligible individuals, health
16 plans certified by the Marketplace pursuant to applicable law, and/or
17 participating in an insurance affordability program pursuant to applica-
18 ble law, provided that coverage under such plans shall not become effec-
19 tive prior to certification by the Marketplace, and/or approval by the
20 commissioner.

21 2. Assign an actuarial value to each Marketplace certified plan
22 offered through the Marketplace in accordance with the criteria devel-
23 oped by the secretary pursuant to federal law or the superintendent
24 pursuant to the insurance law and/or requirements developed by the
25 Marketplace, and determine each health plan's level of coverage in
26 accordance with regulations issued by the secretary pursuant to federal
27 law or the superintendent pursuant to the insurance law.

28 3. Utilize a standardized format for presenting health benefit options
29 in the Marketplace, including the use of the uniform outline of coverage
30 established under section 2715 of the federal public health service act
31 or the insurance law.

32 4. Standardize the benefits available through the Marketplace at each
33 level of coverage defined by the superintendent in the insurance law.

34 5. Maintain enrollment periods in the best interest of qualified indi-
35 viduals consistent with federal and state law.

36 6. Implement procedures for the certification, recertification and
37 decertification of health plans as qualified health plans or health
38 plans approved for sale by the department of financial services or
39 department of health and certified by the Marketplace, consistent with
40 guidelines developed by the secretary pursuant to section 1311(c) of the
41 federal act and requirements developed by the Marketplace.

42 7. Contract for health care coverage offered to qualified individuals
43 through the Marketplace, and in doing so shall seek to provide health
44 care coverage choices that offer the optimal combination of choice,
45 value, quality, and service.

46 8. Contract for health care coverage offered to certain eligible indi-
47 viduals through the Marketplace, pursuant to health insurance programs
48 as determined by the commissioner, and in doing so shall seek to provide
49 health care coverage choices that offer the optimal combination of
50 choice, value, quality, and service;

51 9. Provide the minimum requirements an insurer shall meet to partic-
52 ipate in the Marketplace, in the best interest of qualified individuals
53 or eligible individuals;

54 10. Require qualified health plans and/or other health plans certified
55 by the Marketplace to offer those benefits determined to be essential
56 health benefits pursuant to state law or as required by the Marketplace.

11. Ensure that insurers offering health plans through the Marketplace do not charge an individual enrollee a fee or penalty for termination of coverage.

12. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

13. Maintain an internet website through which enrollees and prospective enrollees of qualified health plans and health plans certified by the Marketplace may obtain standardized comparative information on such plans and insurance affordability programs.

14. Make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 or applicable state law and any cost-sharing reduction under federal or applicable state law.

15. Operate a program under which the Marketplace awards grants to entities to serve as navigators in accordance with applicable federal law and regulations adopted thereunder, and/or a program under which the Marketplace awards grants to entities to provide community based enrollment assistance in accordance with requirements developed by the Marketplace; and/or a program under which the Marketplace certifies New York state licensed producers to provide assistance to eligible individuals and/or small employers pursuant to federal or state law.

16. In accordance with applicable federal and state law, inform individuals of eligibility requirements for the Medicaid program under title XIX of the social security act and the social services law, the children's health insurance program (CHIP) under title XXI of the social security act and this chapter, the basic health program under section three hundred sixty-nine-gg of the social services law, or any applicable state or local public health insurance program and if, through screening of the application by the Marketplace, the Marketplace determines that such individuals are eligible for any such program, enroll such individuals in such program.

17. Grant a certification that an individual is exempt from the requirement to maintain minimum essential coverage pursuant to federal or state law and from any penalties imposed by such requirements because:

(a) there is no affordable health plan available covering the individual, as defined by applicable law; or

(b) the individual meets the requirements for any other such exemption from the requirement to maintain minimum essential coverage or to pay the penalty pursuant to applicable federal or state law.

18. Operate a small business health options program ("SHOP") pursuant to section 1311 of the federal act and applicable state law, through which eligible small employers may select marketplace-certified qualified health plans offered in the small group market, and through which eligible small employers may receive assistance in qualifying for small business tax credits available pursuant to federal and state law.

19. Enter into agreements as necessary with federal and state agencies and other state Marketplaces to carry out its responsibilities under this title, provided such agreements include adequate protections with respect to the confidentiality of any information to be shared and comply with all state and federal laws and regulations.

20. Perform duties required by the secretary, the secretary of the United States department of the treasury or the commissioner related to determining eligibility for premium tax credits or reduced cost-sharing under applicable federal or state law.

1 21. Meet program integrity requirements under applicable law, includ-
2 ing keeping an accurate accounting of receipts and expenditures and
3 providing reports to the secretary regarding Marketplace related activ-
4 ities in accordance with applicable law.

5 22. Submit information provided by Marketplace applicants for verifi-
6 cation as required by section 1411(c) of the federal act and applicable
7 state law.

8 23. Establish rules and regulations that do not conflict with or
9 prevent the application of regulations promulgated by the secretary.

10 24. Determine eligibility, provide notices, and provide opportunities
11 for appeal and redetermination in accordance with the requirements of
12 federal and state law.

13 § 268-d. Special functions of the Marketplace related to health plan
14 certification and qualified health plan oversight. 1. Health plans
15 certified by the Marketplace shall meet the following requirements:

16 (a) The insurer offering the health plan:

17 (i) is licensed or certified by the superintendent or commissioner, in
18 good standing to offer health insurance coverage in this state, and
19 meets the requirements established by the Marketplace;

20 (ii) offers at least one qualified health plan and/or other or addi-
21 tional health plans authorized for sale by the department of financial
22 services or the department in each of the silver and gold levels as
23 required by state law, provided, however, that the Marketplace may
24 require additional benefit levels to be offered by all insurers partic-
25 ipating in the Marketplace;

26 (iii) has filed with and received approval from the superintendent of
27 its premium rates and policy or contract forms pursuant to the insurance
28 law and/or this chapter;

29 (iv) does not charge any cancellation fees or penalties for termi-
30 nation of coverage in violation of applicable law; and

31 (v) complies with the regulations developed by the secretary under
32 section 1311(c) of the federal act and such other requirements as the
33 Marketplace may establish.

34 (b) The health plan: (i) provides the essential health benefits pack-
35 age described in state law or required by the Marketplace and includes
36 such additional benefits as are mandated by state law, except that the
37 health plan shall not be required to provide essential benefits that
38 duplicate the minimum benefits of qualified dental plans if:

39 (A) the Marketplace has determined that at least one qualified dental
40 plan or dental plan approved by the department of financial services or
41 the department is available to supplement the health plan's coverage;
42 and

43 (B) the insurer makes prominent disclosure at the time it offers the
44 health plan, in a form approved by the Marketplace, that the plan does
45 not provide the full range of essential pediatric benefits, and that
46 qualified dental plans or dental plans approved by the department of
47 financial services or department of health providing those benefits and
48 other dental benefits not covered by the plan are offered through the
49 Marketplace;

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

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

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

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

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

15 (c) The Marketplace determines that making the health plan available
16 through the Marketplace is in the interest of qualified individuals in
17 this state.

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

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

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

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

25 3. The Marketplace shall require each insurer certified or seeking
26 certification of a health plan as a qualified health plan or plan
27 approved for sale by the department of financial services or the depart-
28 ment to:

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

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

36 (A) claims payment policies and practices;

37 (B) periodic financial disclosures;

38 (C) data on enrollment and disenrollment;

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

40 (E) data on rating practices;

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

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

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

47 (ii) the information shall be provided in plain language, as that term
48 is defined in section 1311(e)(3)(B) of the federal act and state law,
49 and in guidance jointly issued thereunder by the secretary and the
50 federal secretary of labor; and

51 (c) provide to individuals, in a timely manner upon the request of the
52 individual, the amount of cost-sharing, including deductibles, copay-
53 ments, and coinsurance, under the individual's health plan or coverage
54 that the individual would be responsible for paying with respect to the
55 furnishing of a specific item or service by a participating provider. At
56 a minimum, this information shall be made available to the individual

1 through an internet website and through other means for individuals
2 without access to the internet.

3 4. The Marketplace shall not exempt any insurer seeking certification
4 of a health plan, regardless of the type or size of the insurer, from
5 licensing or solvency requirements under the insurance law or this chap-
6 ter, and shall apply the criteria of this section in a manner that
7 ensures a level playing field for insurers participating in the Market-
8 place.

9 5. (a) The provisions of this article that apply to qualified health
10 plans and plans approved for sale by the department of financial
11 services and the department also shall apply to the extent relevant to
12 qualified dental plans approved for sale by the department of financial
13 services or the department, except as modified in accordance with the
14 provisions of paragraphs (b) and (c) of this subdivision or otherwise
15 required by the Marketplace.

16 (b) The qualified dental plan or dental plan approved for sale by the
17 department of financial services and/or the department shall be limited
18 to dental and oral health benefits, without substantially duplicating
19 the benefits typically offered by health benefit plans without dental
20 coverage, and shall include, at a minimum, the essential pediatric
21 dental benefits prescribed by the secretary pursuant to section
22 1302(b)(1)(J) of the federal act, and such other dental benefits as the
23 Marketplace or secretary may specify in regulations.

24 (c) Insurers may jointly offer a comprehensive plan through the
25 Marketplace in which an insurer provides the dental benefits through a
26 qualified dental plan or plan approved by the department of financial
27 services or the department and an insurer provides the other benefits
28 through a qualified health plan, provided that the plans are priced
29 separately and also are made available for purchase separately at the
30 same price.

31 § 268-e. Appeals and appeal hearings; judicial review. 1. Any appli-
32 cant or enrollee, or any individual authorized to act on behalf of any
33 such applicant or enrollee, may appeal to the department from determi-
34 nations of department officials or failures to make determinations upon
35 grounds specified in subdivision four of this section. The department
36 must review the appeal de novo and give such person an opportunity for
37 an appeal hearing. The department may also, on its own motion, review
38 any decision made or any case in which a decision has not been made by
39 the Marketplace or a social services official within the time specified
40 by law or regulations of the department. The department may make such
41 additional investigation as it may deem necessary, and the commissioner
42 must make such determination as is justified and in accordance with
43 applicable law.

44 2. Regarding any appeal pursuant to this section, with or without an
45 appeal hearing, the commissioner may designate and authorize one or more
46 appropriate members of his staff to consider and decide such appeals.
47 Any staff member so designated and authorized will have authority to
48 decide such appeals on behalf of the commissioner with the same force
49 and effect as if the commissioner had made the decisions. Appeal hear-
50 ings must be held on behalf of the commissioner by members of his staff
51 who are employed for such purposes or who have been designated and
52 authorized by the commissioner.

53 3. Persons entitled to appeal to the department pursuant to this
54 section must include:

55 (a) applicants for or enrollees in insurance affordability programs
56 and qualified health plans; and

1 (b) other persons entitled to an opportunity for an appeal hearing as
2 directed by the commissioner.

3 4. An applicant or enrollee has the right to appeal at least the
4 following issues:

5 (a) An eligibility determination made in accordance with this article
6 and applicable law, including:

7 (i) An initial determination of eligibility, including:

8 (A) eligibility to enroll in a qualified health plan;

9 (B) eligibility for Medicaid;

10 (C) eligibility for Child Health Plus;

11 (D) eligibility for the Basic Health Program;

12 (E) the amount of advance payments of the premium tax credit and level
13 of cost-sharing reductions;

14 (F) the amount of any other subsidy that may be available under law;
15 and

16 (G) eligibility for such other health insurance programs as determined
17 by the commissioner; and

18 (ii) a re-determination of eligibility of the programs under this
19 subdivision.

20 (b) An eligibility determination for an exemption for any mandate to
21 purchase health insurance.

22 (c) A failure by NY State of Health to provide timely written notice
23 of an eligibility determination made in accordance with applicable law.

24 5. The department may, subject to the discretion of the commissioner,
25 promulgate such regulations, consistent with federal or state law, as
26 may be necessary to implement the provisions of this section.

27 6. Regarding every decision of an appeal pursuant to this section, the
28 department must inform every party, and his or her representative, if
29 any, of the availability of judicial review and the time limitation to
30 pursue future review.

31 7. Applicants and enrollees of qualified health plans, with or without
32 advance payments of the premium tax credit and cost-sharing reductions,
33 also have the right to appeal to the United States Department of Health
34 and Human Services appeal entity:

35 (a) appeals decisions issued by NY State of Health upon the exhaustion
36 of the NY State of Health appeals process; and

37 (b) a denial of a request to vacate a dismissal made by the NY State
38 of Health appeals entity.

