

# STATE OF NEW YORK

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S. 1507

A. 2007

## SENATE - ASSEMBLY

January 18, 2019

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IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

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

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

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

LBD12571-01-9

for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medical expenditures, in relation to extending the provisions thereof; to amend the public health law, in relation to hospital assessments; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative costs; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to rates of payments; to amend the public health law, in relation to reimbursement rate promulgation for residential health care facilities; to amend the public health law, in relation to residential health care facility, and certified home health agency services payments; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to transfer of funds and the effectiveness thereof; and to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof (Part E); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions

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

(Part V); to amend part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part W); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings; and providing for the repeal of such provisions upon expiration thereof (Part X); to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to the inclusion and development of certain cost of living adjustments (Part Y); to amend the public health law and the mental hygiene law, in relation to integrated services (Part Z); to amend the social services law, in relation to the definition of a facility or a provider agency (Part AA); and to amend the insurance law, in relation to mental health and substance use disorder health insurance parity; to amend the public health law, in relation to health maintenance organizations; and to repeal certain provisions of the insurance law relating thereto (Subpart A); to amend the public health law, in relation to general hospital policies for substance use disorder treatment (Subpart B); to repeal subparagraph (v) of paragraph (a) of subdivision 2 of section 3343-a of the public health law relating to general hospital prescription drug monitoring (Subpart C); to amend the social services law, in relation to court ordered substance use disorder treatment (Subpart D); and to amend the public health law, in relation to including fentanyl analogs as controlled substances (Subpart E)(Part BB)

**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 BB. The effective date for each particular  
5 provision contained within such Part is set forth in the last section of  
6 such Part. Any provision in any section contained within a Part, includ-  
7 ing the effective date of the Part, which makes a reference to a section  
8 "of this act", when used in connection with that particular component,  
9 shall be deemed to mean and refer to the corresponding section of the  
10 Part in which it is found. Section three of this act sets forth the  
11 general effective date of this act.

12 PART A

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

16 4. The commissioner of health is authorized to assume responsibility  
17 from a local social services official for the provision and reimburse-  
18 ment of transportation costs under this section. If the commissioner  
19 elects to assume such responsibility, the commissioner shall notify the  
20 local social services official in writing as to the election, the date  
21 upon which the election shall be effective and such information as to  
22 transition of responsibilities as the commissioner deems prudent. The  
23 commissioner is authorized to contract with a transportation manager or

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

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

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

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

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

53 § 4. This act shall take effect immediately and shall be deemed to  
54 have been in full force and effect on and after April 1, 2019; provided,  
55 however, that section one of this act shall take effect October 1, 2019;  
56 provided, further that the amendments to subdivision 4 of section 365-h

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

4 PART B

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

8 (a) drugs which may be dispensed without a prescription as required by  
9 section sixty-eight hundred ten of the education law; provided, however,  
10 that the state commissioner of health may by regulation specify certain  
11 of such drugs which may be reimbursed as an item of medical assistance  
12 in accordance with the price schedule established by such commissioner.  
13 Notwithstanding any other provision of law, ~~[additions]~~ modifications to  
14 the list of drugs reimbursable under this paragraph may be filed as  
15 regulations by the commissioner of health without prior notice and  
16 comment;

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(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 (c) 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.]~~



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

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

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

14 (a) If the drug utilization review board recommends a target rebate  
15 amount on a drug referred by the commissioner, the ~~[commissioner shall~~  
16 ~~require]~~ department shall negotiate with the drug's manufacturer for a  
17 supplemental rebate to be paid by the ~~[drug's]~~ manufacturer in an amount  
18 not to exceed such target rebate amount. ~~[With respect to a]~~ A rebate  
19 ~~[required in state fiscal year two thousand seventeen--two thousand~~  
20 ~~eighteen, the rebate]~~ requirement shall apply beginning with the ~~[month~~  
21 ~~of April, two thousand seventeen,]~~ first day of the state fiscal year  
22 during which the rebate was required without regard to the date the  
23 department enters into the rebate agreement with the manufacturer.

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

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

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

54 8. The commissioner shall report by ~~[February]~~ July first annually to  
55 the drug utilization review board on savings achieved through the drug  
56 cap in the last fiscal year. Such report shall provide data on what



savings were achieved through actions pursuant to subdivisions three, five and seven of this section, respectively, and what savings were achieved through other means and how such savings were calculated and implemented.

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

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

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

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

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

(b) The commissioner may promulgate regulations as necessary to establish additional standards for contracts or other arrangements related to the services described in this subdivision.

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

§ 12. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that sections one and two of this act shall take effect July 1, 2019; and provided further, however, that the amendments to paragraph (c) of subdivision 6 of section 367-a of the social services law made by section two of this act shall not affect the repeal of such paragraph 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. Subparagraph (ii) of paragraph (d) of subdivision 1 of section 367-a of the social services law, as amended by section 1 of part J1 of chapter 63 of the laws of 2003, is amended to read as follows:

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

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

(iii) With respect to items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and items and services provided to qualified medicare beneficiaries under part B of title XVIII of the federal social security act, the amount payable for services covered under this title shall be the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B, but shall not exceed the amount that otherwise would be made under this title if provided to an eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary minus the amount payable under part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by ~~[an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, a psychologist licensed under article one hundred fifty-three of the education law, or]~~ a facility under the authority of an operating certificate issued pursuant to article sixteen, thirty-one or thirty-two of the mental hygiene law and with respect to outpatient hospital and clinic items and services provided by a facility under the authority of an operating certificate issued pursuant to article twenty-eight of the public health law, shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

§ 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 expedited 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

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

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

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

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

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

§ 11. This act shall take effect immediately and:

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

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

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

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

12 § 3. This act shall take effect immediately, provided, however, that  
13 subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of  
14 1973, as added by section one of this act, shall expire and be deemed  
15 repealed June 30, [~~2019~~] 2024; and provided further, however, that the  
16 expiration and repeal of such subdivision 15-a shall not affect or  
17 impair in any manner any health facilities bonds issued, or any lease or  
18 purchase of a health facility executed, pursuant to such subdivision  
19 15-a prior to its expiration and repeal and that, with respect to any  
20 such bonds issued and outstanding as of June 30, [~~2019~~] 2024, the  
21 provisions of such subdivision 15-a as they existed immediately prior to  
22 such expiration and repeal shall continue to apply through the latest  
23 maturity date of any such bonds, or their earlier retirement or redemp-  
24 tion, for the sole purpose of authorizing the issuance of refunding  
25 bonds to refund bonds previously issued pursuant thereto.

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

30 (a) sections two, three, three-a, three-b, three-c, three-d, three-e  
31 and twenty-one of this act shall take effect July 1, 2010; sections  
32 fifteen, sixteen, seventeen, eighteen and nineteen of this act shall  
33 take effect January 1, 2011; and provided further that section twenty of  
34 this act shall be deemed repealed [~~eight~~] thirteen years after the date  
35 the contract entered into pursuant to section 365-h of the social  
36 services law, as amended by section twenty of this act, is executed;  
37 provided that the commissioner of health shall notify the legislative  
38 bill drafting commission upon the execution of the contract entered into  
39 pursuant to section 367-h of the social services law in order that the  
40 commission may maintain an accurate and timely effective data base of  
41 the official text of the laws of the state of New York in furtherance of  
42 effectuating the provisions of section 44 of the legislative law and  
43 section 70-b of the public officers law;

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

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

51 § 7. Subdivision (c) of section 122 of part E of chapter 56 of the  
52 laws of 2013 amending the public health law relating to the general  
53 public health work program, as amended by section 5 of part D of chapter  
54 59 of the laws of 2016, is amended to read as follows:

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

§ 8. Subdivision (i) of section 111 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 medical expenditures, as amended by section 19 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

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

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

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two 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-four 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, 2024 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, 2024 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 Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

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

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and 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, 2024;

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

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as



1 amended, shall remain and be in full force and effect on April 1, 1995  
2 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on  
3 and after April 1, 2000 through March 31, 2003 and on and after April 1,  
4 2003 through March 31, 2007, and on and after April 1, 2007 through  
5 March 31, 2009, and on and after April 1, 2009 through March 31, 2011,  
6 and on and after April 1, 2011 through March 31, 2013, and on and after  
7 April 1, 2013 through March 31, 2015, and on and after April 1, 2015  
8 through March 31, 2017 and on and after April 1, 2017 through March 31,  
9 2019, and on and after April 1, 2019 through March 31, 2024.

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

15 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section  
16 2807-c of the public health law, section 21 of chapter 1 of the laws of  
17 1999, or any other contrary provision of law, in determining rates of  
18 payments by state governmental agencies effective for services provided  
19 on and after January 1, 2017 through March 31, ~~2019~~ 2024, for inpa-  
20 tient and outpatient services provided by general hospitals, for inpa-  
21 tient services and adult day health care outpatient services provided by  
22 residential health care facilities pursuant to article 28 of the public  
23 health law, except for residential health care facilities or units of  
24 such facilities providing services primarily to children under twenty-  
25 one years of age, for home health care services provided pursuant to  
26 article 36 of the public health law by certified home health agencies,  
27 long term home health care programs and AIDS home care programs, and for  
28 personal care services provided pursuant to section 365-a of the social  
29 services law, the commissioner of health shall apply no greater than  
30 zero trend factors attributable to the 2017, 2018, ~~and~~ 2019, 2020,  
31 2021, 2022, and 2023 calendar years in accordance with paragraph (c) of  
32 subdivision 10 of section 2807-c of the public health law, provided,  
33 however, that such no greater than zero trend factors attributable to  
34 such 2017, 2018, ~~and~~ 2019, 2020, 2021, 2022, and 2023 calendar years  
35 shall also be applied to rates of payment provided on and after January  
36 1, 2017 through March 31, ~~2019~~ 2024 for personal care services  
37 provided in those local social services districts, including New York  
38 city, whose rates of payment for such services are established by such  
39 local social services districts pursuant to a rate-setting exemption  
40 issued by the commissioner of health to such local social services  
41 districts in accordance with applicable regulations; and provided  
42 further, however, that for rates of payment for assisted living program  
43 services provided on and after January 1, 2017 through March 31, ~~2019~~  
44 2024, such trend factors attributable to the 2017, 2018, ~~and~~ 2019,  
45 2020, 2021, 2022, and 2023 calendar years shall be established at no  
46 greater than zero percent.