39 8. The department must include notice of the right to appeal as
40 provided by subdivision four of this section and instructions regarding
41 how to file an appeal in any eligibility determination issued to the
42 applicant or enrollee in accordance with applicable law. Such notice
43 shall include:

44 (a) an explanation of the applicant or enrollee's appeal rights;

45 (b) a description of the procedures by which the applicant or enrollee
46 may request an appeal;

47 (c) information on the applicant or enrollee's right to represent
48 himself or herself, or to be represented by legal counsel or another
49 representative;

50 (d) an explanation of the circumstances under which the appellant's
51 eligibility may be maintained or reinstated pending an appeal decision;
52 and

53 (e) an explanation that an appeal decision for one household member
54 may result in a change in eligibility for other household members and
55 that such a change will be handled as a redetermination of eligibility

1 for all household members in accordance with the standards specified in
2 applicable law.

3 § 268-f. Marketplace advisory committee. 1. There is hereby created
4 the marketplace advisory committee, which shall consider and advise the
5 department and commissioner on matters concerning the provision of
6 health care coverage through the NY State of Health or Health Plan
7 Marketplace.

8 2. The marketplace advisory committee shall be composed of up to twen-
9 ty-eight members consisting of twenty-four members appointed by the
10 commissioner, two members appointed by the speaker of the assembly, and
11 two members appointed by the temporary president of the senate. The
12 advisory committee shall at all times be representative of each
13 geographic area of the state and include:

14 (a) representatives from the following categories, but not more than
15 six from any single category:

16 (i) health plan consumer advocates;

17 (ii) small business consumer representatives;

18 (iii) health care provider representatives;

19 (iv) representatives of the health insurance industry;

20 (b) representatives from the following categories, but not more than
21 two from either category:

22 (i) licensed insurance producers; and

23 (ii) representatives of labor organizations.

24 3. The commissioner shall select the chair of the advisory committee
25 from among the members of such committee and shall designate an officer
26 or employee of the department to assist the marketplace advisory commit-
27 tee in the performance of its duties under this section. The Marketplace
28 shall adopt rules for the governance of the advisory committee, which
29 shall meet as frequently as its business may require and at such other
30 times as determined by the chair to be necessary, in consultation with
31 the executive director of the Marketplace.

32 4. Members of the advisory committee shall serve without compensation
33 for their services as members, but each shall be allowed the necessary
34 and actual expenses incurred in the performance of his or her duties
35 under this section.

36 § 268-g. Funding of the Marketplace. 1. The Marketplace shall be fund-
37 ed by state and federal sources as authorized by applicable law, includ-
38 ing but not limited to applicable law authorizing the respective insur-
39 ance affordability programs available through the Marketplace.

40 2. The accounts of the Marketplace shall be subject to supervision of
41 the comptroller and such accounts shall include receipts, expenditures,
42 contracts and other matters which pertain to the fiscal soundness of the
43 Marketplace.

44 3. Notwithstanding any law to the contrary, and in accordance with
45 section four of the state finance law, upon request of the director of
46 the budget, in consultation with the commissioner, the superintendent
47 and the executive director of the Marketplace, the comptroller is hereby
48 authorized and directed to sub-allocate or transfer special revenue
49 federal funds appropriated to the department for planning and implement-
50 ing various healthcare and insurance reform initiatives authorized by
51 applicable law. Marketplace moneys sub-allocated or transferred pursu-
52 ant to this section shall be paid out of the fund upon audit and warrant
53 of the state comptroller on vouchers certified or approved by the
54 Marketplace.

55 § 268-h. Construction. Nothing in this article, and no action taken by
56 the Marketplace pursuant hereto, shall be construed to:

1 1. preempt or supersede the authority of the superintendent or the
2 commissioner; or

3 2. exempt insurers, insurance producers or qualified health plans from
4 this chapter or the insurance law and any regulations promulgated there-
5 under.

6 § 3. Severability. If any provision of this article, or the applica-
7 tion thereof to any person or circumstances is held invalid or unconsti-
8 tutional, that invalidity or unconstitutionality shall not affect other
9 provisions or applications of this article that can be given effect
10 without the invalid or unconstitutional provision or application, and to
11 this end the provisions and application of this article are severable.

12 § 4. This act shall take effect immediately.

13 PART U

14 Section 1. Section 203 of the elder law is amended by adding a new
15 subdivision 12 to read as follows:

16 12.(a) The director is hereby authorized to implement private pay
17 protocols for programs and services administered by the office. These
18 protocols may be implemented by area agencies on aging at their option
19 and such protocols shall not be applied to services for a participant
20 when being paid for with federal funds or funds designated as federal
21 match, or for individuals with an income below four hundred percent of
22 the federal poverty level. All private payments received directly by an
23 area agency on aging or indirectly by one of its contractors shall be
24 used to supplement, not supplant, funds by state, federal, or county
25 appropriations. Such private pay payments shall be set at a cost to the
26 participant of not more than twenty percent above either the unit cost
27 to the area agency on aging to provide the program or service directly,
28 or the amount that the area agency on aging pays to its contractor to
29 provide the program or service. Private pay payments received under this
30 subdivision shall be used by the area agency on aging to first reduce
31 any unmet need for programs and services, and then to support and
32 enhance services or programs provided by the area agency on aging. No
33 participant, regardless of income, shall be required to pay for any
34 program or service that they are receiving at the time these protocols
35 are implemented by the area agency on aging. This subdivision shall not
36 prevent cost sharing for the programs and services established pursuant
37 to section two hundred fourteen of this title for individuals below four
38 hundred percent of the federal poverty level. Consistent with federal
39 and state statute and regulations, when providing programs and services,
40 area agencies on aging and their contractors shall continue to give
41 priority for programs and services to individuals with the greatest
42 economic or social needs. In the event that the capacity to provide
43 programs and services is limited, such programs and services shall be
44 provided to individuals with incomes below four hundred percent of the
45 federal poverty level before such programs and services are provided to
46 those participating in the private pay protocol pursuant to this subdivi-
47 vision.

48 (b) Area agencies on aging participating in the private pay protocol
49 shall annually report to the office the unmet need, if any, for all
50 programs and services offered, the number of participants that privately
51 paid for each program or service for that year, the rates participants
52 were charged for each program or service provided, and how unmet need
53 for programs or services offered by the area agency on aging were
54 affected by revenue from the private pay protocol. Such annual report

1 shall also be shared with the Temporary President of the Senate and the
2 Speaker of the Assembly no later than July first, two thousand twenty-
3 one and shall be updated and reissued on an annual basis thereafter.

4 § 2. This act shall take effect on the three hundred sixty-fifth day
5 after it shall have become a law; provided, however, that effective
6 immediately, any actions necessary for the implementation of this act on
7 its effective date are authorized to be completed on or before such
8 date.

9 PART V

10 Section 1. Paragraph (d) of subdivision 32 of section 364-j of the
11 social services law, as added by section 15 of part B of chapter 59 of
12 the laws of 2016, is amended to read as follows:

13 (d) (i) Penalties under this subdivision may be applied to any and all
14 circumstances described in paragraph (b) of this subdivision until the
15 managed care organization complies with the requirements for submission
16 of encounter data.

17 (ii) No penalties for late, incomplete or inaccurate encounter data
18 shall be assessed against managed care organizations in addition to
19 those provided for in this subdivision, provided, however, that nothing
20 in this paragraph shall prohibit the imposition of penalties, in cases
21 of fraud or abuse, otherwise authorized by law.

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

24 34. For purposes of recovery of overpayments pursuant to subdivision
25 thirty-five of this section, any payment made pursuant to the state's
26 managed care program, including payments made by managed long term care
27 plans, shall be deemed a payment by the state's medical assistance
28 program, provided that this subdivision shall not permit the imposition
29 of a lien or recovery against property of an individual or estate on
30 account of medical assistance payments where recovery is made against
31 the individual's managed care provider or provider of medical assistance
32 program items or services. Provided however nothing in this subdivision
33 shall be construed to limit recoveries under other relevant sections of
34 law.

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

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

40 (b) The Medicaid inspector general shall conduct periodic reviews of
41 the contractual performance of each managed care provider as it relates
42 to the managed care provider's program integrity obligations under its
43 contract with the department. The Medicaid inspector general, in consul-
44 tation with the commissioner, shall publish on its website, a list of
45 those contractual obligations pursuant to which the managed care provid-
46 er's program integrity performance shall be evaluated, including bench-
47 marks, prior to commencing any review. A Medicaid program integrity
48 review of a managed care provider conducted pursuant to this subdivi-
49 sion, may be completed no more than annually. Reviews performed pursuant
50 to this subdivision shall include a review of compliance with contractu-
51 al standards which prevent fraud, waste, or abuse. Such standards may
52 include but are not limited to excluded providers, restricted recipient
53 program, reporting obligations, compliance programs, and suspension of
54 payments. However, if the Medicaid inspector general determines that a

1 subsequent review, pursuant to this subdivision, is necessary, a second
2 review may occur within one year.

3 (c) If, as a result of his or her review, the Medicaid inspector
4 general determines that a managed care provider is not meeting its
5 program integrity obligations, the Medicaid inspector general may
6 recover from the managed care provider up to two percent of the Medicaid
7 premiums paid to the managed care provider for the period under review.
8 Any premium recovery under this subdivision shall be a percentage of the
9 administrative component of the Medicaid premium calculated by the
10 department and may be recovered by the department in the same manner it
11 recovers overpayments.

12 (d) The managed care provider shall be entitled to receive a draft
13 audit report and final audit report containing the results of the Medi-
14 caid inspector general's review. If the Medicaid inspector general
15 determines to recover a percentage of the premium as described in para-
16 graph (c) of this subdivision, the managed care provider shall be enti-
17 tled to notice and an opportunity to be heard in accordance with section
18 twenty-two of this chapter.

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

22 3. Upon enrollment in the medical assistance program, a provider shall
23 certify to the department that the provider satisfactorily meets the
24 requirements of this section. Additionally, the commissioner of health
25 and Medicaid inspector general shall have the authority to determine at
26 any time if a provider has a compliance program that satisfactorily
27 meets the requirements of this section.

28 (a) A compliance program that is accepted by the federal department of
29 health and human services office of inspector general and remains in
30 compliance with the standards promulgated by such office shall be deemed
31 in compliance with the provisions of this section, so long as such plans
32 adequately address medical assistance program risk areas and compliance
33 issues.

34 (b) A compliance program that meets Federal requirements for managed
35 care provider compliance programs, as specified in the contract or
36 contracts between the department and the Medicaid managed care provider
37 shall be deemed in compliance with the provisions in this section, so
38 long as such programs adequately address medical assistance program risk
39 areas and compliance issues. For purposes of this section, a managed
40 care provider is as defined in paragraph (c) of subdivision one of
41 section three hundred sixty-four-j of this chapter, and includes managed
42 long term care plans.

43 (c) In the event that the commissioner of health or the Medicaid
44 inspector general finds that the provider does not have a satisfactory
45 program within ninety days after the effective date of the regulations
46 issued pursuant to subdivision four of this section, the provider may be
47 subject to any sanctions or penalties permitted by federal or state laws
48 and regulations, including revocation of the provider's agreement to
49 participate in the medical assistance program.

50 § 5. Intentionally omitted.

51 § 6. Section 364-j of the social services law is amended by adding a
52 new subdivision 35 to read as follows:

53 35. Recovery of overpayments from network providers. (a) Where the
54 Medicaid inspector general during the course of an audit, investigation,
55 or review, or the deputy attorney general for the Medicaid fraud control
56 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; provided, however, in no event shall the state duplicate the recovery of an overpayment from a provider or subcontractor.

(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 and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that the amendments to section 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 or thereafter 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 commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, ~~2019~~ 2022; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, ~~2019~~ 2022.

§ 2. This act shall take effect immediately.

PART X

Intentionally Omitted

PART Y

Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living

adjustment for designated human services programs, as amended by section 1 of part AA of chapter 57 of the laws of 2018, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and ending March 31, ~~2019~~ 2020, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement, provided that the commissioners of the office for people with developmental disabilities, the office of mental health, and the office of alcoholism and substance abuse services shall not include a COLA beginning April 1, 2017 and ending March 31, ~~2019~~ 2021.

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

§ 2. Section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, is amended by adding a new subdivision 3-f to read as follows:

3-f. (i) Notwithstanding the provisions of subdivision 3-b of this section or any other inconsistent provision of law, and subject to the availability of the appropriation therefor, for the programs listed in paragraphs (i), (ii), and (iii) of subdivision 4 of this section, the commissioners shall provide funding to support (1) an overall average two percent (2.00%) increase to total salaries for direct care staff, direct support professionals for each eligible state-funded program beginning January 1, 2020; and (2) an overall average two percent (2.00%) increase to total salaries for direct care staff and direct support professionals, and clinical staff for each eligible state-funded program beginning April 1, 2020. For the purpose of this funding increase, direct support professionals are individuals employed in consolidated fiscal reporting position title codes ranging from 100 to 199; direct care staff are individuals employed in consolidated fiscal reporting position title codes ranging from 200 to 299; and clinical staff are individuals employed in consolidated fiscal reporting position title codes ranging from 300 to 399.

(ii) The funding made available pursuant to paragraph (i) of this subdivision shall be used: (1) to help alleviate the recruitment and retention challenges of direct care staff, direct support professionals and clinical staff employed in eligible programs; and (2) to continue and to expand efforts to support the professionalism of the direct care workforce. Each local government unit or direct contract provider receiving such funding shall have flexibility in allocating such funding to support salary increases to particular job titles to best address the needs of its direct care staff, direct support professionals and clinical staff. Each local government unit or direct contract provider receiving such funding shall also submit a written certification, in such form and at such time as each commissioner shall prescribe, attesting to how such funding will be or was used for purposes eligible under this section. Further, providers shall submit a resolution from their governing body to the appropriate commissioner, attesting that the fund-

ing received will be used solely to support salary and salary-related fringe benefit increases for direct care staff, direct support professionals and clinical staff, pursuant to paragraph (i) of this subdivision. Salary increases that take effect on and after April 1, 2019 may be used to demonstrate compliance with the January 1, 2020 funding increase authorized by this section, except for salary increases necessary to comply with state minimum wage requirements. Such commissioners shall be authorized to recoup any funds as appropriated herein determined to have been used in a manner inconsistent with such standards or inconsistent with the provisions of this subdivision, and such commissioners shall be authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such local governmental unit or provider.

(iii) Where appropriate transfers to the department of health shall be made as reimbursement for the state share of medical assistance.

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

PART Z

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

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health ~~or~~, substance use disorder services or developmental disability services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation

1 with the commissioner of the office of mental health [~~and~~], the commis-
2 sioner of the office of alcoholism and substance abuse services and the
3 commissioner of the office for people with developmental disabilities,
4 including regulations issued pursuant to subdivision seven of section
5 three hundred sixty-five-1 of the social services law or part L of chap-
6 ter fifty-six of the laws of two thousand twelve; (b) require a provider
7 licensed pursuant to article thirty-one of the mental hygiene law or
8 certified pursuant to article sixteen or article thirty-two of the
9 mental hygiene law to obtain an operating certificate from the depart-
10 ment if such provider has been authorized to provide integrated services
11 in accordance with regulations issued by the commissioner in consulta-
12 tion with the commissioner of the office of mental health [~~and~~], the
13 commissioner of the office of alcoholism and substance abuse services
14 and the commissioner of the office for people with developmental disa-
15 bilities, including regulations issued pursuant to subdivision seven of
16 section three hundred sixty-five-1 of the social services law or part L
17 of chapter fifty-six of the laws of two thousand twelve.

18 § 2. Subdivision (f) of section 31.02 of the mental hygiene law, as
19 added by section 2 of subpart B of part S of chapter 57 of the laws of
20 2018, is amended to read as follows:

21 (f) No provision of this article or any other provision of law shall
22 be construed to require a provider licensed pursuant to article twenty-
23 eight of the public health law or certified pursuant to article sixteen
24 or article thirty-two of this chapter to obtain an operating certificate
25 from the office of mental health if such provider has been authorized to
26 provide integrated services in accordance with regulations issued by the
27 commissioner of the office of mental health in consultation with the
28 commissioner of the department of health [~~and~~], the commissioner of the
29 office of alcoholism and substance abuse services and the commissioner
30 of the office for people with developmental disabilities, including
31 regulations issued pursuant to subdivision seven of section three
32 hundred sixty-five-1 of the social services law or part L of chapter
33 fifty-six of the laws of two thousand twelve.

34 § 3. Subdivision (b) of section 32.05 of the mental hygiene law, as
35 amended by section 3 of subpart B of part S of chapter 57 of the laws of
36 2018, is amended to read as follow:

37 (b) (i) Methadone, or such other controlled substance designated by
38 the commissioner of health as appropriate for such use, may be adminis-
39 tered to an addict, as defined in section thirty-three hundred two of
40 the public health law, by individual physicians, groups of physicians
41 and public or private medical facilities certified pursuant to article
42 twenty-eight or thirty-three of the public health law as part of a chem-
43 ical dependence program which has been issued an operating certificate
44 by the commissioner pursuant to subdivision (b) of section 32.09 of this
45 article, provided, however, that such administration must be done in
46 accordance with all applicable federal and state laws and regulations.
47 Individual physicians or groups of physicians who have obtained authori-
48 zation from the federal government to administer buprenorphine to
49 addicts may do so without obtaining an operating certificate from the
50 commissioner. (ii) No provision of this article or any other provision
51 of law shall be construed to require a provider licensed pursuant to
52 article twenty-eight of the public health law [~~or~~], article thirty-one
53 of this chapter or a provider certified pursuant to article sixteen of
54 this chapter to obtain an operating certificate from the office of alco-
55 holism and substance abuse services if such provider has been authorized
56 to provide integrated services in accordance with regulations issued by

1 the commissioner of alcoholism and substance abuse services in consulta-
2 tion with the commissioner of the department of health ~~[and]~~, the
3 commissioner of the office of mental health and the commissioner of the
4 office for people with developmental disabilities, including regulations
5 issued pursuant to subdivision seven of section three hundred sixty-
6 five-1 of the social services law or part L of chapter fifty-six of the
7 laws of two thousand twelve.

8 § 4. Section 16.03 of the mental hygiene law is amended by adding a
9 new subdivision (g) to read as follows:

10 (g) No provision of this article or any other provision of law shall
11 be construed to require a provider licensed pursuant to article twenty-
12 eight of the public health law or certified pursuant to article thirty-
13 one or thirty-two of this chapter to obtain an operating certificate
14 from the office for people with developmental disabilities if such
15 provider has been authorized to provide integrated services in accord-
16 ance with regulations issued by the commissioner of the office for
17 people with developmental disabilities, in consultation with the commis-
18 sioner of the department of health, the commissioner of the office of
19 mental health and the commissioner of the office of alcoholism and
20 substance abuse services, including regulations issued pursuant to
21 subdivision seven of section three hundred sixty-five-1 of the social
22 services law or part L of chapter fifty-six of the laws of two thousand
23 twelve.

24 § 5. This act shall take effect October 1, 2019; provided, however,
25 that the commissioner of the department of health, the commissioner of
26 the office of mental health, the commissioner of the office of alcohol-
27 ism and substance abuse services, and the commissioner of the office for
28 people with developmental disabilities are authorized to issue any rule
29 or regulation necessary for the implementation of this act on or before
30 its effective date.

31 PART AA

32 Intentionally Omitted

33 PART BB

34 Section 1. This part enacts into law major components of legislation
35 which are necessary to effectuate provisions relating to mental health
36 and substance use disorder treatment. Each component is wholly
37 contained within a Subpart identified as Subparts A through E. The
38 effective date for each particular provision contained within such
39 Subpart is set forth in the last section of such Subpart. Any provision
40 in any section contained within a Subpart, including the effective date
41 of the Subpart, which makes a reference to a section "of this act", when
42 used in connection with that particular component, shall be deemed to
43 mean and refer to the corresponding section of the Subpart in which it
44 is found. Section three of this Part sets forth the general effective
45 date of this Part.

46 SUBPART A

47 Section 1. Paragraph 4 of subsection (i) of section 3216 of the insur-
48 ance law is amended to read as follows:

49 (4) If a policy provides for reimbursement for psychiatric or psycho-
50 logical services or for diagnosis and treatment of mental ~~[nervous, or~~

1 ~~emotional disorders or ailments,~~ health conditions however defined in
2 the policy, the insured shall be entitled to reimbursement for such
3 services, diagnosis or treatment whether performed by a physician,
4 psychiatrist ~~[or]~~, a certified and registered psychologist, or a nurse
5 practitioner when the services rendered are within the lawful scope of
6 their practice.

7 § 2. Subparagraph (B) of paragraph 25 of subsection (i) of section
8 3216 of the insurance law, as amended by section 38 of part D of chapter
9 56 of the laws of 2013, is amended to read as follows:

10 (B) Every policy that provides physician services, medical, major
11 medical or similar comprehensive-type coverage shall provide coverage
12 for the screening, diagnosis and treatment of autism spectrum disorder
13 in accordance with this paragraph and shall not exclude coverage for the
14 screening, diagnosis or treatment of medical conditions otherwise
15 covered by the policy because the individual is diagnosed with autism
16 spectrum disorder. Such coverage may be subject to annual deductibles,
17 copayments and coinsurance as may be deemed appropriate by the super-
18 intendent and shall be consistent with those imposed on other benefits
19 under the policy. ~~[Coverage for applied behavior analysis shall be~~
20 ~~subject to a maximum benefit of six hundred eighty hours of treatment~~
21 ~~per policy or calendar year per covered individual.]~~ This paragraph
22 shall not be construed as limiting the benefits that are otherwise
23 available to an individual under the policy, provided however that such
24 policy shall not contain any limitations on visits that are solely
25 applied to the treatment of autism spectrum disorder. No insurer shall
26 terminate coverage or refuse to deliver, execute, issue, amend, adjust,
27 or renew coverage to an individual solely because the individual is
28 diagnosed with autism spectrum disorder or has received treatment for
29 autism spectrum disorder. Coverage shall be subject to utilization
30 review and external appeals of health care services pursuant to article
31 forty-nine of this chapter as well as ~~[7]~~ case management~~[7]~~ and other
32 managed care provisions.

33 § 3. Items (i) and (iii) of subparagraph (C) of paragraph 25 of
34 subsection (i) of section 3216 of the insurance law, as amended by chap-
35 ter 596 of the laws of 2011, are amended to read as follows:

36 (i) "autism spectrum disorder" means any pervasive developmental
37 disorder as defined in the most recent edition of the diagnostic and
38 statistical manual of mental disorders~~[, including autistic disorder,~~
39 ~~Asperger's disorder, Rett's disorder, childhood disintegrative disorder,~~
40 ~~or pervasive developmental disorder not otherwise specified (PDD-NOS)].~~

41 (iii) "behavioral health treatment" means counseling and treatment
42 programs, when provided by a licensed provider, and applied behavior
43 analysis, when provided ~~[or supervised]~~ by a ~~[behavior analyst certified~~
44 ~~pursuant to the behavior analyst certification board]~~ person licensed,
45 certified or otherwise authorized to provide applied behavior analysis,
46 that are necessary to develop, maintain, or restore, to the maximum
47 extent practicable, the functioning of an individual. ~~[Individuals that~~
48 ~~provide behavioral health treatment under the supervision of a certified~~
49 ~~behavior analyst pursuant to this paragraph shall be subject to stand-~~
50 ~~ards of professionalism, supervision and relevant experience pursuant to~~
51 ~~regulations promulgated by the superintendent in consultation with the~~
52 ~~commissioners of health and education.]~~

53 § 4. Paragraph 25 of subsection (i) of section 3216 of the insurance
54 law is amended by adding four new subparagraphs (H), (I), (J), and (K)
55 to read as follows:

1 (H) Coverage under this paragraph shall not apply financial require-
2 ments or treatment limitations to autism spectrum disorder benefits that
3 are more restrictive than the predominant financial requirements and
4 treatment limitations applied to substantially all medical and surgical
5 benefits covered by the policy.

6 (I) The criteria for medical necessity determinations under the policy
7 with respect to autism spectrum disorder benefits shall be made avail-
8 able by the insurer to any insured, prospective insured, or in-network
9 provider upon request.