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

50 (b) Notwithstanding any inconsistent provision of law or regulation to  
51 the contrary, for the state fiscal years beginning April first, two  
52 thousand ten and ending March thirty-first, two thousand ~~nineteen~~  
53 twenty-four, the commissioner shall not be required to revise certified  
54 rates of payment established pursuant to this article for rate periods  
55 prior to April first, two thousand ~~nineteen~~ twenty-four, based on  
56 consideration of rate appeals filed by residential health care facili-

ties or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand ~~nineteen~~ twenty-four. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

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

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

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

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and 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, 2006 and on and after April 1, 2006 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 sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 and on and after April 1, 2015

1 through March 31, 2017 and on and after April 1, 2017 through March 31,  
2 2019, and on and after April 1, 2019 through March 31, 2024;

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

8 § 48-a. 1. Notwithstanding any contrary provision of law, the commis-  
9 sioners of the office of alcoholism and substance abuse services and the  
10 office of mental health are authorized, subject to the approval of the  
11 director of the budget, to transfer to the commissioner of health state  
12 funds to be utilized as the state share for the purpose of increasing  
13 payments under the medicaid program to managed care organizations  
14 licensed under article 44 of the public health law or under article 43  
15 of the insurance law. Such managed care organizations shall utilize such  
16 funds for the purpose of reimbursing providers licensed pursuant to  
17 article 28 of the public health law or article 31 or 32 of the mental  
18 hygiene law for ambulatory behavioral health services, as determined by  
19 the commissioner of health, in consultation with the commissioner of  
20 alcoholism and substance abuse services and the commissioner of the  
21 office of mental health, provided to medicaid enrolled outpatients and  
22 for all other behavioral health services except inpatient included in  
23 New York state's Medicaid redesign waiver approved by the centers for  
24 medicare and Medicaid services (CMS). Such reimbursement shall be in  
25 the form of fees for such services which are equivalent to the payments  
26 established for such services under the ambulatory patient group (APG)  
27 rate-setting methodology as utilized by the department of health, the  
28 office of alcoholism and substance abuse services, or the office of  
29 mental health for rate-setting purposes or any such other fees pursuant  
30 to the Medicaid state plan or otherwise approved by CMS in the Medicaid  
31 redesign waiver; provided, however, that the increase to such fees that  
32 shall result from the provisions of this section shall not, in the  
33 aggregate and as determined by the commissioner of health, in consulta-  
34 tion with the commissioner of alcoholism and substance abuse services  
35 and the commissioner of the office of mental health, be greater than the  
36 increased funds made available pursuant to this section. The increase  
37 of such ambulatory behavioral health fees to providers available under  
38 this section shall be for all rate periods on and after the effective  
39 date of section ~~[29] 1~~ of part ~~[B] P~~ of chapter ~~[59] 57~~ of the laws of  
40 ~~[2016] 2017~~ through March 31, ~~[2020] 2022~~ for patients in the city of  
41 New York, for all rate periods on and after the effective date of  
42 section ~~[29] 1~~ of part ~~[B] P~~ of chapter ~~[59] 57~~ of the laws of ~~[2016]~~  
43 ~~2017~~ through ~~[March 31, 2020]~~ March 31, 2022 for patients outside the  
44 city of New York, and for all rate periods on and after the effective  
45 date of such chapter through ~~[March 31, 2020]~~ March 31, 2022 for all  
46 services provided to persons under the age of twenty-one; provided,  
47 however, the commissioner of health, in consultation with the commis-  
48 sioner of alcoholism and substance abuse services and the commissioner  
49 of mental health, may require, as a condition of approval of such ambu-  
50 latory behavioral health fees, that aggregate managed care expenditures  
51 to eligible providers meet the alternative payment methodology require-  
52 ments as set forth in attachment I of the New York state medicaid  
53 section one thousand one hundred fifteen medicaid redesign team waiver  
54 as approved by the centers for medicare and medicaid services. The  
55 commissioner of health shall, in consultation with the commissioner of  
56 alcoholism and substance abuse services and the commissioner of mental

1 health, waive such conditions if a sufficient number of providers, as  
2 determined by the commissioner, suffer a financial hardship as a conse-  
3 quence of such alternative payment methodology requirements, or if he or  
4 she shall determine that such alternative payment methodologies signif-  
5 icantly threaten individuals access to ambulatory behavioral health  
6 services. Such waiver may be applied on a provider specific or industry  
7 wide basis. Further, such conditions may be waived, as the commissioner  
8 determines necessary, to comply with federal rules or regulations  
9 governing these payment methodologies. Nothing in this section shall  
10 prohibit managed care organizations and providers from negotiating  
11 different rates and methods of payment during such periods described  
12 above, subject to the approval of the department of health. The depart-  
13 ment of health shall consult with the office of alcoholism and substance  
14 abuse services and the office of mental health in determining whether  
15 such alternative rates shall be approved. The commissioner of health  
16 may, in consultation with the commissioner of alcoholism and substance  
17 abuse services and the commissioner of the office of mental health,  
18 promulgate regulations, including emergency regulations promulgated  
19 prior to October 1, 2015 to establish rates for ambulatory behavioral  
20 health services, as are necessary to implement the provisions of this  
21 section. Rates promulgated under this section shall be included in the  
22 report required under section 45-c of part A of this chapter.

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

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

55 Section 1. a. Notwithstanding any contrary provision of law, the  
56 commissioners of mental health and alcoholism and substance abuse

1 services are authorized, subject to the approval of the director of the  
2 budget, to transfer to the commissioner of health state funds to be  
3 utilized as the state share for the purpose of increasing payments under  
4 the medicaid program to managed care organizations licensed under arti-  
5 cle 44 of the public health law or under article 43 of the insurance  
6 law. Such managed care organizations shall utilize such funds for the  
7 purpose of reimbursing providers licensed pursuant to article 28 of the  
8 public health law, or pursuant to article 31 or article 32 of the mental  
9 hygiene law for ambulatory behavioral health services, as determined by  
10 the commissioner of health in consultation with the commissioner of  
11 mental health and commissioner of alcoholism and substance abuse  
12 services, provided to medicaid enrolled outpatients and for all other  
13 behavioral health services except inpatient included in New York state's  
14 Medicaid redesign waiver approved by the centers for medicare and Medi-  
15 caid services (CMS). Such reimbursement shall be in the form of fees for  
16 such services which are equivalent to the payments established for such  
17 services under the ambulatory patient group (APG) rate-setting methodol-  
18 ogy as utilized by the department of health or by the office of mental  
19 health or office of alcoholism and substance abuse services for rate-  
20 setting purposes or any such other fees pursuant to the Medicaid state  
21 plan or otherwise approved by CMS in the Medicaid redesign waiver;  
22 provided, however, that the increase to such fees that shall result from  
23 the provisions of this section shall not, in the aggregate and as deter-  
24 mined by the commissioner of health in consultation with the commission-  
25 ers of mental health and alcoholism and substance abuse services, be  
26 greater than the increased funds made available pursuant to this  
27 section. The increase of such behavioral health fees to providers avail-  
28 able under this section shall be for all rate periods on and after the  
29 effective date of section [~~30~~] 2 of part [~~B~~] P of chapter [~~59~~] 57 of the  
30 laws of [~~2016~~] 2017 through March 31, [~~2020~~] 2022 for patients in the  
31 city of New York, for all rate periods on and after the effective date  
32 of section [~~30~~] 2 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~]  
33 2017 through March 31, [~~2020~~] 2022 for patients outside the city of New  
34 York, and for all rate periods on and after the effective date of  
35 section [~~30~~] 2 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~]  
36 2017 through March 31, [~~2020~~] 2022 for all services provided to persons  
37 under the age of twenty-one; provided, however, the commissioner of  
38 health, in consultation with the commissioner of alcoholism and  
39 substance abuse services and the commissioner of mental health, may  
40 require, as a condition of approval of such ambulatory behavioral health  
41 fees, that aggregate managed care expenditures to eligible providers  
42 meet the alternative payment methodology requirements as set forth in  
43 attachment I of the New York state medicaid section one thousand one  
44 hundred fifteen medicaid redesign team waiver as approved by the centers  
45 for medicare and medicaid services. The commissioner of health shall, in  
46 consultation with the commissioner of alcoholism and substance abuse  
47 services and the commissioner of mental health, waive such conditions if  
48 a sufficient number of providers, as determined by the commissioner,  
49 suffer a financial hardship as a consequence of such alternative payment  
50 methodology requirements, or if he or she shall determine that such  
51 alternative payment methodologies significantly threaten individuals  
52 access to ambulatory behavioral health services. Such waiver may be  
53 applied on a provider specific or industry wide basis. Further, such  
54 conditions may be waived, as the commissioner determines necessary, to  
55 comply with federal rules or regulations governing these payment method-  
56 ologies. Nothing in this section shall prohibit managed care organiza-



tions and providers from negotiating different rates and methods of payment during such periods described, 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 commissioner of health may, in consultation with the commissioners of mental health and alcoholism and substance abuse services, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title ~~[one-A]~~ 1-A of article 25 of the public health law, 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. The commissioner of health shall consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in 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]~~ 2022, 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.

§ 20. 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, as amended by section 16 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

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

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

§ 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed on March 31, ~~[2020]~~ 2025 provided, however that the



1 amendments to section 364-j of the social services law made by section  
2 four of this act shall not affect the expiration of such section and  
3 shall be deemed to expire therewith and provided, further, that the  
4 provisions of subdivisions 8, 9 and 10 of section 4401 of the public  
5 health law, as added by section one of this act; section 4403-d of the  
6 public health law as added by section two of this act and the provisions  
7 of section seven of this act, except for the provisions relating to the  
8 establishment of no more than twelve comprehensive HIV special needs  
9 plans, shall expire and be deemed repealed on July 1, 2000.

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

14 (a) Notwithstanding any inconsistent provision of law or regulation to  
15 the contrary, effective beginning August 1, 1996, for the period April  
16 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,  
17 1998 through March 31, 1999, August 1, 1999, for the period April 1,  
18 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000  
19 through March 31, 2001, April 1, 2001, for the period April 1, 2001  
20 through March 31, 2002, April 1, 2002, for the period April 1, 2002  
21 through March 31, 2003, and for the state fiscal year beginning April 1,  
22 2005 through March 31, 2006, and for the state fiscal year beginning  
23 April 1, 2006 through March 31, 2007, and for the state fiscal year  
24 beginning April 1, 2007 through March 31, 2008, and for the state fiscal  
25 year beginning April 1, 2008 through March 31, 2009, and for the state  
26 fiscal year beginning April 1, 2009 through March 31, 2010, and for the  
27 state fiscal year beginning April 1, 2010 through March 31, 2016, and  
28 for the state fiscal year beginning April 1, 2016 through March 31, 2019  
29 and annually thereafter, the department of health is authorized to pay  
30 public general hospitals, as defined in subdivision 10 of section 2801  
31 of the public health law, operated by the state of New York or by the  
32 state university of New York or by a county, which shall not include a  
33 city with a population of over one million, of the state of New York,  
34 and those public general hospitals located in the county of Westchester,  
35 the county of Erie or the county of Nassau, additional payments for  
36 inpatient hospital services as medical assistance payments pursuant to  
37 title 11 of article 5 of the social services law for patients eligible  
38 for federal financial participation under title XIX of the federal  
39 social security act in medical assistance pursuant to the federal laws  
40 and regulations governing disproportionate share payments to hospitals  
41 up to one hundred percent of each such public general hospital's medical  
42 assistance and uninsured patient losses after all other medical assist-  
43 ance, including disproportionate share payments to such public general  
44 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on  
45 reported 1994 reconciled data as further reconciled to actual reported  
46 1996 reconciled data, and for 1997 based initially on reported 1995  
47 reconciled data as further reconciled to actual reported 1997 reconciled  
48 data, for 1998 based initially on reported 1995 reconciled data as  
49 further reconciled to actual reported 1998 reconciled data, for 1999  
50 based initially on reported 1995 reconciled data as further reconciled  
51 to actual reported 1999 reconciled data, for 2000 based initially on  
52 reported 1995 reconciled data as further reconciled to actual reported  
53 2000 data, for 2001 based initially on reported 1995 reconciled data as  
54 further reconciled to actual reported 2001 data, for 2002 based initial-  
55 ly on reported 2000 reconciled data as further reconciled to actual  
56 reported 2002 data, and for state fiscal years beginning on April 1,

1 2005, based initially on reported 2000 reconciled data as further recon-  
2 ciled to actual reported data for 2005, and for state fiscal years  
3 beginning on April 1, 2006, based initially on reported 2000 reconciled  
4 data as further reconciled to actual reported data for 2006, for state  
5 fiscal years beginning on and after April 1, 2007 through March 31,  
6 2009, based initially on reported 2000 reconciled data as further recon-  
7 ciled to actual reported data for 2007 and 2008, respectively, for state  
8 fiscal years beginning on and after April 1, 2009, based initially on  
9 reported 2007 reconciled data, adjusted for authorized Medicaid rate  
10 changes applicable to the state fiscal year, and as further reconciled  
11 to actual reported data for 2009, for state fiscal years beginning on  
12 and after April 1, 2010, based initially on reported reconciled data  
13 from the base year two years prior to the payment year, adjusted for  
14 authorized Medicaid rate changes applicable to the state fiscal year,  
15 and further reconciled to actual reported data from such payment year,  
16 and to actual reported data for each respective succeeding year. The  
17 payments may be added to rates of payment or made as aggregate payments  
18 to an eligible public general hospital.