10 (J) For purposes of this paragraph:

11 (i) "financial requirement" means deductible, copayments, coinsurance
12 and out-of-pocket expenses;

13 (ii) "predominant" means that a financial requirement or treatment
14 limitation is the most common or frequent of such type of limit or
15 requirement; and

16 (iii) "treatment limitation" means limits on the frequency of treat-
17 ment, number of visits, days of coverage, or other similar limits on the
18 scope or duration of treatment and includes nonquantitative treatment
19 limitations such as: medical management standards limiting or excluding
20 benefits based on medical necessity, or based on whether the treatment
21 is experimental or investigational; formulary design for prescription
22 drugs; network tier design; standards for provider admission to partic-
23 ipate in a network, including reimbursement rates; methods for deter-
24 mining usual, customary, and reasonable charges; fail-first or step
25 therapy protocols; exclusions based on failure to complete a course of
26 treatment; and restrictions based on geographic location, facility type,
27 provider specialty, and other criteria that limit the scope or duration
28 of benefits for services provided under the policy.

29 (K) An insurer shall provide coverage under this paragraph, at a mini-
30 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
31 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

32 § 5. Paragraph 30 of subsection (i) of section 3216 of the insurance
33 law, as amended by section 1 of part B of chapter 71 of the laws of
34 2016, is amended to read as follows:

35 (30)(A) Every policy that provides hospital, major medical or similar
36 comprehensive coverage ~~[must]~~ shall provide inpatient coverage for the
37 diagnosis and treatment of substance use disorder, including detoxifica-
38 tion and rehabilitation services. Such inpatient coverage shall include
39 unlimited medically necessary treatment for substance use disorder
40 treatment services provided in residential settings ~~[as required by the~~
41 ~~Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §~~
42 ~~1185a)]~~. Further, such inpatient coverage shall not apply financial
43 requirements or treatment limitations, including utilization review
44 requirements, to inpatient substance use disorder benefits that are more
45 restrictive than the predominant financial requirements and treatment
46 limitations applied to substantially all medical and surgical benefits
47 covered by the policy. ~~[Further, such coverage shall be provided~~
48 ~~consistent with the federal Paul Wellstone and Pete Domenici Mental~~
49 ~~Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]~~

50 (B) Coverage provided under this paragraph may be limited to facili-
51 ties in New York state ~~[which are certified]~~ that are licensed, certi-
52 fied or otherwise authorized by the office of alcoholism and substance
53 abuse services and, in other states, to those which are accredited by
54 the joint commission as alcoholism, substance abuse, or chemical depend-
55 ence treatment programs and are similarly licensed, certified or other-
56 wise authorized in the state in which the facility is located.

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

(D) 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-eight 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 at or just prior to the fourteenth day of treatment 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. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined 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. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. 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-eight days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial ~~[fourteen]~~ twenty-eight 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

1 is experimental or investigational; formulary design for prescription
2 drugs; network tier design; standards for provider admission to partic-
3 ipate in a network, including reimbursement rates; methods for determin-
4 ing usual, customary, and reasonable charges; fail-first or step therapy
5 protocols; exclusions based on failure to complete a course of treat-
6 ment; and restrictions based on geographic location, facility type,
7 provider specialty, and other criteria that limit the scope or duration
8 of benefits for services provided under the policy; and

9 (iv) "substance use disorder" shall have the meaning set forth in the
10 most recent edition of the diagnostic and statistical manual of mental
11 disorders or the most recent edition of another generally recognized
12 independent standard of current medical practice, such as the interna-
13 tional classification of diseases.

14 (G) An insurer shall provide coverage under this paragraph, at a mini-
15 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
16 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

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

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

32 (B) Coverage under this paragraph may be limited to facilities in New
33 York state ~~[certified]~~ that are licensed, certified or otherwise author-
34 ized by the office of alcoholism and substance abuse services ~~[or~~
35 ~~licensed by such office as outpatient clinics or medically supervised~~
36 ~~ambulatory]~~ to provide outpatient substance ~~[abuse programs]~~ use disor-
37 der services and, in other states, to those which are accredited by the
38 joint commission as alcoholism or chemical dependence substance abuse
39 treatment programs and are similarly licensed, certified, or otherwise
40 authorized in the state in which the facility is located.

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

45 (D) A policy providing coverage for substance use disorder services
46 pursuant to this paragraph shall provide up to twenty outpatient visits
47 per policy or calendar year to an individual who identifies him or
48 herself as a family member of a person suffering from substance use
49 disorder and who seeks treatment as a family member who is otherwise
50 covered by the applicable policy pursuant to this paragraph. The cover-
51 age required by this paragraph shall include treatment as a family
52 member pursuant to such family member's own policy provided such family
53 member:

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

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

3 (E) This subparagraph shall apply to facilities in this state that are
4 licensed, certified or otherwise authorized by the office of alcoholism
5 and substance abuse services for the provision of outpatient, intensive
6 outpatient, outpatient rehabilitation and opioid treatment that are
7 participating in the insurer's provider network. Coverage provided under
8 this paragraph shall not be subject to preauthorization. Coverage
9 provided under this paragraph shall not be subject to concurrent review
10 for the first [~~two~~] four weeks of continuous treatment, not to exceed
11 [~~fourteen~~] twenty-eight visits, provided the facility notifies the
12 insurer of both the start of treatment and the initial treatment plan
13 within [~~forty-eight hours~~] two business days. The facility shall perform
14 clinical assessment of the patient at each visit, including [~~the~~] peri-
15 odic consultation with the insurer at or just prior to the fourteenth
16 day of treatment to ensure that the facility is using the evidence-based
17 and peer reviewed clinical review tool utilized by the insurer which is
18 designated by the office of alcoholism and substance abuse services and
19 appropriate to the age of the patient, to ensure that the outpatient
20 treatment is medically necessary for the patient. Any utilization review
21 of the treatment provided under this subparagraph may include a review
22 of all services provided during such outpatient treatment, including all
23 services provided during the first [~~two~~] four weeks of continuous treat-
24 ment, not to exceed [~~fourteen~~] twenty-eight visits, of such outpatient
25 treatment. Provided, however, the insurer shall only deny coverage for
26 any portion of the initial [~~two~~] four weeks of continuous treatment, not
27 to exceed [~~fourteen~~] twenty-eight visits, for outpatient treatment on
28 the basis that such treatment was not medically necessary if such outpa-
29 tient treatment was contrary to the evidence-based and peer reviewed
30 clinical review tool utilized by the insurer which is designated by the
31 office of alcoholism and substance abuse services. An insured shall not
32 have any financial obligation to the facility for any treatment under
33 this subparagraph other than any copayment, coinsurance, or deductible
34 otherwise required under the policy.

35 (F) The criteria for medical necessity determinations under the policy
36 with respect to outpatient substance use disorder benefits shall be made
37 available by the insurer to any insured, prospective insured, or in-net-
38 work provider upon request.

39 (G) For purposes of this paragraph:

40 (i) "financial requirement" means deductible, copayments, coinsurance
41 and out-of-pocket expenses;

42 (ii) "predominant" means that a financial requirement or treatment
43 limitation is the most common or frequent of such type of limit or
44 requirement;

45 (iii) "treatment limitation" means limits on the frequency of treat-
46 ment, number of visits, days of coverage, or other similar limits on the
47 scope or duration of treatment and includes nonquantitative treatment
48 limitations such as: medical management standards limiting or excluding
49 benefits based on medical necessity, or based on whether the treatment
50 is experimental or investigational; formulary design for prescription
51 drugs; network tier design; standards for provider admission to partic-
52 ipate in a network, including reimbursement rates; methods for determin-
53 ing usual, customary, and reasonable charges; fail-first or step therapy
54 protocols; exclusions based on failure to complete a course of treat-
55 ment; and restrictions based on geographic location, facility type,

1 provider specialty, and other criteria that limit the scope or duration
2 of benefits for services provided under the policy; and

3 (iv) "substance use disorder" shall have the meaning set forth in the
4 most recent edition of the diagnostic and statistical manual of mental
5 disorders or the most recent edition of another generally recognized
6 independent standard of current medical practice such as the interna-
7 tional classification of diseases.

8 (H) An insurer shall provide coverage under this paragraph, at a mini-
9 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
10 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

11 § 7. Paragraph 31-a of subsection (i) of section 3216 of the insurance
12 law, as added by section 1 of part B of chapter 69 of the laws of 2016,
13 is amended to read as follows:

14 (31-a) [~~(A)~~] Every policy that provides medical, major medical or
15 similar comprehensive-type coverage and provides coverage for
16 prescription drugs for medication for the treatment of a substance use
17 disorder shall include immediate access, without prior authorization, to
18 [~~a five day emergency supply~~] the formulary forms of prescribed medica-
19 tions covered under the policy for the treatment of substance use disorder
20 [~~where an emergency condition exists~~], including a prescribed drug
21 or medication associated with the management of opioid withdrawal and/or
22 stabilization, except where otherwise prohibited by law. Further, cover-
23 age [~~of an emergency supply~~] without prior authorization shall include
24 formulary forms of medication for opioid overdose reversal otherwise
25 covered under the policy prescribed or dispensed to an individual
26 covered by the policy.

27 [~~(B) For purposes of this paragraph, an "emergency condition" means a~~
28 ~~substance use disorder condition that manifests itself by acute symptoms~~
29 ~~of sufficient severity, including severe pain or the expectation of~~
30 ~~severe pain, such that a prudent layperson, possessing an average know-~~
31 ~~ledge of medicine and health, could reasonably expect the absence of~~
32 ~~immediate medical attention to result in:~~

33 ~~(i) placing the health of the person afflicted with such condition in~~
34 ~~serious jeopardy, or in the case of a behavioral condition, placing the~~
35 ~~health of such person or others in serious jeopardy;~~

36 ~~(ii) serious impairment to such person's bodily functions;~~

37 ~~(iii) serious dysfunction of any bodily organ or part of such person;~~

38 ~~(iv) serious disfigurement of such person; or~~

39 ~~(v) a condition described in clause (i), (ii), or (iii) of section~~
40 ~~1867(e)(1)(A) of the Social Security Act.~~

41 ~~(C) Coverage provided under this paragraph may be subject to copay-~~
42 ~~ments, coinsurance, and annual deductibles that are consistent with~~
43 ~~those imposed on other benefits within the policy; provided, however, no~~
44 ~~policy shall impose an additional copayment or coinsurance on an insured~~
45 ~~who received an emergency supply of medication and then received up to a~~
46 ~~thirty day supply of the same medication in the same thirty day period~~
47 ~~in which the emergency supply of medication was dispensed. This subpara-~~
48 ~~graph shall not preclude the imposition of a copayment or coinsurance on~~
49 ~~the initial emergency supply of medication in an amount that is less~~
50 ~~than the copayment or coinsurance otherwise applicable to a thirty day~~
51 ~~supply of such medication, provided that the total sum of the copayments~~
52 ~~or coinsurance for an entire thirty day supply of the medication does~~
53 ~~not exceed the copayment or coinsurance otherwise applicable to a thirty~~
54 ~~day supply of such medication.]~~

55 § 8. Subsection (i) of section 3216 of the insurance law is amended by
56 adding a new paragraph 35 to read as follows:

1 (35) (A) Every policy delivered or issued for delivery in this state
2 that provides coverage for inpatient hospital care or coverage for
3 physician services shall provide coverage for the diagnosis and treat-
4 ment of mental health conditions as follows:

5 (i) where the policy provides coverage for inpatient hospital care,
6 benefits for inpatient care in a hospital as defined by subdivision ten
7 of section 1.03 of the mental hygiene law and benefits for outpatient
8 care provided in a facility issued an operating certificate by the
9 commissioner of mental health pursuant to the provisions of article
10 thirty-one of the mental hygiene law, or in a facility operated by the
11 office of mental health, or, for care provided in other states, to simi-
12 larly licensed or certified hospitals or facilities; and

13 (ii) where the policy provides coverage for physician services, bene-
14 fits for outpatient care provided by a psychiatrist or psychologist
15 licensed to practice in this state, a licensed clinical social worker
16 who meets the requirements of subparagraph (D) of paragraph four of
17 subsection (1) of section three thousand two hundred twenty-one of this
18 article, a nurse practitioner licensed to practice in this state, or a
19 professional corporation or university faculty practice corporation
20 thereof.

21 (B) Coverage required by this paragraph may be subject to annual
22 deductibles, copayments and coinsurance as may be deemed appropriate by
23 the superintendent and shall be consistent with those imposed on other
24 benefits under the policy.

25 (C) Coverage under this paragraph shall not apply financial require-
26 ments or treatment limitations to mental health benefits that are more
27 restrictive than the predominant financial requirements and treatment
28 limitations applied to substantially all medical and surgical benefits
29 covered by the policy.