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

25 PART F

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

31 (a) The superintendent of financial services and the commissioner of  
32 health or their designee shall, from funds available in the hospital  
33 excess liability pool created pursuant to subdivision 5 of this section,  
34 purchase a policy or policies for excess insurance coverage, as author-  
35 ized by paragraph 1 of subsection (e) of section 5502 of the insurance  
36 law; or from an insurer, other than an insurer described in section 5502  
37 of the insurance law, duly authorized to write such coverage and actual-  
38 ly writing medical malpractice insurance in this state; or shall  
39 purchase equivalent excess coverage in a form previously approved by the  
40 superintendent of financial services for purposes of providing equiv-  
41 alent excess coverage in accordance with section 19 of chapter 294 of  
42 the laws of 1985, for medical or dental malpractice occurrences between  
43 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,  
44 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June  
45 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991  
46 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July  
47 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,  
48 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June  
49 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998  
50 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July  
51 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,  
52 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June  
53 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005  
54 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July

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

1 be in an amount of not less than the dollar amount of such coverage  
2 available at nine percent per annum; the required level of such coverage  
3 for all claimants under that policy shall be in an amount not less than  
4 three times the dollar amount of coverage for each claimant; and excess  
5 coverage, when combined with such primary malpractice insurance cover-  
6 age, shall increase the aggregate level for each claimant by one million  
7 dollars and three million dollars for all claimants; and provided  
8 further, that, with respect to policies of primary medical malpractice  
9 coverage that include occurrences between April 1, 2002 and June 30,  
10 2002, such requirement that coverage be in amounts no less than one  
11 million three hundred thousand dollars for each claimant and three  
12 million nine hundred thousand dollars for all claimants for such occur-  
13 rences shall be effective April 1, 2002.

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

18 (3)(a) The superintendent of financial services shall determine and  
19 certify to each general hospital and to the commissioner of health the  
20 cost of excess malpractice insurance for medical or dental malpractice  
21 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988  
22 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July  
23 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,  
24 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June  
25 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995  
26 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July  
27 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,  
28 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June  
29 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002  
30 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July  
31 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,  
32 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June  
33 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009  
34 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July  
35 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and  
36 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June  
37 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1,  
38 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, ~~and~~  
39 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and  
40 June 30, 2020 allocable to each general hospital for physicians or  
41 dentists certified as eligible for purchase of a policy for excess  
42 insurance coverage by such general hospital in accordance with subdivi-  
43 sion 2 of this section, and may amend such determination and certif-  
44 ication as necessary.

45 (b) The superintendent of financial services shall determine and  
46 certify to each general hospital and to the commissioner of health the  
47 cost of excess malpractice insurance or equivalent excess coverage for  
48 medical or dental malpractice occurrences between July 1, 1987 and June  
49 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989  
50 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July  
51 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,  
52 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June  
53 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996  
54 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July  
55 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,  
56 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June

1 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003  
2 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July  
3 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,  
4 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June  
5 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010  
6 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July  
7 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,  
8 between July 1, 2014 and June 30, 2015, between July 1, 2015 and June  
9 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017  
10 and June 30, 2018, [~~and~~] between July 1, 2018 and June 30, 2019, and  
11 between July 1, 2019 and June 30, 2020 allocable to each general hospi-  
12 tal for physicians or dentists certified as eligible for purchase of a  
13 policy for excess insurance coverage or equivalent excess coverage by  
14 such general hospital in accordance with subdivision 2 of this section,  
15 and may amend such determination and certification as necessary. The  
16 superintendent of financial services shall determine and certify to each  
17 general hospital and to the commissioner of health the ratable share of  
18 such cost allocable to the period July 1, 1987 to December 31, 1987, to  
19 the period January 1, 1988 to June 30, 1988, to the period July 1, 1988  
20 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to  
21 the period July 1, 1989 to December 31, 1989, to the period January 1,  
22 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990,  
23 to the period January 1, 1991 to June 30, 1991, to the period July 1,  
24 1991 to December 31, 1991, to the period January 1, 1992 to June 30,  
25 1992, to the period July 1, 1992 to December 31, 1992, to the period  
26 January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December  
27 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period  
28 July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June  
29 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period  
30 January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December  
31 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period  
32 July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June  
33 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period  
34 January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December  
35 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period  
36 July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June  
37 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period  
38 July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30,  
39 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1,  
40 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to  
41 the period July 1, 2007 and June 30, 2008, to the period July 1, 2008  
42 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the  
43 period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and  
44 June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the  
45 period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and  
46 June 30, 2015, to the period July 1, 2015 and June 30, 2016, [~~and~~  
47 ~~between~~] to the period July 1, 2016 and June 30, 2017, [~~and~~] to the  
48 period July 1, 2017 to June 30, 2018, [~~and~~] to the period July 1, 2018  
49 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020.

50 § 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section  
51 18 of chapter 266 of the laws of 1986, amending the civil practice law  
52 and rules and other laws relating to malpractice and professional  
53 medical conduct, as amended by section 3 of part M of chapter 57 of the  
54 laws of 2018, are amended to read as follows:

55 (a) To the extent funds available to the hospital excess liability  
56 pool pursuant to subdivision 5 of this section as amended, and pursuant

1 to section 6 of part J of chapter 63 of the laws of 2001, as may from  
2 time to time be amended, which amended this subdivision, are insuffi-  
3 cient to meet the costs of excess insurance coverage or equivalent  
4 excess coverage for coverage periods during the period July 1, 1992 to  
5 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during  
6 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995  
7 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,  
8 during the period July 1, 1997 to June 30, 1998, during the period July  
9 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,  
10 2000, during the period July 1, 2000 to June 30, 2001, during the period  
11 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to  
12 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during  
13 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004  
14 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,  
15 during the period July 1, 2006 to June 30, 2007, during the period July  
16 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,  
17 2009, during the period July 1, 2009 to June 30, 2010, during the period  
18 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June  
19 30, 2012, during the period July 1, 2012 to June 30, 2013, during the  
20 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to  
21 June 30, 2015, during the period July 1, 2015 to June 30, 2016, during  
22 the period July 1, 2016 to June 30, 2017, during the period July 1, 2017  
23 to June 30, 2018, [and] during the period July 1, 2018 to June 30, 2019,  
24 and during the period July 1, 2019 to June 30, 2020 allocated or reallo-  
25 cated in accordance with paragraph (a) of subdivision 4-a of this  
26 section to rates of payment applicable to state governmental agencies,  
27 each physician or dentist for whom a policy for excess insurance cover-  
28 age or equivalent excess coverage is purchased for such period shall be  
29 responsible for payment to the provider of excess insurance coverage or  
30 equivalent excess coverage of an allocable share of such insufficiency,  
31 based on the ratio of the total cost of such coverage for such physician  
32 to the sum of the total cost of such coverage for all physicians applied  
33 to such insufficiency.

34 (b) Each provider of excess insurance coverage or equivalent excess  
35 coverage covering the period July 1, 1992 to June 30, 1993, or covering  
36 the period July 1, 1993 to June 30, 1994, or covering the period July 1,  
37 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,  
38 1996, or covering the period July 1, 1996 to June 30, 1997, or covering  
39 the period July 1, 1997 to June 30, 1998, or covering the period July 1,  
40 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,  
41 2000, or covering the period July 1, 2000 to June 30, 2001, or covering  
42 the period July 1, 2001 to October 29, 2001, or covering the period  
43 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to  
44 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or  
45 covering the period July 1, 2004 to June 30, 2005, or covering the peri-  
46 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to  
47 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or  
48 covering the period July 1, 2008 to June 30, 2009, or covering the peri-  
49 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to  
50 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or  
51 covering the period July 1, 2012 to June 30, 2013, or covering the peri-  
52 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to  
53 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or  
54 covering the period July 1, 2016 to June 30, 2017, or covering the peri-  
55 od July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to  
56 June 30, 2019, or covering the period July 1, 2019 to June 30, 2020



1 shall notify a covered physician or dentist by mail, mailed to the  
2 address shown on the last application for excess insurance coverage or  
3 equivalent excess coverage, of the amount due to such provider from such  
4 physician or dentist for such coverage period determined in accordance  
5 with paragraph (a) of this subdivision. Such amount shall be due from  
6 such physician or dentist to such provider of excess insurance coverage  
7 or equivalent excess coverage in a time and manner determined by the  
8 superintendent of financial services.

9 (c) If a physician or dentist liable for payment of a portion of the  
10 costs of excess insurance coverage or equivalent excess coverage cover-  
11 ing the period July 1, 1992 to June 30, 1993, or covering the period  
12 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to  
13 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or  
14 covering the period July 1, 1996 to June 30, 1997, or covering the peri-  
15 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to  
16 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or  
17 covering the period July 1, 2000 to June 30, 2001, or covering the peri-  
18 od July 1, 2001 to October 29, 2001, or covering the period April 1,  
19 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,  
20 2003, or covering the period July 1, 2003 to June 30, 2004, or covering  
21 the period July 1, 2004 to June 30, 2005, or covering the period July 1,  
22 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,  
23 2007, or covering the period July 1, 2007 to June 30, 2008, or covering  
24 the period July 1, 2008 to June 30, 2009, or covering the period July 1,  
25 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,  
26 2011, or covering the period July 1, 2011 to June 30, 2012, or covering  
27 the period July 1, 2012 to June 30, 2013, or covering the period July 1,  
28 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,  
29 2015, or covering the period July 1, 2015 to June 30, 2016, or covering  
30 the period July 1, 2016 to June 30, 2017, or covering the period July 1,  
31 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,  
32 2019, or covering the period July 1, 2019 to June 30, 2020 determined in  
33 accordance with paragraph (a) of this subdivision fails, refuses or  
34 neglects to make payment to the provider of excess insurance coverage or  
35 equivalent excess coverage in such time and manner as determined by the  
36 superintendent of financial services pursuant to paragraph (b) of this  
37 subdivision, excess insurance coverage or equivalent excess coverage  
38 purchased for such physician or dentist in accordance with this section  
39 for such coverage period shall be cancelled and shall be null and void  
40 as of the first day on or after the commencement of a policy period  
41 where the liability for payment pursuant to this subdivision has not  
42 been met.

43 (d) Each provider of excess insurance coverage or equivalent excess  
44 coverage shall notify the superintendent of financial services and the  
45 commissioner of health or their designee of each physician and dentist  
46 eligible for purchase of a policy for excess insurance coverage or  
47 equivalent excess coverage covering the period July 1, 1992 to June 30,  
48 1993, or covering the period July 1, 1993 to June 30, 1994, or covering  
49 the period July 1, 1994 to June 30, 1995, or covering the period July 1,  
50 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,  
51 1997, or covering the period July 1, 1997 to June 30, 1998, or covering  
52 the period July 1, 1998 to June 30, 1999, or covering the period July 1,  
53 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,  
54 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-  
55 ing the period April 1, 2002 to June 30, 2002, or covering the period  
56 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to

1 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or  
2 covering the period July 1, 2005 to June 30, 2006, or covering the peri-  
3 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to  
4 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or  
5 covering the period July 1, 2009 to June 30, 2010, or covering the peri-  
6 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to  
7 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or  
8 covering the period July 1, 2013 to June 30, 2014, or covering the peri-  
9 od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to  
10 June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or  
11 covering the period July 1, 2017 to June 30, 2018, or covering the peri-  
12 od July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to  
13 June 30, 2020 that has made payment to such provider of excess insurance  
14 coverage or equivalent excess coverage in accordance with paragraph (b)  
15 of this subdivision and of each physician and dentist who has failed,  
16 refused or neglected to make such payment.

17 (e) A provider of excess insurance coverage or equivalent excess  
18 coverage shall refund to the hospital excess liability pool any amount  
19 allocable to the period July 1, 1992 to June 30, 1993, and to the period  
20 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June  
21 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the  
22 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to  
23 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to  
24 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000  
25 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,  
26 and to the period April 1, 2002 to June 30, 2002, and to the period July  
27 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,  
28 2004, and to the period July 1, 2004 to June 30, 2005, and to the period  
29 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June  
30 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the  
31 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to  
32 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to  
33 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012  
34 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and  
35 to the period July 1, 2014 to June 30, 2015, and to the period July 1,  
36 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and  
37 to the period July 1, 2017 to June 30, 2018, and to the period July 1,  
38 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020  
39 received from the hospital excess liability pool for purchase of excess  
40 insurance coverage or equivalent excess coverage covering the period  
41 July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to  
42 June 30, 1994, and covering the period July 1, 1994 to June 30, 1995,  
43 and covering the period July 1, 1995 to June 30, 1996, and covering the  
44 period July 1, 1996 to June 30, 1997, and covering the period July 1,  
45 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30,  
46 1999, and covering the period July 1, 1999 to June 30, 2000, and cover-  
47 ing the period July 1, 2000 to June 30, 2001, and covering the period  
48 July 1, 2001 to October 29, 2001, and covering the period April 1, 2002  
49 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003,  
50 and covering the period July 1, 2003 to June 30, 2004, and covering the  
51 period July 1, 2004 to June 30, 2005, and covering the period July 1,  
52 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30,  
53 2007, and covering the period July 1, 2007 to June 30, 2008, and cover-  
54 ing the period July 1, 2008 to June 30, 2009, and covering the period  
55 July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to  
56 June 30, 2011, and covering the period July 1, 2011 to June 30, 2012,

1 and covering the period July 1, 2012 to June 30, 2013, and covering the  
2 period July 1, 2013 to June 30, 2014, and covering the period July 1,  
3 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,  
4 2016, and covering the period July 1, 2016 to June 30, 2017, and cover-  
5 ing the period July 1, 2017 to June 30, 2018, and covering the period  
6 July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to  
7 June 30, 2020 for a physician or dentist where such excess insurance  
8 coverage or equivalent excess coverage is cancelled in accordance with  
9 paragraph (c) of this subdivision.

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

14 § 40. The superintendent of financial services shall establish rates  
15 for policies providing coverage for physicians and surgeons medical  
16 malpractice for the periods commencing July 1, 1985 and ending June 30,  
17 ~~[2019,]~~ 2020; provided, however, that notwithstanding any other  
18 provision of law, the superintendent shall not establish or approve any  
19 increase in rates for the period commencing July 1, 2009 and ending June  
20 30, 2010. The superintendent shall direct insurers to establish segre-  
21 gated accounts for premiums, payments, reserves and investment income  
22 attributable to such premium periods and shall require periodic reports  
23 by the insurers regarding claims and expenses attributable to such peri-  
24 ods to monitor whether such accounts will be sufficient to meet incurred  
25 claims and expenses. On or after July 1, 1989, the superintendent shall  
26 impose a surcharge on premiums to satisfy a projected deficiency that is  
27 attributable to the premium levels established pursuant to this section  
28 for such periods; provided, however, that such annual surcharge shall  
29 not exceed eight percent of the established rate until July 1, ~~[2019,]~~  
30 2020, at which time and thereafter such surcharge shall not exceed twen-  
31 ty-five percent of the approved adequate rate, and that such annual  
32 surcharges shall continue for such period of time as shall be sufficient  
33 to satisfy such deficiency. The superintendent shall not impose such  
34 surcharge during the period commencing July 1, 2009 and ending June 30,  
35 2010. On and after July 1, 1989, the surcharge prescribed by this  
36 section shall be retained by insurers to the extent that they insured  
37 physicians and surgeons during the July 1, 1985 through June 30, ~~[2019]~~  
38 2020 policy periods; in the event and to the extent physicians and  
39 surgeons were insured by another insurer during such periods, all or a  
40 pro rata share of the surcharge, as the case may be, shall be remitted  
41 to such other insurer in accordance with rules and regulations to be  
42 promulgated by the superintendent. Surcharges collected from physicians  
43 and surgeons who were not insured during such policy periods shall be  
44 apportioned among all insurers in proportion to the premium written by  
45 each insurer during such policy periods; if a physician or surgeon was  
46 insured by an insurer subject to rates established by the superintendent  
47 during such policy periods, and at any time thereafter a hospital,  
48 health maintenance organization, employer or institution is responsible  
49 for responding in damages for liability arising out of such physician's  
50 or surgeon's practice of medicine, such responsible entity shall also  
51 remit to such prior insurer the equivalent amount that would then be  
52 collected as a surcharge if the physician or surgeon had continued to  
53 remain insured by such prior insurer. In the event any insurer that  
54 provided coverage during such policy periods is in liquidation, the  
55 property/casualty insurance security fund shall receive the portion of  
56 surcharges to which the insurer in liquidation would have been entitled.

1 The surcharges authorized herein shall be deemed to be income earned for  
2 the purposes of section 2303 of the insurance law. The superintendent,  
3 in establishing adequate rates and in determining any projected defi-  
4 ciency pursuant to the requirements of this section and the insurance  
5 law, shall give substantial weight, determined in his discretion and  
6 judgment, to the prospective anticipated effect of any regulations  
7 promulgated and laws enacted and the public benefit of stabilizing  
8 malpractice rates and minimizing rate level fluctuation during the peri-  
9 od of time necessary for the development of more reliable statistical  
10 experience as to the efficacy of such laws and regulations affecting  
11 medical, dental or podiatric malpractice enacted or promulgated in 1985,  
12 1986, by this act and at any other time. Notwithstanding any provision  
13 of the insurance law, rates already established and to be established by  
14 the superintendent pursuant to this section are deemed adequate if such  
15 rates would be adequate when taken together with the maximum authorized  
16 annual surcharges to be imposed for a reasonable period of time whether  
17 or not any such annual surcharge has been actually imposed as of the  
18 establishment of such rates.

19 § 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of  
20 chapter 63 of the laws of 2001, amending chapter 266 of the laws of  
21 1986, amending the civil practice law and rules and other laws relating  
22 to malpractice and professional medical conduct, relating to the effec-  
23 tiveness of certain provisions of such chapter, as amended by section 5  
24 of part M of chapter 57 of the laws of 2018, are amended to read as  
25 follows:

26 § 5. The superintendent of financial services and the commissioner of  
27 health shall determine, no later than June 15, 2002, June 15, 2003, June  
28 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,  
29 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,  
30 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June  
31 15, 2018, ~~and~~ June 15, 2019, and June 15, 2020 the amount of funds  
32 available in the hospital excess liability pool, created pursuant to  
33 section 18 of chapter 266 of the laws of 1986, and whether such funds  
34 are sufficient for purposes of purchasing excess insurance coverage for  
35 eligible participating physicians and dentists during the period July 1,  
36 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003  
37 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to  
38 June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June  
39 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30,  
40 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30,  
41 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,  
42 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,  
43 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,  
44 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020  
45 as applicable.

46 (a) This section shall be effective only upon a determination, pursu-  
47 ant to section five of this act, by the superintendent of financial  
48 services and the commissioner of health, and a certification of such  
49 determination to the state director of the budget, the chair of the  
50 senate committee on finance and the chair of the assembly committee on  
51 ways and means, that the amount of funds in the hospital excess liabil-  
52 ity pool, created pursuant to section 18 of chapter 266 of the laws of  
53 1986, is insufficient for purposes of purchasing excess insurance cover-  
54 age for eligible participating physicians and dentists during the period  
55 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July  
56 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,

1 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007  
2 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to  
3 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June  
4 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,  
5 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,  
6 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,  
7 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020  
8 as applicable.

9 (e) The commissioner of health shall transfer for deposit to the  
10 hospital excess liability pool created pursuant to section 18 of chapter  
11 266 of the laws of 1986 such amounts as directed by the superintendent  
12 of financial services for the purchase of excess liability insurance  
13 coverage for eligible participating physicians and dentists for the  
14 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,  
15 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,  
16 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,  
17 2007, as applicable, and the cost of administering the hospital excess  
18 liability pool for such applicable policy year, pursuant to the program  
19 established in chapter 266 of the laws of 1986, as amended, no later  
20 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June  
21 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,  
22 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,  
23 2015, June 15, 2016, June 15, 2017, June 15, 2018, [~~and~~] June 15, 2019,  
24 and June 15, 2020 as applicable.