30 (D) The criteria for medical necessity determinations under the policy
31 with respect to mental health benefits shall be made available by the
32 insurer to any insured, prospective insured, or in-network provider upon
33 request.

34 (E) For purposes of this paragraph:

35 (i) "financial requirement" means deductible, copayments, coinsurance
36 and out-of-pocket expenses;

37 (ii) "predominant" means that a financial requirement or treatment
38 limitation is the most common or frequent of such type of limit or
39 requirement;

40 (iii) "treatment limitation" means limits on the frequency of treat-
41 ment, number of visits, days of coverage, or other similar limits on the
42 scope or duration of treatment and includes nonquantitative treatment
43 limitations such as: medical management standards limiting or excluding
44 benefits based on medical necessity, or based on whether the treatment
45 is experimental or investigational; formulary design for prescription
46 drugs; network tier design; standards for provider admission to partic-
47 ipate in a network, including reimbursement rates; methods for determin-
48 ing usual, customary, and reasonable charges; fail-first or step therapy
49 protocols; exclusions based on failure to complete a course of treat-
50 ment; and restrictions based on geographic location, facility type,
51 provider specialty, and other criteria that limit the scope or duration
52 of benefits for services provided under the policy; and

53 (iv) "mental health condition" means any mental health disorder as
54 defined in the most recent edition of the diagnostic and statistical
55 manual of mental disorders or the most recent edition of another gener-

1 ally recognized independent standard of current medical practice such as
2 the international classification of diseases.

3 (F) An insurer shall provide coverage under this paragraph, at a mini-
4 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
5 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

6 (G) This subparagraph shall apply to hospitals in this state that are
7 licensed by the office of mental health that are participating in the
8 insurer's provider network. Where the policy provides coverage for inpa-
9 tient hospital care, benefits for inpatient hospital care in a hospital
10 as defined by subdivision ten of section 1.03 of the mental hygiene law
11 provided to individuals who have not attained the age of eighteen shall
12 not be subject to preauthorization. Coverage provided under this subpar-
13 agraph shall also not be subject to concurrent utilization review during
14 the first fourteen days of the inpatient admission, provided the facili-
15 ty notifies the insurer of both the admission and the initial treatment
16 plan within two business days of the admission, performs daily clinical
17 review of the patient, and participates in periodic consultation with
18 the insurer to ensure that the facility is using the evidence-based and
19 peer reviewed clinical review criteria utilized by the insurer which is
20 approved by the office of mental health and appropriate to the age of
21 the patient, to ensure that the inpatient care is medically necessary
22 for the patient. All treatment provided under this subparagraph may be
23 reviewed retrospectively. Where care is denied retrospectively, an
24 insured shall not have any financial obligation to the facility for any
25 treatment under this subparagraph other than any copayment, coinsurance,
26 or deductible otherwise required under the policy.

27 § 9. Paragraphs 17, 19 and 20 of subsection 2 of section 3217-a of the
28 insurance law, paragraph 17 as amended and paragraphs 19 and 20 as added
29 by section 1 of part H of chapter 60 of the laws of 2014, are amended
30 and a new paragraph 21 is added to read as follows:

31 (17) where applicable, a listing by specialty, which may be in a sepa-
32 rate document that is updated annually, of the name, address, and tele-
33 phone number of all participating providers, including facilities, and:
34 (A) whether the provider is accepting new patients; (B) in the case of
35 mental health or substance use disorder services providers, any affil-
36 iations with participating facilities certified or authorized by the
37 office of mental health or the office of alcoholism and substance abuse
38 services, and any restrictions regarding the availability of the indi-
39 vidual provider's services; and [~~in addition,~~] (C) in the case of physi-
40 cians, board certification, languages spoken and any affiliations with
41 participating hospitals. The listing shall also be posted on the insur-
42 er's website and the insurer shall update the website within fifteen
43 days of the addition or termination of a provider from the insurer's
44 network or a change in a physician's hospital affiliation;

45 (19) with respect to out-of-network coverage:

46 (A) a clear description of the methodology used by the insurer to
47 determine reimbursement for out-of-network health care services;

48 (B) the amount that the insurer will reimburse under the methodology
49 for out-of-network health care services set forth as a percentage of the
50 usual and customary cost for out-of-network 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 (20) information in writing and through an internet website that
54 reasonably permits an insured or prospective insured to estimate the
55 anticipated out-of-pocket cost for out-of-network health care services
56 in a geographical area or zip code based upon the difference between

1 what the insurer will reimburse for out-of-network health care services
2 and the usual and customary cost for out-of-network health care
3 services[~~+~~]; and

4 (21) the most recent comparative analysis performed by the insurer to
5 assess the provision of its covered services in accordance with the Paul
6 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
7 Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal
8 guidance or regulations issued under those acts.

9 § 10. Subsection (b) of section 3217-b of the insurance law, as added
10 by chapter 705 of the laws of 1996, is amended to read as follows:

11 (b) No insurer subject to this article shall by contract, written
12 policy [~~ex~~], written procedure or practice prohibit or restrict any
13 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 insurer which the provider believes may negatively
16 impact upon the quality of, or access to, patient care. Nor shall an
17 insurer subject to this article take any adverse action, including but
18 not limited to refusing to renew or execute a contract or agreement with
19 a health care provider as retaliation against a health care provider for
20 filing a complaint, making a report or commenting to an appropriate
21 governmental body regarding policies or practices of such insurer which
22 may violate this chapter including paragraphs thirty, as added by chap-
23 ter forty-one of the laws of 2014, thirty-one, thirty-one-a and thirty-
24 five of subsection (i) of section thirty-two hundred sixteen and para-
25 graphs five, six, seven, seven-a and seven-b of subsection (l) of
26 section thirty-two hundred twenty-one of this article.

27 § 11. Subparagraph (A) of paragraph 4 of subsection (1) of section
28 3221 of the insurance law, as amended by chapter 230 of the laws of
29 2004, is amended to read as follows:

30 (A) Every insurer delivering a group policy or issuing a group policy
31 for delivery, in this state, [~~which~~] that provides reimbursement for
32 psychiatric or psychological services or for the diagnosis and treatment
33 of mental[~~-, nervous or emotional disorders and ailments~~] health condi-
34 tions, however defined in such policy, by physicians, psychiatrists or
35 psychologists, [~~must~~] shall make available and if requested by the poli-
36 cyholder provide the same coverage to insureds for such services when
37 performed by a licensed clinical social worker, within the lawful scope
38 of his or her practice, who is licensed pursuant to article one hundred
39 fifty-four of the education law. Written notice of the availability of
40 such coverage shall be delivered to the policyholder prior to inception
41 of such group policy and annually thereafter, except that this notice
42 shall not be required where a policy covers two hundred or more employ-
43 ees or where the benefit structure was the subject of collective
44 bargaining affecting persons who are employed in more than one state.

45 § 12. Subparagraph (D) of paragraph 4 of subsection (1) of section
46 3221 of the insurance law, as amended by section 50 of part D of chapter
47 56 of the laws of 2013, is amended to read as follows:

48 (D) In addition to the requirements of subparagraph (A) of this para-
49 graph, every insurer issuing a group policy for delivery in this state
50 where the policy provides reimbursement to insureds for psychiatric or
51 psychological services or for the diagnosis and treatment of mental[~~+~~
52 ~~nervous or emotional disorders and ailments~~] health conditions, however
53 defined in such policy, by physicians, psychiatrists or psychologists,
54 shall provide the same coverage to insureds for such services when
55 performed by a licensed clinical social worker, within the lawful scope
56 of his or her practice, who is licensed pursuant to subdivision two of

1 section seven thousand seven hundred four of the education law and in
2 addition shall have either: (i) three or more additional years experi-
3 ence in psychotherapy, which for the purposes of this subparagraph shall
4 mean the use of verbal methods in interpersonal relationships with the
5 intent of assisting a person or persons to modify attitudes and behavior
6 that are intellectually, socially or emotionally maladaptive, under
7 supervision, satisfactory to the state board for social work, in a
8 facility, licensed or incorporated by an appropriate governmental
9 department, providing services for diagnosis or treatment of mental[
10 ~~nervous or emotional disorders or ailments~~] health conditions; (ii)
11 three or more additional years experience in psychotherapy under the
12 supervision, satisfactory to the state board for social work, of a
13 psychiatrist, a licensed and registered psychologist or a licensed clin-
14 ical social worker qualified for reimbursement pursuant to subsection
15 (e) of this section, or (iii) a combination of the experience specified
16 in items (i) and (ii) of this subparagraph totaling three years, satis-
17 factory to the state board for social work.

18 § 13. Subparagraphs (A) and (B) of paragraph 5 of subsection (1) of
19 section 3221 of the insurance law, as amended by chapter 502 of the laws
20 of 2007, are amended to read as follows:

21 (A) Every insurer delivering a group or school blanket policy or issu-
22 ing a group or school blanket policy for delivery, in this state, which
23 provides coverage for inpatient hospital care or coverage for physician
24 services shall provide [~~as part of such policy broad-based~~] coverage for
25 the diagnosis and treatment of mental[~~, nervous or emotional disorders~~
26 ~~or ailments, however defined in such policy, at least equal to the~~
27 ~~coverage provided for other~~] health conditions and:

28 (i) where the policy provides coverage for inpatient hospital care,
29 benefits for inpatient care in a hospital as defined by subdivision ten
30 of section 1.03 of the mental hygiene law[~~, which benefits may be limit-~~
31 ~~ed to not less than thirty days of active treatment in any contract~~
32 ~~year, plan year or calendar year,~~] and benefits for outpatient care
33 provided in a facility issued an operating certificate by the commis-
34 sioner of mental health pursuant to the provisions of article thirty-one
35 of the mental hygiene law, or in a facility operated by the office of
36 mental health[~~, which benefits may be limited to not less than twenty~~
37 ~~visits in any contract year, plan year or calendar year. Benefits for~~
38 ~~partial hospitalization program services shall be provided as an offset~~
39 ~~to covered inpatient days at a ratio of two partial hospitalization~~
40 ~~visits to one inpatient day of treatment.] or, for care provided in~~
41 other states, to similarly licensed or certified hospitals or facili-
42 ties; and

43 (ii) where the policy provides coverage for physician services, it
44 shall include benefits for outpatient care provided by a psychiatrist or
45 psychologist licensed to practice in this state, a licensed clinical
46 social worker who meets the requirements of subparagraph (D) of para-
47 graph four of this subsection, a nurse practitioner licensed to practice
48 in this state, or a professional corporation or university faculty prac-
49 tice corporation thereof. [~~Such benefits may be limited to not less than~~
50 ~~twenty visits in any contract year, plan year, or calendar year.]~~

51 [~~(iii)~~] (B) Coverage required by this paragraph may be [~~provided on a~~
52 ~~contract year, plan year or calendar year basis and shall be consistent~~
53 ~~with the provision of other benefits under the policy. Such coverage may~~
54 ~~be~~] subject to annual deductibles, co-pays and coinsurance as may be
55 deemed appropriate by the superintendent and shall be consistent with
56 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, exclusions, 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

1 limitations such as: medical management standards limiting or excluding
2 benefits based on medical necessity, or based on whether the treatment
3 is experimental or investigational; formulary design for prescription
4 drugs; network tier design; standards for provider admission to partic-
5 ipate in a network, including reimbursement rates; methods for determin-
6 ing usual, customary, and reasonable charges; fail-first or step therapy
7 protocols; exclusions based on failure to complete a course of treat-
8 ment; and restrictions based on geographic location, facility type,
9 provider specialty, and other criteria that limit the scope or duration
10 of benefits for services provided under the policy; and

11 (iv) "mental health condition" means any mental health disorder as
12 defined in the most recent edition of the diagnostic and statistical
13 manual of mental disorders or the most recent edition of another gener-
14 ally recognized independent standard of current medical practice such as
15 the international classification of diseases.

16 (F) An insurer shall provide coverage under this paragraph, at a mini-
17 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
18 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

19 (G) This subparagraph shall apply to hospitals in this state that are
20 licensed by the office of mental health that are participating in the
21 insurer's provider network. Where the policy provides coverage for inpa-
22 tient hospital care, benefits for inpatient hospital care in a hospital
23 as defined by subdivision ten of section 1.03 of the mental hygiene law
24 provided to individuals who have not attained the age of eighteen shall
25 not be subject to preauthorization. Coverage provided under this subpar-
26 agraph shall also not be subject to concurrent utilization review during
27 the first fourteen days of the inpatient admission, provided the facili-
28 ty notifies the insurer of both the admission and the initial treatment
29 plan within two business days of the admission, performs daily clinical
30 review of the patient, and participates in periodic consultation with
31 the insurer to ensure that the facility is using the evidence-based and
32 peer reviewed clinical review criteria utilized by the insurer which is
33 approved by the office of mental health and appropriate to the age of
34 the patient, to ensure that the inpatient care is medically necessary
35 for the patient. All treatment provided under this subparagraph may be
36 reviewed retrospectively. Where care is denied retrospectively, an
37 insured shall not have any financial obligation to the facility for any
38 treatment under this subparagraph other than any copayment, coinsurance,
39 or deductible otherwise required under the policy.