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

29 § 20. Notwithstanding any law, rule or regulation to the contrary,  
30 only physicians or dentists who were eligible, and for whom the super-  
31 intendent of financial services and the commissioner of health, or their  
32 designee, purchased, with funds available in the hospital excess liabil-  
33 ity pool, a full or partial policy for excess coverage or equivalent  
34 excess coverage for the coverage period ending the thirtieth of June,  
35 two thousand [~~eighteen~~] nineteen, shall be eligible to apply for such  
36 coverage for the coverage period beginning the first of July, two thou-  
37 sand [~~eighteen~~] nineteen; provided, however, if the total number of  
38 physicians or dentists for whom such excess coverage or equivalent  
39 excess coverage was purchased for the policy year ending the thirtieth  
40 of June, two thousand [~~eighteen~~] nineteen exceeds the total number of  
41 physicians or dentists certified as eligible for the coverage period  
42 beginning the first of July, two thousand [~~eighteen~~] nineteen, then the  
43 general hospitals may certify additional eligible physicians or dentists  
44 in a number equal to such general hospital's proportional share of the  
45 total number of physicians or dentists for whom excess coverage or  
46 equivalent excess coverage was purchased with funds available in the  
47 hospital excess liability pool as of the thirtieth of June, two thousand  
48 [~~eighteen~~] nineteen, as applied to the difference between the number of  
49 eligible physicians or dentists for whom a policy for excess coverage or  
50 equivalent excess coverage was purchased for the coverage period ending  
51 the thirtieth of June, two thousand [~~eighteen~~] nineteen and the number  
52 of such eligible physicians or dentists who have applied for excess  
53 coverage or equivalent excess coverage for the coverage period beginning  
54 the first of July, two thousand [~~eighteen~~] nineteen.

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



## PART G

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

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

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

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

(iii) the applicant executes an assignment of support from the community spouse in favor of the social services district and the department, unless the applicant is unable to execute such assignment due to physical or mental impairment or to deny assistance would create an undue hardship, as defined by the commissioner; or

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

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

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

§ 3. Section 365-f of the social services law is REPEALED, and a new section 365-f is added to read as follows:

§ 365-f. Consumer directed personal assistance program. 1. Purpose and intent. The consumer directed personal assistance program is intended to permit chronically ill and/or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services. The department shall regularly monitor district participation in the program by reviewing the implementation plans submitted pursuant to this section. The department shall provide guidance to the districts to improve compliance with implementation plans and promote consistency among counties regarding approved service levels based on the assessments required by this section. In addition, the department shall provide technical assistance and such other assistance as may be necessary to assist such districts in assuring access to the program for eligible individuals.

2. Eligibility. All eligible individuals receiving home care shall be provided notice of the availability of the program, and no less frequently than annually thereafter, and shall have the opportunity to apply for participation in the program. Each social services district shall file an implementation plan with the commissioner of the department of health, which shall be updated annually. Such updates shall be submitted no later than November thirtieth of each year. The plans and updates submitted by districts shall require the approval of the depart-



1 ment. Implementation plans shall include district enrollment targets,  
2 describe methods for the provision of notice and assistance to inter-  
3 ested individuals eligible for enrollment in the program, and shall  
4 contain such other information as, shall be required by the department.  
5 An "eligible individual", for purposes of this section is a person who:

6 (a) is eligible for long term care and services provided by a certi-  
7 fied home health agency, long term home health care program or AIDS home  
8 care program authorized pursuant to article thirty-six of the public  
9 health law, or is eligible for personal care services provided pursuant  
10 to this article;

11 (b) is eligible for medical assistance;

12 (c) has been determined by the social services district or an entity  
13 certified under article forty-four of the public health law, pursuant  
14 to an assessment of the person's appropriateness for the program,  
15 conducted with an appropriate long term home health care program, a  
16 certified home health agency, or an AIDS home care program or pursuant  
17 to the personal care program, as being in need of home care services or  
18 private duty nursing and is able and willing or has a designated repre-  
19 sentative, including a legal guardian able and willing to make informed  
20 choices, or a designated relative or other adult who is able and willing  
21 to assist in making informed choices, as to the type and quality of  
22 services, including but not limited to such services as nursing care,  
23 personal care, transportation and respite services; and

24 (d) meets such other criteria, as may be established by the commis-  
25 sioner, which are necessary to effectively implement the objectives of  
26 this section.

27 3. Eligible individuals. Eligible individuals who elect to participate  
28 in the program assume the responsibility for services under such  
29 program as mutually agreed to by the eligible individual and provider  
30 and as documented in the eligible individual's record, including, but  
31 not limited to, recruiting, hiring and supervising their personal  
32 assistants. For the purposes of this section, personal assistant shall  
33 mean an adult who provides services under this section to the eligible  
34 individual under the eligible individual's instruction, supervision and  
35 direction or under the instruction, supervision and direction of the  
36 eligible individual's designated representative, provided that a person  
37 legally responsible for an eligible individual's care and support, an  
38 eligible individual's spouse or designated representative may not be the  
39 personal assistant for the eligible individual; however, a personal  
40 assistant may include any other adult relative of the eligible individ-  
41 ual, provided, however, that the program determines that the services  
42 provided by such relative are consistent with an individual's plan of  
43 care and that the aggregate cost for such services does not exceed the  
44 aggregate costs for equivalent services provided by a non-relative  
45 personal assistant. Such individuals shall be assisted as appropriate  
46 with service coverage, supervision, advocacy and management. Providers  
47 shall not be liable for fulfillment of responsibilities agreed to be  
48 undertaken by the eligible individual. This subdivision, however, shall  
49 not diminish the participating provider's liability for failure to exer-  
50 cise reasonable care in properly carrying out its responsibilities  
51 under this program, which shall include monitoring such individual's  
52 continuing ability to fulfill those responsibilities documented in his  
53 or her records. Failure of the individual to carry out his or her  
54 agreed to responsibilities may be considered in determining such indi-  
55 vidual's continued appropriateness for the program.

1 4. Participating providers. All agencies or individuals who meet the  
2 qualifications to provide home health, personal care or nursing services  
3 and who elect to provide such services to persons receiving medical  
4 assistance may participate in the program. Any agency or individuals  
5 providing services under a patient managed home care program authorized  
6 under the former section thirty-six hundred twenty-two of the public  
7 health law or the former section three hundred sixty-five-f of this  
8 chapter may continue to provide such services under this section.

9 5. Fiscal intermediaries. (a) For the purposes of this section "fiscal  
10 intermediary" means:

11 (i) an entity that has a contract with the department of health to  
12 provide fiscal intermediary services pursuant to paragraph (e) of this  
13 subdivision; or

14 (ii) an entity authorized by the commissioner upon application with a  
15 history of providing fiscal intermediary services that:

16 (A) is a service center for independent living under section one thou-  
17 sand one hundred twenty-one of the education law; or

18 (B) has experience providing fiscal intermediary services for persons  
19 with disabilities, in accordance with such criteria as the department  
20 may develop, as demonstrated by having a continuous history of arrange-  
21 ments with local departments of social services beginning no later than  
22 January first, two thousand twelve.

23 (b) An application for authorization as a fiscal intermediary under  
24 subparagraph (ii) of paragraph (a) of this subdivision shall be filed  
25 with the commissioner, together with such other forms and information as  
26 shall be prescribed by, or acceptable to the commissioner.

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

30 (i) wage and benefit processing for consumer directed personal assist-  
31 ants;

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

33 (iii) complying with workers' compensation, disability and unemploy-  
34 ment requirements;

35 (iv) maintaining personnel records for each consumer directed personal  
36 assistants including time sheets and other documentation needed for  
37 wages and benefit processing and a copy of the medical documentation  
38 required pursuant to regulations established by the commissioner;

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

42 (vi) maintaining records of service authorizations or reauthori-  
43 zations;

44 (vii) monitoring the consumer's or, if applicable, the designated  
45 representative's continuing ability to fulfill the consumer's responsi-  
46 bilities under the program and promptly notifying the authorizing entity  
47 of any circumstance that may affect the consumer's or, if applicable,  
48 the designated representative's ability to fulfill such responsibil-  
49 ities;

50 (viii) complying with regulations established by the commissioner  
51 specifying the responsibilities of fiscal intermediaries providing  
52 services under this title; and

53 (ix) entering into a department approved memorandum of understanding  
54 with the consumer that describes the parties' responsibilities under  
55 this program.

(d) Fiscal intermediaries are not responsible for, and fiscal intermediary services shall not include, fulfillment of the responsibilities of the consumer or, if applicable, the consumer's designated representative as established by the commissioner. A fiscal intermediary's responsibilities shall not include, and a fiscal intermediary shall not engage in: managing the plan of care including recruiting and hiring a sufficient number of individuals who meet the definition of consumer directed personal assistant, as such term is defined by the commissioner, to provide authorized services that are included on the consumer's plan of care; training, supervising and scheduling each consumer directed personal assistant; terminating the consumer directed personal assistant's employment; or assuring that each consumer directed personal assistant competently and safely performs the personal care services, home health aide services and skilled nursing tasks that are included on the consumer's plan of care. A fiscal intermediary shall exercise reasonable care in properly carrying out its responsibilities under the program.

(e) Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under this subdivision with an entity or entities without a competitive bid or request for proposal process, provided, however, that:

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

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

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

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

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

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

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

6. Actions involving the authorization of a fiscal intermediary. (a) A fiscal intermediary's authorization under subparagraph (ii) of paragraph (a) of subdivision five of this section may be revoked, suspended, limited or annulled upon thirty days' 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. Notwithstanding the foregoing, upon determining that the public health or safety would be imminently endangered by the continued authorization of the fiscal intermediary, the commissioner may revoke, suspend, limit or annul the fiscal intermediary's authorization immediately.

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

7. Waivers, regulations and effectiveness. (a) The commissioner may, subject to the approval of the director of budget, file for such federal waivers as may be needed for the implementation of the program.

(b) Notwithstanding any other provision of law, the commissioner is authorized to waive any provision of section three hundred sixty-seven-b of this title related to payment and may promulgate regulations necessary to carry out the objectives of the program, and which describe the responsibilities of the eligible individuals in arranging and paying for services and the protections assured such individuals if they are unable or no longer desire to continue in the program.

8. Notwithstanding any inconsistent provision of this section or any other contrary provision of law, managed care programs established pursuant to section three hundred sixty-four-j of this title and managed long term care plans and other care coordination models established pursuant to section four thousand four hundred three-f of the public health law shall offer consumer directed personal assistance programs to enrollees.

9. Notwithstanding any provision of this section or any other law to the contrary, the provisions pertaining to consumer directed personal assistance services and fiscal intermediaries pursuant to this section shall only be available if the commissioner of health determines that there is adequate Federal Financial Participation to fund such programs and/or entities.

10. Subject to the availability of federal financial participation, the provisions of this section governing consumer directed personal assistance services shall also apply to such services when offered under the home and community-based attendant services and supports state plan option, community first choice, pursuant to 42 U.S.C. § 1396n(k).

§ 4. 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 three of this act shall take effect January 1, 2020.

#### PART H

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

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

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

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

(i) For rate periods on and after April first, two thousand ten, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for determining the operating cost components of rates of payments for services described in this

paragraph. Such regulations shall utilize two thousand five operating costs as submitted to the department prior to July first, two thousand nine and ~~shall~~ may provide for methodologies establishing per diem inpatient rates that utilize case mix adjustment mechanisms. Such regulations ~~shall~~ may contain criteria for adjustments based on length of stay and may also provide for a base year update, provided, however, that such base year update shall take effect no earlier than April first, two thousand fifteen, and provided further, however, that the commissioner may make such adjustments to such utilization and to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to such rates, as compared to such aggregate expenditures from the prior year. In determining the updated base year to be utilized pursuant to this subparagraph, the commissioner shall take into account the base year determined in accordance with paragraph (c) of subdivision thirty-five of this section.

§ 4. Paragraph (b) of subdivision 35 of section 2807-c of the public health law is amended by adding a new subparagraph (xiv) to read as follows:

(xiv) Such rates and payment methodologies may incorporate methodologies to reduce payments to facilities with a higher percentage of potentially avoidable inpatient services by instituting lower inpatient payment rates for both fee-for-service and managed care to incentivize the provision of preventative care to reduce preventable events and overall inpatient costs. A portion of such savings derived from the implementation of such payment methodologies shall be reinvested in initiatives to incentivize the provision of preventative care, maternity services, and other ambulatory care services to reduce preventable health care costs.

§ 5. This act shall take effect immediately.

## PART I

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

### ARTICLE 29

#### PHARMACY BENEFIT MANAGERS

##### Section 2901. Definitions.

2902. Acting without a registration.

2903. Registration requirements for pharmacy benefit managers.

2904. Reporting requirements for pharmacy benefit managers.

2905. Acting without a license.

2906. Licensing of a pharmacy benefit manager.

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

2908. Penalties for violations.

2909. Stay or suspension of superintendent's determination.

2910. Revoked registration or licenses.

2911. Change of address.

2912. Applicability of other laws.

2913. Assessments.

§ 2901. Definitions. For purposes of this article:

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



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

10 (c) "Pharmacy benefit management services" means directly or through  
11 an intermediary, managing the prescription drug coverage provided by a  
12 health insurer under a contract or policy delivered or issued for deliv-  
13 ery in this state or a plan subject to section three hundred  
14 sixty-four-j of the social services law, including the processing and  
15 payment of claims for prescription drugs, the performance of drug utili-  
16 zation review, the processing of drug prior authorization requests, the  
17 adjudication of appeals or grievances related to prescription drug  
18 coverage, contracting with network pharmacies, and controlling the cost  
19 of covered prescription drugs.

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

24 (1) an officer or employee of a registered or licensed pharmacy bene-  
25 fit manager; or

26 (2) a health insurer, or any manager thereof, individual or corporate,  
27 or any officer, director or regular salaried employee thereof, providing  
28 pharmacy benefit management services under a policy or contract issued  
29 by the health insurer.

30 § 2902. Acting without a registration. (a) No person, firm, associ-  
31 ation, corporation or other entity may act as a pharmacy benefits manag-  
32 er prior to January first, two thousand twenty without having a valid  
33 registration as a pharmacy benefit manager filed with the superintendent  
34 in accordance with this article and any regulations promulgated there-  
35 under.

36 (b) Prior to January first, two thousand twenty, no health insurer may  
37 pay any fee or other compensation to any person, firm, association,  
38 corporation or other entity for performing pharmacy benefit management  
39 services unless the person, firm, association, corporation or other  
40 entity is registered as a pharmacy benefit manager in accordance with  
41 this article.

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

49 § 2903. Registration requirements for pharmacy benefit managers. (a)  
50 Every pharmacy benefit manager that performs pharmacy benefit management  
51 services prior to January first, two thousand twenty-one shall register  
52 with the superintendent in a manner acceptable to the superintendent,  
53 and shall pay a fee of one thousand dollars for each year or fraction of  
54 a year in which the registration shall be valid. The superintendent, in  
55 consultation with the commissioner of health, may establish, by regu-  
56 lation, minimum registration standards required for a pharmacy benefit

1 manager. The superintendent can reject a registration application filed  
2 by a pharmacy benefit manager that fails to comply with the minimum  
3 registration standards.

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

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

10 (d) Every pharmacy benefit manager that performs pharmacy benefit  
11 management services at any time between January first, two thousand  
12 nineteen and June first, two thousand nineteen, shall make the registra-  
13 tion and fee payment required by subsection (a) of this section on or  
14 before June first, two thousand nineteen. Any other pharmacy benefit  
15 manager shall make the registration and fee payment required by  
16 subsection (a) of this section prior to performing pharmacy benefit  
17 management services.

18 (e) Registrants under this section shall be subject to examination by  
19 the superintendent as often as the superintendent may deem it necessary.  
20 The superintendent may promulgate regulations establishing methods and  
21 procedures for facilitating and verifying compliance with the require-  
22 ments of this article and such other regulations as necessary to enforce  
23 the provisions of this article.

24 § 2904. Reporting requirements for pharmacy benefit managers. (a)(1)  
25 On or before July first of each year, beginning in two thousand twenty,  
26 every pharmacy benefit manager shall report to the superintendent, in a  
27 statement subscribed and affirmed as true under penalties of perjury,  
28 the information requested by the superintendent including, without limi-  
29 tation, disclosure of any financial incentive or benefit for promoting  
30 the use of certain drugs and other financial arrangements affecting  
31 health insurers or their policyholders or insureds and any information  
32 relating to the business, financial condition, or market conduct of the  
33 pharmacy benefit manager. The superintendent also may require the filing  
34 of quarterly or other statements, which shall be in such form and shall  
35 contain such matters as the superintendent shall prescribe.

36 (2) The superintendent also may address to any pharmacy benefit manag-  
37 er or its officers any inquiry in relation to its provision of pharmacy  
38 benefit management services or any matter connected therewith. Every  
39 pharmacy benefit manager or person so addressed shall reply in writing  
40 to such inquiry promptly and truthfully, and such reply shall be, if  
41 required by the superintendent, subscribed by such individual, or by  
42 such officer or officers of the pharmacy benefit manager, as the super-  
43 intendent shall designate, and affirmed by them as true under the penal-  
44 ties of perjury.

45 (b) In the event any pharmacy benefit manager or person does not  
46 submit the report required by paragraph one of subsection (a) of this  
47 section or does not provide a good faith response to an inquiry from the  
48 superintendent pursuant to paragraph two of subsection (a) of this  
49 section within a time period specified by the superintendent of not less  
50 than fifteen business days, the superintendent is authorized to levy a  
51 civil penalty, after notice and hearing, against such pharmacy benefit  
52 manager or person not to exceed five hundred dollars per day for each  
53 day beyond the date the report is due or the date specified by the  
54 superintendent for response to the inquiry.

55 (c) All information disclosed by a pharmacy benefit manager shall be  
56 deemed confidential and not subject to disclosure unless the superinten-

1 dent determines that such disclosure is in the public interest, or is  
2 necessary to carry out this article or to allow the department to  
3 perform examinations or investigations authorized by law.

4 § 2905. Acting without a license. (a) No person, firm, association,  
5 corporation or other entity may act as a pharmacy benefit manager on or  
6 after January first, two thousand twenty-one without having authority to  
7 do so by virtue of a license issued in force pursuant to the provisions  
8 of this article.

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

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

21 § 2906. Licensing of a pharmacy benefit manager. (a) The superinten-  
22 dent may issue a pharmacy benefit manager's license to any person, firm,  
23 association or corporation who or that has complied with the require-  
24 ments of this article, including regulations promulgated by the super-  
25 intendent. The superintendent, in consultation with the commissioner of  
26 health, may establish, by regulation, minimum standards for the issuance  
27 of a license to a pharmacy benefit manager.

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

30 (1) conflicts of interest between pharmacy benefit managers and health  
31 insurers;

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

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

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

38 (5) protection of consumers.

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

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

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

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

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

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

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

(f) The superintendent may refuse to issue a pharmacy benefit manager's license if, in the superintendent's judgment, the applicant or any member, principal, officer or director of the applicant, is not trustworthy and competent to act as or in connection with a pharmacy benefit manager, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(g) Licensees and applicants for a license under this section shall be subject to examination by the superintendent as often as the superintendent may deem it expedient. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this section and such other regulations as necessary.

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

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

(1) violated any insurance laws, or violated any regulation, subpoena or order of the superintendent or of another state's insurance commissioner, or has violated any law in the course of his or her dealings in such capacity;

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

1 (3) obtained or attempted to obtain a registration or license through  
2 misrepresentation or fraud;

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

4 (B) demonstrated incompetence;

5 (C) demonstrated untrustworthiness; or

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

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

11 (6) intentionally misrepresented the terms of an actual or proposed  
12 insurance contract;

13 (7) been convicted of a felony;

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

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

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

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

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

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

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

38 (e)(1) No individual, corporation, firm or association whose registra-  
39 tion or license as a pharmacy benefit manager has been revoked pursuant  
40 to subsection (a) of this section, and no firm or association of which  
41 such individual is a member, and no corporation of which such individual  
42 is an officer or director, and no controlling person of the registrant  
43 or licensee shall be entitled to obtain any registration or license  
44 under the provisions of this article for a period of one year after such  
45 revocation, or, if such revocation be judicially reviewed, for one year  
46 after the final determination thereof affirming the action of the super-  
47 intendent in revoking such license.

48 (2) If any such registration or license held by a firm, association or  
49 corporation be revoked, no member of such firm or association and no  
50 officer or director of such corporation or any controlling person of the  
51 registrant or licensee shall be entitled to obtain any registration or  
52 license, or to be named as a sub-licensee in any such license, under  
53 this article for the same period of time, unless the superintendent  
54 determines, after notice and hearing, that such member, officer or  
55 director was not personally at fault in the matter on account of which  
56 such registration or license was revoked.



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

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

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

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

25 § 2908. Penalties for violations. (a) The superintendent, in lieu of  
26 revoking or suspending the registration or license of a registrant or  
27 licensee in accordance with the provisions of this article, may in any  
28 one proceeding by order, require the registrant or licensee to pay to  
29 the people of this state a penalty in a sum not exceeding the greater of  
30 (1) one thousand dollars for each offense and two thousand five hundred  
31 dollars for each subsequent violation or (2) the aggregate gross  
32 receipts attributable to all offenses.

33 (b) Upon the failure of such a registrant or licensee to pay the  
34 penalty ordered pursuant to subsection (a) of this section within twenty  
35 days after the mailing of the order, postage prepaid, registered, and  
36 addressed to the last known place of business of the licensee, unless  
37 the order is stayed by an order of a court of competent jurisdiction,  
38 the superintendent may revoke the registration or license of the regis-  
39 trant or licensee or may suspend the same for such period as the super-  
40 intendent determines.

41 § 2909. Stay or suspension of superintendent's determination. The  
42 commencement of a proceeding under article seventy-eight of the civil  
43 practice law and rules, to review the action of the superintendent in  
44 suspending or revoking or refusing to renew any certificate under this  
45 article, shall stay such action of the superintendent for a period of  
46 thirty days. Such stay shall not be extended for a longer period unless  
47 the court shall determine, after a preliminary hearing of which the  
48 superintendent is notified forty-eight hours in advance, that a stay of  
49 the superintendent's action pending the final determination or further  
50 order of the court will not unduly injure the interests of the people of  
51 the state.