40 § 15. Subparagraphs (A), (B) and (D) of paragraph 6 of subsection (1)
41 of section 3221 of the insurance law, as amended by section 2 of part B
42 of chapter 71 of the laws of 2016, are amended and three new subpara-
43 graphs (E), (F) and (G) are added to read as follows:

44 (A) Every policy that provides hospital, major medical or similar
45 comprehensive coverage [~~must~~] **shall** provide inpatient coverage for the
46 diagnosis and treatment of substance use disorder, including detoxifica-
47 tion and rehabilitation services. Such inpatient coverage shall include
48 unlimited medically necessary treatment for substance use disorder
49 treatment services provided in residential settings [~~as required by the~~
50 ~~Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §~~
51 ~~1185a)~~]. Further, such inpatient coverage shall not apply financial
52 requirements or treatment limitations, including utilization review
53 requirements, to inpatient substance use disorder benefits that are more
54 restrictive than the predominant financial requirements and treatment
55 limitations applied to substantially all medical and surgical benefits
56 covered by the policy. [~~Further, such coverage shall be provided~~

~~consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).~~]

(B) Coverage provided under this paragraph may be limited to facilities in New York state [~~which are certified~~] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse or chemical dependence treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

(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-eight 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 at or just prior to the fourteenth day of treatment 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. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined 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. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. 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-eight days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [~~fourteen~~] twenty-eight 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) The criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(F) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(G) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 16. Subparagraphs (A) and (B) of paragraph 7 of subsection (1) of section 3221 of the insurance law, as amended by chapter 41 of the laws of 2014, are amended and a new subparagraph (C-1) is added to read as follows:

(A) Every policy that provides medical, major medical or similar comprehensive-type coverage ~~[must]~~ shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. ~~[Further,~~

~~such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]~~

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

(C-1) A large group policy that provides coverage under this paragraph shall not impose copayments or coinsurance for outpatient substance use disorder services that exceeds the copayment or coinsurance imposed for a primary care office visit. Provided that no greater than one such copayment may be imposed for all services provided in a single day by a facility licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services to provide outpatient substance use disorder services.

§ 17. Subparagraph (E) of paragraph 7 of subsection (1) of section 3221 of the insurance law, as added by section 4 of part MM of chapter

57 of the laws of 2018, is amended and three new subparagraphs (F), (G) and (H) are added to read as follows:

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first ~~[two]~~ four weeks of continuous treatment, not to exceed ~~[fourteen]~~ twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within ~~[forty-eight hours]~~ two business days. The facility shall perform clinical assessment of the patient at each visit, including ~~[the]~~ periodic consultation with the insurer at or just prior to the fourteenth day of treatment 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 outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first ~~[two]~~ four weeks of continuous treatment, not to exceed ~~[fourteen]~~ twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial ~~[two]~~ four weeks of continuous treatment, not to exceed ~~[fourteen]~~ twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient 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.

(F) The criteria for medical necessity determinations under the policy with respect to outpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(G) 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,

1 provider specialty, and other criteria that limit the scope or duration
2 of benefits for services provided under the policy; and

3 (iv) "substance use disorder" shall have the meaning set forth in the
4 most recent edition of the diagnostic and statistical manual of mental
5 disorders or the most recent edition of another generally recognized
6 independent standard of current medical practice such as the interna-
7 tional classification of diseases.

8 (H) An insurer shall provide coverage under this paragraph, at a mini-
9 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental
10 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

11 § 18. Paragraph 7-b of subsection (1) of section 3221 of the insurance
12 law, as added by section 2 of part B of chapter 69 of the laws of 2016,
13 is amended to read as follows:

14 (7-b) ~~[(A)]~~ Every policy that provides medical, major medical or simi-
15 lar comprehensive-type coverage and provides coverage for prescription
16 drugs for medication for the treatment of a substance use disorder shall
17 include immediate access, without prior authorization, ~~[to a five-day~~
18 ~~emergency supply]~~ to the formulary forms of prescribed medications
19 covered under the policy for the treatment of substance use disorder
20 ~~[where an emergency condition exists]~~, including a prescribed drug or
21 medication associated with the management of opioid withdrawal and/or
22 stabilization, except where otherwise prohibited by law. Further, cover-
23 age ~~[of an emergency supply]~~ without prior authorization shall include
24 formulary forms medication for opioid overdose reversal otherwise
25 covered under the policy prescribed or dispensed to an individual
26 covered by the policy.

27 ~~[(B) For purposes of this paragraph, an "emergency condition" means a~~
28 ~~substance use disorder condition that manifests itself by acute symptoms~~
29 ~~of sufficient severity, including severe pain or the expectation of~~
30 ~~severe pain, such that a prudent layperson, possessing an average know-~~
31 ~~ledge of medicine and health, could reasonably expect the absence of~~
32 ~~immediate medical attention to result in:~~

33 ~~(i) placing the health of the person afflicted with such condition in~~
34 ~~serious jeopardy, or in the case of a behavioral condition, placing the~~
35 ~~health of such person or others in serious jeopardy;~~

36 ~~(ii) serious impairment to such person's bodily functions;~~

37 ~~(iii) serious dysfunction of any bodily organ or part of such person;~~

38 ~~(iv) serious disfigurement of such person; or~~

39 ~~(v) a condition described in clause (i), (ii), or (iii) of section~~
40 ~~1867(e)(1)(A) of the Social Security Act.~~

41 ~~(C) Coverage provided under this paragraph may be subject to copay-~~
42 ~~ments, coinsurance, and annual deductibles that are consistent with~~
43 ~~those imposed on other benefits within the policy; provided, however, no~~
44 ~~policy shall impose an additional copayment or coinsurance on an insured~~
45 ~~who received an emergency supply of medication and then received up to a~~
46 ~~thirty day supply of the same medication in the same thirty day period~~
47 ~~in which the emergency supply of medication was dispensed. This subpara-~~
48 ~~graph shall not preclude the imposition of a copayment or coinsurance on~~
49 ~~the initial emergency supply of medication in an amount that is less~~
50 ~~than the copayment or coinsurance otherwise applicable to a thirty day~~
51 ~~supply of such medication, provided that the total sum of the copayments~~
52 ~~or coinsurance for an entire thirty day supply of the medication does~~
53 ~~not exceed the copayment or coinsurance otherwise applicable to a thirty~~
54 ~~day supply of such medication.]~~

§ 19. Subparagraph (B) of paragraph 17 of subsection (1) of section 3221 of the insurance law, as amended by section 39 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(B) Every group or blanket policy 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 policy 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 group or blanket policy. ~~[Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per policy 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 group or blanket policy, provided however that such policy 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 ~~[r]~~ case management~~[r]~~ 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.

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
13 the scope or duration of treatment and includes nonquantitative treat-
14 ment limitations such as: medical management standards limiting or
15 excluding benefits based on medical necessity, or based on whether the
16 treatment is experimental or investigational; formulary design for
17 prescription drugs; network tier design; standards for provider admis-
18 sion to participate in a network, including reimbursement rates; methods
19 for determining usual, customary, and reasonable charges; fail-first or
20 step therapy protocols; exclusions based on failure to complete a course
21 of treatment; and restrictions based on geographic location, facility
22 type, provider specialty, and other criteria that limit the scope or
23 duration 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 § 22. Paragraphs 1, 2, and 3 of subsection (g) of section 4303 of the
28 insurance law, as amended by chapter 502 of the laws of 2007, are
29 amended to read as follows:

30 ~~[(1)]~~ A medical expense indemnity corporation, hospital service corpo-
31 ration or a health service corporation, ~~[which]~~ that provides group,
32 group remittance or school blanket coverage for inpatient hospital
33 care~~[,~~ or coverage for physician services shall provide as part of its
34 contract ~~[broad-based]~~ coverage for the diagnosis and treatment of
35 mental~~[, nervous or emotional disorders or ailments, however defined in~~
36 ~~such contract, at least equal to the coverage provided for other]~~ health
37 conditions and ~~[shall include]~~:

38 ~~[(A)]~~

39 (1) where the contract provides coverage for inpatient hospital care,
40 benefits for in-patient care in a hospital as defined by subdivision ten
41 of section 1.03 of the mental hygiene law~~[, which benefits may be limit-~~
42 ~~ed to not less than thirty days of active treatment in any contract~~
43 ~~year, plan year or calendar year.~~

44 ~~(B)]~~ or for inpatient care provided in other states, to similarly
45 licensed hospitals, and benefits for out-patient care provided in a
46 facility issued an operating certificate by the commissioner of mental
47 health pursuant to the provisions of article thirty-one of the mental
48 hygiene law or in a facility operated by the office of mental health~~[,~~
49 ~~which benefits may be limited to not less than twenty visits in any~~
50 ~~contract year, plan year or calendar year. Benefits for partial hospi-~~
51 ~~talization program services shall be provided as an offset to covered~~
52 ~~inpatient days at a ratio of two partial hospitalization visits to one~~
53 ~~inpatient day of treatment.~~

54 ~~(C) Such coverage may be provided on a contract year, plan year or~~
55 ~~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 (D) 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 subsection 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 subsection, 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 paragraph 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 utiliza-

tion 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 paragraph 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 paragraph 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, provide the same coverage 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. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection. Such coverage shall be made available at the inception of all new contracts and, with respect to all other contracts, at any anniversary date subject to evidence of insurability. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract and annually thereafter, except that this notice shall not be required where a ~~[policy]~~ contract 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.

§ 26. Subsection (k) of section 4303 of the insurance law, as amended by section 3 of part B of chapter 71 of the laws of 2016, is amended to read as follows:

(k)(1) Every contract that provides hospital, major medical or similar comprehensive coverage ~~[must]~~ shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings ~~[as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a)]~~. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract. ~~[Further, such coverage shall be provided~~

~~consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).~~]

(2) Coverage provided under this subsection may be limited to facilities in New York state [~~which are certified~~] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse, or chemical dependence treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given contract.

(4) This paragraph shall apply to facilities in this state [~~certified~~] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall also not be subject to concurrent utilization review during the first [~~fourteen~~] twenty-eight days of the inpatient admission provided that the facility notifies the corporation 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 corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation 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. Prior to discharge, the facility shall provide the patient and the corporation with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the corporation whether services included in the discharge plan are secured or determined to be reasonably available. Any utilization review of treatment provided under this paragraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [~~fourteen~~] twenty-eight days of such inpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial [~~fourteen~~] twenty-eight 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 corporation 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 paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(5) The criteria for medical necessity determinations under the contract with respect to inpatient substance use disorder 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:

1 (A) "financial requirement" means deductible, copayments, coinsurance
2 and out-of-pocket expenses;

3 (B) "predominant" means that a financial requirement or treatment
4 limitation is the most common or frequent of such type of limit or
5 requirement;

6 (C) "treatment limitation" means limits on the frequency of treatment,
7 number of visits, days of coverage, or other similar limits on the
8 scope or duration of treatment and includes nonquantitative treatment
9 limitations such as: medical management standards limiting or excluding
10 benefits based on medical necessity, or based on whether the treatment
11 is experimental or investigational; formulary design for prescription
12 drugs; network tier design; standards for provider admission to partic-
13 ipate in a network, including reimbursement rates; methods for deter-
14 mining usual, customary, and reasonable charges; fail-first or step
15 therapy protocols; exclusions based on failure to complete a course of
16 treatment; and restrictions based on geographic location, facility type,
17 provider specialty, and other criteria that limit the scope or duration
18 of benefits for services provided under the contract; and

19 (D) "substance use disorder" shall have the meaning set forth in the
20 most recent edition of the diagnostic and statistical manual of mental
21 disorders or the most recent edition of another generally recognized
22 independent standard of current medical practice such as the interna-
23 tional classification of diseases.

24 (7) A corporation shall provide coverage under this subsection, at a
25 minimum, consistent with the federal Paul Wellstone and Pete Domenici
26 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
27 1185a).

28 § 27. Paragraphs 1 and 2 of subsection (1) of section 4303 of the
29 insurance law, as amended by chapter 41 of the laws of 2014, are amended
30 and a new paragraph 3-a is added to read as follows:

31 (1) Every contract that provides medical, major medical or similar
32 comprehensive-type coverage ~~[must]~~ shall provide outpatient coverage for
33 the diagnosis and treatment of substance use disorder, including detoxi-
34 fication and rehabilitation services. Such coverage shall not apply
35 financial requirements or treatment limitations to outpatient substance
36 use disorder benefits that are more restrictive than the predominant
37 financial requirements and treatment limitations applied to substantial-
38 ly all medical and surgical benefits covered by the contract. ~~[Further,~~
39 ~~such coverage shall be provided consistent with the federal Paul Well-~~
40 ~~stone and Pete Domenici Mental Health Parity and Addiction Equity Act of~~
41 ~~2008 (29 U.S.C. § 1185a).]~~

42 (2) Coverage under this subsection may be limited to facilities in New
43 York state that are licensed, certified or otherwise authorized by the
44 office of alcoholism and substance abuse services ~~[or licensed by such~~
45 ~~office as outpatient clinics or medically supervised ambulatory]~~ to
46 provide outpatient substance [abuse programs] use disorder services and,
47 in other states, to those which are accredited by the joint commission
48 as alcoholism or chemical dependence substance abuse treatment programs
49 and are similarly licensed, certified or otherwise authorized in the
50 state in which the facility is located.

51 (3-a) A contract that provides large group coverage under this
52 subsection shall not impose copayments or coinsurance for outpatient
53 substance use disorder services that exceed the copayment or coinsurance
54 imposed for a primary care office visit. Provided that no greater than
55 one such copayment may be imposed for all services provided in a single
56 day by a facility licensed, certified or otherwise authorized by the

office of alcoholism and substance abuse services to provide outpatient substance use disorder services.

§ 28. Paragraph 5 of subsection (1) of section 4303 of the insurance law, as added by section 5 of part MM of chapter 57 of the laws of 2018, is amended and three new paragraphs 6, 7 and 8 are added to read as follows:

(5) This paragraph shall apply to facilities in this state [~~certified~~ that are licensed, certified or otherwise authorized] by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first [~~two~~ four] weeks of continuous treatment, not to exceed [~~fourteen~~ twenty-eight] visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within [~~forty-eight hours~~ two business days]. The facility shall perform clinical assessment of the patient at each visit, including [~~the~~] periodic consultation with the corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [~~two~~ four] weeks of continuous treatment, not to exceed [~~fourteen~~ twenty-eight] visits, of such outpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial [~~two~~ four] weeks of continuous treatment, not to exceed [~~fourteen~~ twenty-eight] visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. A subscriber shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(6) The criteria for medical necessity determinations under the contract with respect to outpatient substance use disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(7) 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 partic-

1 ipate in a network, including reimbursement rates; methods for determin-
2 ing usual, customary, and reasonable charges; fail-first or step therapy
3 protocols; exclusions based on failure to complete a course of treat-
4 ment; and restrictions based on geographic location, facility type,
5 provider specialty, and other criteria that limit the scope or duration
6 of benefits for services provided under the contract; and

7 (D) "substance use disorder" shall have the meaning set forth in the
8 most recent edition of the diagnostic and statistical manual of mental
9 disorders or the most recent edition of another generally recognized
10 independent standard of current medical practice such as the interna-
11 tional classification of diseases.

12 (8) A corporation shall provide coverage under this subsection, at a
13 minimum, consistent with the federal Paul Wellstone and Pete Domenici
14 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
15 1185a).

16 § 29. Subsection (1-2) of section 4303 of the insurance law, as added
17 by section 3 of part B of chapter 69 of the laws of 2016, is amended to
18 read as follows:

19 (1-2) ~~[(1)]~~ Every contract that provides medical, major medical or
20 similar comprehensive-type coverage and provides coverage for
21 prescription drugs for medication for the treatment of a substance use
22 disorder shall include immediate access, without prior authorization, to
23 ~~[a five day emergency supply]~~ the formulary forms of prescribed medica-
24 tions covered under the contract for the treatment of substance use
25 disorder ~~[where an emergency condition exists]~~, including a prescribed
26 drug or medication associated with the management of opioid withdrawal
27 and/or stabilization, except where otherwise prohibited by law. Further,
28 coverage ~~[of an emergency supply]~~ without prior authorization shall
29 include formulary forms of medication for opioid overdose reversal
30 otherwise covered under the contract prescribed or dispensed to an indi-
31 vidual covered by the contract.

32 ~~[(2) For purposes of this paragraph, an "emergency condition" means a~~
33 ~~substance use disorder condition that manifests itself by acute symptoms~~
34 ~~of sufficient severity, including severe pain or the expectation of~~
35 ~~severe pain, such that a prudent layperson, possessing an average know-~~
36 ~~ledge of medicine and health, could reasonably expect the absence of~~
37 ~~immediate medical attention to result in:~~

38 ~~(i) placing the health of the person afflicted with such condition in~~
39 ~~serious jeopardy, or in the case of a behavioral condition, placing the~~
40 ~~health of such person or others in serious jeopardy;~~

41 ~~(ii) serious impairment to such person's bodily functions;~~

42 ~~(iii) serious dysfunction of any bodily organ or part of such person;~~

43 ~~(iv) serious disfigurement of such person; or~~

44 ~~(v) a condition described in clause (i), (ii) or (iii) of section~~
45 ~~1867(e)(1)(A) of the Social Security Act.~~

46 ~~(3) Coverage provided under this subsection may be subject to copay-~~
47 ~~ments, coinsurance, and annual deductibles that are consistent with~~
48 ~~those imposed on other benefits within the contract; provided, however,~~
49 ~~no contract shall impose an additional copayment or coinsurance on an~~
50 ~~insured who received an emergency supply of medication and then received~~
51 ~~up to a thirty day supply of the same medication in the same thirty day~~
52 ~~period in which the emergency supply of medication was dispensed. This~~
53 ~~paragraph shall not preclude the imposition of a copayment or coinsu-~~
54 ~~rance on the initial limited supply of medication in an amount that is~~
55 ~~less than the copayment or coinsurance otherwise applicable to a thirty~~
56 ~~day supply of such medication, provided that the total sum of the copay-~~

~~ments 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

1 is diagnosed with autism spectrum disorder or has received treatment for
2 autism spectrum disorder. Coverage shall be subject to utilization
3 review and external appeals of health care services pursuant to article
4 forty-nine of this chapter as well as[~~7~~] case management[~~7~~] and other
5 managed care provisions.

6 § 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of
7 section 4303 of the insurance law, as amended by chapter 596 of the laws
8 of 2011, are amended to read as follows:

9 (A) "autism spectrum disorder" means any pervasive developmental
10 disorder as defined in the most recent edition of the diagnostic and
11 statistical manual of mental disorders[~~, including autistic disorder,~~
12 ~~Asperger's disorder, Rett's disorder, childhood disintegrative disorder,~~
13 ~~or pervasive developmental disorder not otherwise specified (PDD-NOS)].~~

14 (C) "behavioral health treatment" means counseling and treatment
15 programs, when provided by a licensed provider, and applied behavior
16 analysis, when provided [~~or supervised~~] by a [~~behavior analyst certified~~
17 ~~pursuant to the behavior analyst certification board~~] person that is
18 licensed, certified or otherwise authorized to provide applied behavior
19 analysis, that are necessary to develop, maintain, or restore, to the
20 maximum extent practicable, the functioning of an individual. [~~Individ-~~
21 ~~uals that provide behavioral health treatment under the supervision of a~~
22 ~~certified behavior analyst pursuant to this subsection shall be subject~~
23 ~~to standards of professionalism, supervision and relevant experience~~
24 ~~pursuant to regulations promulgated by the superintendent in consulta-~~
25 ~~tion with the commissioners of health and education.~~]

26 § 33. Subsection (ee) of section 4303 of the insurance law is amended
27 by adding four new paragraphs 8, 9, 10, and 11 to read as follows:

28 (8) Coverage under this subsection shall not apply financial require-
29 ments or treatment limitations to autism spectrum disorder benefits that
30 are more restrictive than the predominant financial requirements and
31 treatment limitations applied to substantially all medical and surgical
32 benefits covered by the policy.

33 (9) The criteria for medical necessity determinations under the
34 contract with respect to autism spectrum disorder benefits shall be made
35 available by the corporation to any insured, prospective insured, or
36 in-network provider upon request.

37 (10) For purposes of this subsection:

38 (A) "financial requirement" means deductible, copayments, coinsurance
39 and out-of-pocket expenses;

40 (B) "predominant" means that a financial requirement or treatment
41 limitation is the most common or frequent of such type of limit or
42 requirement; and

43 (C) "treatment limitation" means limits on the frequency of treatment,
44 number of visits, days of coverage, or other similar limits on the scope
45 or duration of treatment and includes nonquantitative treatment limita-
46 tions such as: medical management standards limiting or excluding bene-
47 fits based on medical necessity, or based on whether the treatment is
48 experimental or investigational; formulary design for prescription
49 drugs; network tier design; standards for provider admission to partic-
50 ipate in a network, including reimbursement rates; methods for determin-
51 ing usual, customary, and reasonable charges; fail-first or step therapy
52 protocols; exclusions based on failure to complete a course of treat-
53 ment; and restrictions based on geographic location, facility type,
54 provider specialty, and other criteria that limit the scope or duration
55 of benefits for services provided under the contract.

(11) A corporation shall provide coverage under this subsection, 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).

§ 34. Paragraphs 17, 20 and 21 of subsection (a) of section 4324 of the insurance law, paragraph 17 as amended and paragraphs 20 and 21 as added by section 8 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph 22 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 in addition,~~] 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; (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

(20) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the corporation to determine reimbursement for out-of-network health care services;

(B) a description of the amount that the corporation 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~~]

(21) information in writing and through an internet website that reasonably permits a subscriber or prospective subscriber 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 corporation will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[~~;~~]; and

(22) the most recent comparative analysis performed by the corporation 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.

§ 35. Subsection (b) of section 4325 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) No corporation organized under 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 corporation which the provider believes may negatively impact upon the quality of or access to patient care. Nor shall a corporation organized under 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 corpo-

ration which may violate this chapter including subsection (g), (k), (1), (1-1) or (1-2) of section forty-three hundred three of this article.

§ 36. Subparagraph (C) of paragraph 1 of subsection (b) of section 4900 of the insurance law, as added by chapter 41 of the laws of 2014, is amended and a new subparagraph (D) is added to read as follows:

(C) for purposes of a determination involving substance use disorder treatment:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; ~~and~~ or

(D) for purposes of a determination involving treatment for a mental health condition:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

§ 37. Paragraph 9 of subsection (a) of section 4902 of the insurance law, as amended by section 1 of part A of chapter 69 of the laws of 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 ~~[ex]~~, 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 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 health care plan which may violate this chapter or the insurance law including subsection (g), (k), (l), (l-1) or (l-2) of section forty-three hundred three of the insurance law.

§ 41. Paragraphs (r), (t) and (u) of subdivision 1 of section 4408 of the public health law, paragraph (r) as amended and paragraphs (t) and (u) as added by section 18 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph (v) is added to read as follows:

(r) 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, in addition,]~~ and: (i) whether the provider is accepting new patients; (ii) 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 (iii) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance

1 organization's website and the health maintenance organization shall
2 update the website within fifteen days of the addition or termination of
3 a provider from the health maintenance organization's network or a
4 change in a physician's hospital affiliation;

5 (t) with respect to out-of-network coverage:

6 (i) a clear description of the methodology used by the health mainte-
7 nance organization to determine reimbursement for out-of-network health
8 care services;

9 (ii) the amount that the health maintenance organization will reim-
10 burse under the methodology for out-of-network health care services set
11 forth as a percentage of the usual and customary cost for out-of-network
12 health care services;

13 (iii) examples of anticipated out-of-pocket costs for frequently
14 billed out-of-network health care services; ~~and~~

15 (u) information in writing and through an internet website that
16 reasonably permits an enrollee or prospective enrollee to estimate the
17 anticipated out-of-pocket cost for out-of-network health care services
18 in a geographical area or zip code based upon the difference between
19 what the health maintenance organization will reimburse for out-of-net-
20 work health care services and the usual and customary cost for out-of-
21 network health care services~~[-]; and~~

22 (v) the most recent comparative analysis performed by the health main-
23 tenance organization to assess the provision of its covered services in
24 accordance with the Paul Wellstone and Pete Dominici Mental Health Pari-
25 ty and Addiction Equity Act of 2008, 42 U.S.C. 18031(j) and any amend-
26 ments to, and federal guidance and regulations issued under, those Acts.