52 § 2910. Revoked registrations or licenses. (a)(1) No person, firm,  
53 association, corporation or other entity subject to the provisions of  
54 this article whose registration or license under this article has been  
55 revoked, or whose registration or license to engage in the business of  
56 pharmacy benefit management in any capacity has been revoked by any

1 other state or territory of the United States shall become employed or  
2 appointed by a pharmacy benefit manager as an officer, director, manag-  
3 er, controlling person or for other services, without the prior written  
4 approval of the superintendent, unless such services are for maintenance  
5 or are clerical or ministerial in nature.

6 (2) No person, firm, association, corporation or other entity subject  
7 to the provisions of this article shall knowingly employ or appoint any  
8 person or entity whose registration or license issued under this article  
9 has been revoked, or whose registration or license to engage in the  
10 business of pharmacy benefit management in any capacity has been revoked  
11 by any other state or territory of the United States, as an officer,  
12 director, manager, controlling person or for other services, without the  
13 prior written approval of the superintendent, unless such services are  
14 for maintenance or are clerical or ministerial in nature.

15 (3) No corporation or partnership subject to the provisions of this  
16 article shall knowingly permit any person whose registration or license  
17 issued under this article has been revoked, or whose registration or  
18 license to engage in the business of pharmacy benefit management in any  
19 capacity has been revoked by any other state, or territory of the United  
20 States, to be a shareholder or have an interest in such corporation or  
21 partnership, nor shall any such person become a shareholder or partner  
22 in such corporation or partnership, without the prior written approval  
23 of the superintendent.

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

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

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

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

44 § 2911. Change of address. A registrant or licensee under this article  
45 shall inform the superintendent by a means acceptable to the superinten-  
46 dent of a change of address within thirty days of the change.

47 § 2912. Applicability of other laws. Nothing in this article shall be  
48 construed to exempt a pharmacy benefit manager from complying with the  
49 provisions of articles twenty-one and forty-nine of this chapter and  
50 article forty-nine of the public health law or any other provision of  
51 this chapter or the financial services law.

52 § 2913. Assessments. Pharmacy benefit managers that file a registra-  
53 tion with the department or are licensed by the department shall be  
54 assessed by the superintendent for the operating expenses of the depart-  
55 ment that are solely attributable to regulating such pharmacy benefit

1 managers in such proportions as the superintendent shall deem just and  
2 reasonable.

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

6 (b) "Defined violation" means the commission by a person of an act  
7 prohibited by: subsection (a) of section one thousand one hundred two,  
8 section one thousand two hundred fourteen, one thousand two hundred  
9 seventeen, one thousand two hundred twenty, one thousand three hundred  
10 thirteen, subparagraph (B) of paragraph two of subsection (i) of section  
11 one thousand three hundred twenty-two, subparagraph (B) of paragraph two  
12 of subsection (i) of section one thousand three hundred twenty-four, two  
13 thousand one hundred two, two thousand one hundred seventeen, two thou-  
14 sand one hundred twenty-two, two thousand one hundred twenty-three,  
15 subsection (p) of section two thousand three hundred thirteen, section  
16 two thousand three hundred twenty-four, two thousand five hundred two,  
17 two thousand five hundred three, two thousand five hundred four, two  
18 thousand six hundred one, two thousand six hundred two, two thousand six  
19 hundred three, two thousand six hundred four, two thousand six hundred  
20 six, two thousand seven hundred three, two thousand nine hundred two,  
21 two thousand nine hundred five, three thousand one hundred nine, three  
22 thousand two hundred twenty-four-a, three thousand four hundred twenty-  
23 nine, three thousand four hundred thirty-three, paragraph seven of  
24 subsection (e) of section three thousand four hundred twenty-six, four  
25 thousand two hundred twenty-four, four thousand two hundred twenty-five,  
26 four thousand two hundred twenty-six, seven thousand eight hundred nine,  
27 seven thousand eight hundred ten, seven thousand eight hundred eleven,  
28 seven thousand eight hundred thirteen, seven thousand eight hundred  
29 fourteen and seven thousand eight hundred fifteen of this chapter; or  
30 section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one  
31 hundred five of the penal law.

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

34 PART J

35 Section 1. This Part enacts into law major components of legislation  
36 which are necessary to protect health care consumers; increase access to  
37 more affordable quality health insurance coverage; and preserve and  
38 foster New York's health insurance markets. Each component is wholly  
39 contained within a Subpart identified as Subparts A through F. The  
40 effective date for each particular provision contained within such  
41 Subpart is set forth in the last section of such Subpart. Any provision  
42 in any section contained within a Subpart, including the effective date  
43 of the Subpart, which makes a reference to a section "of this act," when  
44 used in connection with that particular component, shall be deemed to  
45 mean and refer to the corresponding section of the Subpart in which it  
46 is found. Section five of this Part sets forth the general effective  
47 date of this Part.

48 SUBPART A

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

51 (t) (1) Any insurer that delivers or issues for delivery in this state  
52 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~~].

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

(A) A policy issued to an employer or to a trustee or trustees of a fund established by an employer, which employer or trustee or trustees shall be deemed the policyholder, insuring with or without evidence of insurability satisfactory to the insurer, employees of such employer, and insuring, except as hereinafter provided, all of such employees or all of any class or classes thereof determined by conditions pertaining to the employment or a combination of such conditions and conditions pertaining to the family status of the employee, for insurance coverage on each person insured based upon some plan [~~which~~] that will preclude individual selection. However, such a plan may permit a limited number of selections by employees if the selections offered utilize consistent

1 plans of coverage for individual group members so that the resulting  
2 plans of coverage are reasonable. The premium for the policy shall be  
3 paid by the policyholder, either from the employer's funds, or from  
4 funds contributed by the insured employees, or from funds contributed  
5 jointly by the employer and employees. If all or part of the premium is  
6 to be derived from funds contributed by the insured employees, then  
7 ~~[such] the insurer issuing the policy [must insure not less than fifty~~  
8 ~~percent of such eligible employees or, if less, fifty or more]~~ shall not  
9 require a minimum number or minimum percentage of such employees be  
10 insured when ~~[such] the~~ policy is providing coverage for group hospital,  
11 medical, major medical or similar comprehensive types of expense reim-  
12 bursed insurance and, for all other types of group accident and health  
13 insurance, ~~[must] the policy shall~~ insure a minimum of fifty percent or  
14 five of such eligible employees, whichever is fewer.

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

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

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

27 § 7. Paragraph 1 of subsection (d) of section 4317 of the insurance  
28 law, as amended by section 72 of part D of chapter 56 of the laws of  
29 2013, is amended to read as follows:

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

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

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

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



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

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

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

(2) Notwithstanding paragraph one of this subsection, an employee welfare fund registered with the superintendent prior to June first, two thousand nineteen, which, as of February first, two thousand nineteen directly provided medical, surgical or hospital care or benefits in the event of sickness or injury for employees or their families or dependents, or for both, may continue to provide those benefits directly rather than under a group comprehensive-type health insurance policy or contract delivered or issued for delivery in this state by an authorized insurer or a health maintenance organization issued a certificate of authority under article forty-four of the public health law; provided, however, that, if the employee welfare fund ceases offering the benefits directly, it may not resume providing the benefits directly.

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

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

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

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

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

#### SUBPART B

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

(A) Any family policy providing hospital or surgical expense insurance (but not including such insurance against accidental injury only) shall provide that, in the event such insurance on any person, other than the policyholder, is terminated because the person is no longer within the definition of the family as set forth in the policy but before such person has attained the limiting age, if any, for coverage of adults specified in the policy, such person shall be entitled to have issued to that person by the insurer, without evidence of insurability, upon application therefor and payment of the first premium, within sixty days

1 after such insurance shall have terminated, an individual conversion  
2 policy that contains the essential health benefits package described in  
3 paragraph ~~[one]~~ three of subsection ~~[(b)]~~ (f) of section ~~[four thousand~~  
4 ~~three hundred twenty-eight of this chapter. The insurer shall offer one~~  
5 ~~policy at each level of coverage as defined in section 1302(d) of the~~  
6 ~~affordable care act, 42 U.S.C. § 18022(d).]~~ three thousand two hundred  
7 seventeen-i of this article. The insurer shall offer one policy at each  
8 level of coverage as defined in subsection (c) of section three thousand  
9 two hundred seventeen-i of this article. The individual may choose any  
10 such policy offered by the insurer. Provided, however, the superinten-  
11 dent may, after giving due consideration to the public interest, approve  
12 a request made by an insurer for the insurer to satisfy the requirements  
13 of this subparagraph through the offering of policies that comply with  
14 this subparagraph by another insurer, corporation or health maintenance  
15 organization within the insurer's holding company system, as defined in  
16 article fifteen of this chapter. The conversion privilege afforded here-  
17 in shall also be available upon the divorce or annulment of the marriage  
18 of the policyholder to the former spouse of such policyholder.

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

22 (E) The superintendent may, after giving due consideration to the  
23 public interest, approve a request made by an insurer for the insurer to  
24 satisfy the requirements of subparagraph (C) of this paragraph through  
25 the offering of policies at each level of coverage as defined in  
26 subsection (c) of section [1302(d) of the affordable care act, 42 U.S.C.  
27 § 18022(d)] three thousand two hundred seventeen-i of this article that  
28 contains the essential health benefits package described in paragraph  
29 ~~[one]~~ three of subsection ~~[(b)]~~ (f) of section ~~[four thousand three~~  
30 ~~hundred twenty-eight of this chapter]~~ three thousand two hundred seven-  
31 teen-i of this article by another insurer, corporation or health mainte-  
32 nance organization within the insurer's same holding company system, as  
33 defined in article fifteen of this chapter.

34 § 3. Items (i) and (ii) of subparagraph (D) of paragraph 11 of  
35 subsection (i) of section 3216 of the insurance law, as added by chapter  
36 219 of the laws of 2011, are amended, and a new item (iii) is added to  
37 read as follows:

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

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

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

49 § 4. Items (i) and (ii) of subparagraph (D) of paragraph 15 of  
50 subsection (i) of section 3216 of the insurance law, as added by chapter  
51 219 of the laws of 2011, are amended, and a new item (iii) is added to  
52 read as follows:

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

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

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

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

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

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

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

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

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

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

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

§ 8. Subsection (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. § 18031, or any regulations promulgated thereunder,]~~ by this state also shall meet any requirements established by the health benefit exchange.

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

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

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

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

- (1) ambulatory patient services;
- (2) emergency services;
- (3) hospitalization;
- (4) maternity and newborn care;
- (5) mental health and substance use disorder services, including behavioral health treatment;
- (6) prescription drugs;
- (7) rehabilitative and habilitative services and devices;
- (8) laboratory services;



1 (9) preventive and wellness services and chronic disease management;  
2 and

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

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

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

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

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

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

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

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

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

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

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

49 (f) For purposes of this section:

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

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

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

1 (A) provides for essential health benefits;  
2 (B) limits cost-sharing for such coverage in accordance with  
3 subsection (d) of this section; and

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

6 (4) "grandfathered health plan" means coverage provided by an insurer  
7 in which an individual was enrolled on March twenty-third, two thousand  
8 ten for as long as the coverage maintains grandfathered status in  
9 accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. §  
10 18011(e);

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

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

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

18 (g) For conversion purposes, an insurer shall offer to the employee or  
19 member a policy at each level of coverage as defined in subsection (c)  
20 of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)]  
21 three thousand two hundred seventeen-i of this article that contains the  
22 essential health benefits package described in paragraph [one] three of  
23 subsection [(b)] (f) of section [four thousand three hundred twenty-  
24 eight of this chapter] three thousand two hundred seventeen-i of this  
25 article. Provided, however, the superintendent may, after giving due  
26 consideration to the public interest, approve a request made by an  
27 insurer for the insurer to satisfy the requirements of this subsection  
28 and subsections (e) and (f) of this section through the offering of  
29 policies that comply with this subsection by another insurer, corpo-  
30 ration or health maintenance organization within the insurer's holding  
31 company system, as defined in article fifteen of this chapter.