27 § 42. Subparagraph (iii) of paragraph (a) of subdivision 2 of section
28 4900 of the public health law, as added by chapter 41 of the laws of
29 2014, is amended and a new subparagraph (iv) is added to read as
30 follows:

31 (iii) for purposes of a determination involving substance use disorder
32 treatment:

33 (A) a physician who possesses a current and valid non-restricted
34 license to practice medicine and who specializes in behavioral health
35 and has experience in the delivery of substance use disorder courses of
36 treatment; or

37 (B) a health care professional other than a licensed physician who
38 specializes in behavioral health and has experience in the delivery of
39 substance use disorder courses of treatment and, where applicable,
40 possesses a current and valid non-restricted license, certificate or
41 registration or, where no provision for a license, certificate or regis-
42 tration exists, is credentialed by the national accrediting body appro-
43 priate to the profession; ~~and~~ or

44 (iv) for purposes of a determination involving treatment for a mental
45 health condition:

46 (A) a physician who possesses a current and valid non-restricted
47 license to practice medicine and who specializes in behavioral health
48 and has experience in the delivery of mental health courses of treat-
49 ment; or

50 (B) a health care professional other than a licensed physician who
51 specializes in behavioral health and has experience in the delivery of a
52 mental health courses of treatment and, where applicable, possesses a
53 current and valid non-restricted license, certificate, or registration
54 or, where no provision for a license, certificate or registration
55 exists, is credentialed by the national accrediting body appropriate to
56 the profession; and

§ 43. Paragraph (i) of subdivision 1 of section 4902 of the public health law, as amended by section 2 of part A of chapter 69 of the laws of 2016, is amended and a new paragraph (j) is added to read as follows:

(i) 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.

(j) 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 and the superintendent of financial services. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

§ 44. 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; provided, however, notwithstanding any provision of law to the contrary, nothing in this act shall limit the rights accruing to employees pursuant to a collective bargaining agreement with any state or local government employer for the unexpired term of such agreement where such agreement is in effect on the effective date of this act and so long as such agreement remains in effect thereafter or the eligibility of any member of an employee organization to join a health insurance plan open to him or her pursuant to such a collectively negotiated agreement.

SUBPART B

Section 1. Subdivision 1 of section 2803-u of the public health law, as added by section 1 of part C of chapter 70 of the laws of 2016, is amended to read as follows:

1. The office of alcoholism and substance abuse services, in consultation with the department, shall develop or utilize existing educational materials to be provided to general hospitals to disseminate to individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder during discharge planning pursuant to section twenty-eight hundred three-i of this ~~chapter~~ article. Such materials shall include information regarding the various types of treatment and recovery services, including but not limited to: inpatient, outpatient, and medication-assisted treatment; how to recognize the need for treatment services; information for individuals to deter-

mine what type and level of treatment is most appropriate and what resources are available to them; and any other information the commissioner deems appropriate. General hospitals shall include in their policies and procedures treatment protocols, consistent with medical standards, to be utilized by the emergency departments in general hospitals for the appropriate use of medication-assisted treatment, including buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department of a general hospital is not feasible.

§ 2. This act shall take effect immediately.

SUBPART C

Intentionally Omitted

SUBPART D

Section 1. Paragraph (r) of subdivision 4 of section 364-j of the social services law, as amended by section 39 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(r) A managed care provider shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal social security act, provided that services for a substance use disorder shall be provided by a program licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services.

§ 2. This act shall take effect immediately; provided, however that 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

Intentionally Omitted

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part 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 part thereof directly involved in the controversy in which such judgment shall have been rendered. It has 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. This act shall take effect immediately provided, however, that the applicable effective date of Subparts A through E of this act shall be as specifically set forth in the last section of such Subparts.

PART CC

Intentionally Omitted

PART DD

Intentionally Omitted

PART EE

Section 1. Subdivision 10 of section 2899-a of the public health law, as amended by section 5 of part C of chapter 57 of the laws of 2018, is amended to read as follows:

10. Notwithstanding subdivision eleven of section eight hundred forty-five-b of the executive law, a certified home health agency, licensed home care services agency or long term home health care program certified, licensed or approved under article thirty-six of this chapter or a home care services agency exempt from certification or licensure under article thirty-six of this chapter, a hospice program under article forty of this chapter, or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, or a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all enrollees enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-1 of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act may temporarily approve a prospective employee while the results of the criminal history information check and the determination are pending, upon the condition that the provider conducts appropriate direct observation and evaluation of the temporary employee, while he or she is temporarily employed, and the care recipient; provided, however, that for a health home, or any subcontractor of a health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to all enrollees enrolled pursuant to a diagnosis of developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-1 of the social services law, or any entity that provides home and community based services to enrollees who are under twenty-one years of age under a demonstration program pursuant to section eleven hundred fifteen of the federal social security act, direct observation and evaluation of temporary employees shall not be required until ~~April~~ July first, two thousand nineteen. The results of such observations shall be documented in the temporary employee's personnel file and shall be maintained. For purposes of providing such appropriate direct observation and evaluation, the provider shall utilize an individual employed by such provider with a minimum of one year's experience working in an agency certified, licensed or approved under article thirty-six of this chapter or an adult home, enriched housing program or residence for adults licensed under article seven of the social services law, a health home, or any subcontractor of such health home, who contracts with or is approved or otherwise authorized by the department to provide health home services to those enrolled pursuant to a diagnosis of a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and enrollees who are under twenty-one years of age under section three hundred sixty-five-1 of the social services law, or any entity that provides home and community based services to enrollees who are under

1 twenty-one years of age under a demonstration program pursuant to
2 section eleven hundred fifteen of the federal social security act. If
3 the temporary employee is working under contract with another provider
4 certified, licensed or approved under article thirty-six of this chap-
5 ter, such contract provider's appropriate direct observation and evalu-
6 ation of the temporary employee, shall be considered sufficient for the
7 purposes of complying with this subdivision.

8 § 2. This act shall take effect immediately, except that if this act
9 shall have become a law on or after April 1, 2019 this act shall take
10 effect immediately and shall be deemed to have been in full force and
11 effect on and after April 1, 2019.

12 PART FF

13 Section 1. Section 4 of chapter 495 of the laws of 2004, amending the
14 insurance law and the public health law relating to the New York state
15 health insurance continuation assistance demonstration project, as
16 amended by section 1 of part QQ of chapter 58 of the laws of 2018, is
17 amended to read as follows:

18 § 4. This act shall take effect on the sixtieth day after it shall
19 have become a law; provided, however, that this act shall remain in
20 effect until July 1, [~~2019~~] 2020 when upon such date the provisions of
21 this act shall expire and be deemed repealed; provided, further, that a
22 displaced worker shall be eligible for continuation assistance retroac-
23 tive to July 1, 2004.

24 § 2. This act shall take effect immediately.

25 PART GG

26 Section 1. It is the intent of the legislature that, subject to the
27 approval of the director of the budget and sufficient appropriation
28 authority, no less than one hundred million dollars of existing revenue
29 shall be made available annually to support programs operated by the New
30 York state office of alcoholism and substance abuse services or agencies
31 certified, authorized, approved or otherwise funded by the New York
32 state office of alcoholism and substance abuse services to provide
33 opioid treatment, recovery and prevention and education services.

34 § 2. This act shall take effect immediately.

35 PART HH

36 Section 1. Subdivision 5 of section 209 of the elder law, as amended
37 by section 1 of part S of chapter 59 of the laws of 2016, is amended to
38 read as follows:

39 5. Within amounts specifically appropriated therefor and consistent
40 with the criteria developed and required pursuant to this section the
41 director shall approve grants to eligible applicants. Individual grants
42 awarded for classic NORC programs shall be in amounts not to exceed
43 [~~two~~] three hundred thousand (~~[\$200,000]~~ \$300,000) dollars and for
44 neighborhood NORCs not less than sixty thousand (\$60,000) dollars in any
45 twelve month period.

46 § 2. This act shall take effect immediately.

47 PART II

1 Section 1. Section 13 of chapter 141 of the laws of 1994, amending the
2 legislative law and the state finance law relating to the operation and
3 administration of the legislature, as amended by section 2 of part GGG
4 of chapter 59 of the laws of 2018, is amended to read as follows:

5 § 13. This act shall take effect immediately and shall be deemed to
6 have been in full force and effect as of April 1, 1994, provided that,
7 the provisions of section 5-a of the legislative law as amended by
8 sections two and two-a of this act shall take effect on January 1, 1995,
9 and provided further that, the provisions of article 5-A of the legisla-
10 tive law as added by section eight of this act shall expire June 30,
11 ~~2019~~ 2020 when upon such date the provisions of such article shall be
12 deemed repealed; and provided further that section twelve of this act
13 shall be deemed to have been in full force and effect on and after April
14 10, 1994.

15 § 2. This act shall take effect immediately, provided, however, if
16 section one of this act shall take effect on or after June 30, 2019
17 section one of this act shall be deemed to have been in full force and
18 effect on and after June 30, 2019.

19 PART JJ

20 Section 1. Section 2815 of the public health law is amended by adding
21 a new subdivision 5-a to read as follows:

22 5-a. Notwithstanding anything in this section to the contrary, the
23 authority is authorized and directed to transfer from the restructuring
24 pool to the department, upon written request of the director of the
25 budget and within thirty days thereof, funds repaid by participating
26 borrowers, and held by the authority relating to restructuring pool
27 loans funded by amounts transferred to the restructuring pool by the
28 department or remaining funds in the restructuring pool that were trans-
29 ferred by the department, not to exceed a total of eighty-three million
30 five hundred thousand dollars, excepting therefrom amounts necessary to
31 pay expenses of the authority as provided in the agreement described in
32 subdivision three of this section. All participating borrowers shall be
33 obligated in their loan agreement to repay no later than March thirty-
34 first, two thousand twenty all funds borrowed from the eighty-three
35 million five hundred thousand dollars transferred by the department
36 pursuant to this section, to fund these restructuring pool loans.
37 Further, in respect of these borrowed funds, all participating borrowers
38 shall be required under the terms of their loan agreement to immediately
39 upon receipt of quality improvement incentive payments or additional
40 supplemental assistance initiate repayment of an amount equal to the
41 quality improvement incentive payments or additional supplemental
42 assistance not to exceed the amount of such borrowed funds, unless a
43 waiver or extension of repayment has been approved by the director of
44 the budget.

45 § 2. This act shall take effect immediately.

46 PART KK

47 Section 1. The Department of Health shall conduct a study to examine
48 how staffing enhancements and other initiatives could be used to improve
49 patient safety and the quality of healthcare service delivery in hospi-
50 tals and nursing homes subject to article 28 of the public health law.
51 The Department study shall consider minimum staffing levels, other
52 staffing enhancement strategies, and other patient quality improvement

1 initiatives for registered nurses, licensed practical nurses, and certi-
2 fied nurse aides to improve the quality of care and patient safety.

3 The study will analyze the range of potential fiscal impacts of staff-
4 ing levels, other staffing enhancement strategies, and other patient
5 quality improvement initiatives.

6 The Department study will commence no later than May 1, 2019, and
7 shall engage stakeholders, including the statewide hospital and nursing
8 home associations, direct care health workers, and patient and community
9 health advocates, and shall report its findings and recommendations to
10 the Commissioner of the Department of Health and to the Temporary Presi-
11 dent of the Senate and Speaker of the Assembly no later than December
12 31, 2019.

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

15 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-
16 sion, section or part of this act shall be adjudged by any court of
17 competent jurisdiction to be invalid, such judgment shall not affect,
18 impair, or invalidate the remainder thereof, but shall be confined in
19 its operation to the clause, sentence, paragraph, subdivision, section
20 or part thereof directly involved in the controversy in which such judg-
21 ment shall have been rendered. It is hereby declared to be the intent of
22 the legislature that this act would have been enacted even if such
23 invalid provisions had not been included herein.

24 § 3. This act shall take effect immediately provided, however, that
25 the applicable effective date of Parts A through KK of this act shall be
26 as specifically set forth in the last section of such Parts.