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

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

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

45 (2) "grandfathered health plan" means coverage provided by an insurer  
46 in which an individual was enrolled on March twenty-third, two thousand  
47 ten for as long as the coverage maintains grandfathered status in  
48 accordance with section 1251(e) of the affordable care act, 42 U.S.C. §  
49 18011(e);

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

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

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

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

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

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

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

(11) 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]~~.

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

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

(ii) with respect to women, such additional preventive care and screenings for bone mineral density not described in item (i) of this

1 subparagraph and as provided for in comprehensive guidelines supported  
2 by the health resources and services administration[~~+~~]; and

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

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

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

25 § 17. Items (iii) and (iv) of subparagraph (E) of paragraph 8 of  
26 subsection (l) of section 3221 of the insurance law, as added by chapter  
27 219 of the laws of 2011, are amended and a new item (v) is added to read  
28 as follows:

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

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

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

41 § 18. Items (i) and (ii) of subparagraph (D) of paragraph 11 of  
42 subsection (l) of section 3221 of the insurance law, as added by chapter  
43 219 of the laws of 2011, are amended and a new item (iii) is added to  
44 read as follows:

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

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

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

§ 19. Items (i) and (ii) of subparagraph (D) of paragraph 14 of subsection (1) of section 3221 of the insurance law, as added by chapter 219 of the laws of 2011, are amended and a new item (iii) is added to read as follows:

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

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

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

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

(4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy form is the same based on the experience of the entire pool of risks of all individuals or small groups covered by the insurer without regard to age, sex, health status, tobacco usage or occupation, excluding those individuals or small groups covered by medicare supplemental insurance. For medicare supplemental insurance coverage, "community rated" means a rating methodology in which the premiums for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, tobacco usage or occupation. ~~[Catastrophic health insurance policies issued pursuant to section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e), shall be classified in a distinct community rating pool.]~~

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Discontinuance of a class of contract upon not less than ninety days' prior written notice. In exercising the option to discontinue coverage pursuant to this item, the corporation must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and must offer to subscribers or group remitting agents, as may be appropriate, the option to purchase all other individual health insurance coverage currently being offered by the corporation to applicants in that market. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by a corporation for the corporation to satisfy the requirements of this item through the offering of contracts at each level of coverage as defined in subsection (c) of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this article that contains the essential health benefits package described in paragraph [~~one~~] three of subsection [~~(b)~~] (f) of section four thousand three hundred [~~twenty-eight~~] six-h of this [~~chapter~~] article by another corporation, insurer or health maintenance organization within the corporation's same holding company system, as defined in article fifteen of this chapter.

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

(1) (A) If any such contract is terminated in accordance with the provisions of paragraph one of subsection (c) of this section, or any such contract is terminated because of a default by the remitting agent in the payment of premiums not cured within the grace period and the remitting agent has not replaced the contract with similar and continuous coverage for the same group whether insured or self-insured, or any such contract is terminated in accordance with the provisions of subparagraph (E) of paragraph two of subsection (c) of this section, or if an individual other than the contract holder is no longer covered under a "family contract" because the individual is no longer within the definition set forth in the contract, or a spouse is no longer covered under the contract because of divorce from the contract holder or annulment of the marriage, or any such contract is terminated because of the death of the contract holder, then such individual, former spouse, or in the case of the death of the contract holder the surviving spouse or other dependents of the deceased contract holder covered under the contract, as the case may be, shall be entitled to convert, without evidence of insurability, upon application therefor and the making of the first payment thereunder within sixty days after the date of termination of such contract, to a contract that contains the essential health benefits package described in paragraph ~~(one)~~ three of subsection ~~[(b)]~~ (f) of section four thousand three hundred ~~[twenty-eight]~~ six-h of this ~~[chapter]~~ article.

(B) The corporation shall offer one contract at each level of coverage as defined in subsection (c) of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this article. The individual may choose any such contract offered by the corporation. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by a corporation for the corporation to satisfy the requirements of this paragraph through the offering of contracts that comply with this paragraph by another corporation, insurer or health maintenance organization within the corporation's same holding company system, as defined in article fifteen of this chapter.

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

§ 33. Subsection (1) of section 4304 of the insurance law, as added by section 43 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

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

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

§ 4306-h. Essential health benefits package and limit on cost-sharing.  
(a) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

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

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

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



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

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

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

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

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

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

25 (d) Every individual or group contract that provides hospital, surgi-  
26 cal, or medical expense coverage and is not a grandfathered health plan,  
27 and every student accident and health insurance contract shall limit the  
28 insured's cost-sharing for in-network services in a contract year to not  
29 more than the maximum out-of-pocket amount determined by the superinten-  
30 dent for all contracts subject to this section. Such amount shall not  
31 exceed any annual out-of-pocket limit on cost-sharing set by the United  
32 States secretary of health and human services, if available.

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

37 (f) For purposes of this section:

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

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

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

45 (A) provides for essential health benefits;

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

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

50 (4) "grandfathered health plan" means coverage provided by a corpo-  
51 ration in which an individual was enrolled on March twenty-third, two  
52 thousand ten for as long as the coverage maintains grandfathered status  
53 in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C.  
54 § 18011(e);

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

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

4 § 36. Paragraph 4 of subsection (a) of section 4317 of the insurance  
5 law, as amended by section 72 of part D of chapter 56 of the laws of  
6 2013, is amended to read as follows:

7 (4) For the purposes of this section, "community rated" means a rating  
8 methodology in which the premium for all persons covered by a policy or  
9 contract form is the same, based on the experience of the entire pool of  
10 risks of all individuals or small groups covered by the corporation  
11 without regard to age, sex, health status, tobacco usage or occupation  
12 excluding those individuals of small groups covered by Medicare supple-  
13 mental insurance. For medicare supplemental insurance coverage, "commu-  
14 nity rated" means a rating methodology in which the premiums for all  
15 persons covered by a policy or contract form is the same based on the  
16 experience of the entire pool of risks covered by that policy or  
17 contract form without regard to age, sex, health status, tobacco usage  
18 or occupation. [~~Catastrophic health insurance contracts issued pursuant~~  
19 ~~to section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e),~~  
20 ~~shall be classified in a distinct community rating pool.~~]

21 § 37. Subsections (d), (e) and (j) of section 4326 of the insurance  
22 law, as amended by section 56 of part D of chapter 56 of the laws of  
23 2013, are amended to read as follows:

24 (d) A qualifying group health insurance contract shall provide cover-  
25 age for the essential health [~~benefit~~] benefits package as [~~required in~~]  
26 defined in paragraph three of subsection (f) of section [~~2707(a) of the~~  
27 ~~public health service act, 42 U.S.C. § 300gg-6(a). For purposes of this~~  
28 ~~subsection "essential health benefits package" shall have the meaning~~  
29 ~~set forth in section 1302(a) of the affordable care act, 42 U.S.C. §~~  
30 ~~18022(a)] four thousand three hundred six-h of this article.~~

31 (e) A qualifying group health insurance contract [~~issued to a qualify-~~  
32 ~~ing small employer prior to January first, two thousand fourteen that~~  
33 ~~does not include all essential health benefits required pursuant to~~  
34 ~~section 2707(a) of the public health service act, 42 U.S.C. §~~  
35 ~~300gg-6(a), shall be discontinued, including grandfathered health plans.~~  
36 ~~For the purposes of this paragraph, "grandfathered health plans" means~~  
37 ~~coverage provided by a corporation to individuals who were enrolled on~~  
38 ~~March twenty-third, two thousand ten for as long as the coverage main-~~  
39 ~~tains grandfathered status in accordance with section 1251(e) of the~~  
40 ~~affordable care act, 42 U.S.C. § 18011(e). A qualifying small employer~~  
41 ~~shall be transitioned to a plan that provides: (1)] shall provide a  
42 level of coverage that is designed to provide benefits that are actuari-  
43 ally equivalent to eighty percent of the full actuarial value of the  
44 benefits provided under the plan[, ~~and (2) coverage for the essential~~  
45 ~~health benefit package as required in section 2707(a) of the public~~  
46 ~~health service act, 42 U.S.C. § 300gg-6(a)]. The superintendent shall~~  
47 standardize the benefit package and cost sharing requirements of quali-  
48 fied group health insurance contracts consistent with coverage offered  
49 through the health benefit exchange established [~~pursuant to section~~  
50 ~~1311 of the affordable care act, 42 U.S.C. § 18031] by this state.~~~~

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

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

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

§ 39. Paragraphs 1, 2 and 3 of subsection (b) of section 4328 of the insurance law, as added by section 46 of part D of chapter 56 of the laws of 2013, are amended to read as follows:

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

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

1 fit exchange. If a health maintenance organization satisfies the  
2 requirements of subsection (a) of this section by offering individual  
3 enrollee direct payment contracts, only within the health benefit  
4 exchange, the health maintenance organization, not including a holder of  
5 a special purpose certificate of authority issued pursuant to section  
6 four thousand four hundred three-a of the public health law, shall also  
7 offer at least one individual enrollee direct payment contract at each  
8 level of coverage as defined in subsection (c) section [1302 (d) of the  
9 affordable care act, 42 U.S.C. § 18022 (d)] four thousand three hundred  
10 six-h of this article, outside the health benefit exchange.

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

15 SUBPART C

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### SUBPART D

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

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

(b) (1) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, an insurer shall follow the process and procedures specified in article



1 forty-nine of this chapter and article forty-nine of the public health  
2 law, except as otherwise provided in paragraphs two, three, four and  
3 five of this subsection.

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

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

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

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

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

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

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

35 (4) An insurer that denies an exception request under paragraph two or  
36 three of this subsection shall provide written notice of its determi-  
37 nation to the insured or the insured's designee and the insured's  
38 prescribing health care provider within three business days of receipt  
39 of the exception request. The written notice shall be considered a final  
40 adverse determination under section four thousand nine hundred four of  
41 this chapter or section four thousand nine hundred four of the public  
42 health law. Written notice shall also include the name or names of clin-  
43 ically appropriate prescription drugs covered by the insurer to treat  
44 the insured.

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

52 (B) An external appeal agent shall make a determination on the  
53 external appeal and notify the insurer, the insured or the insured's  
54 designee, and the insured's prescribing health care provider by tele-  
55 phone of its determination no later than seventy-two hours following the  
56 external appeal agent's receipt of the request, if the original request

1 was a standard exception request under paragraph two of this subsection.  
2 The external appeal agent shall notify the insurer, the insured or the  
3 insured's designee, and the insured's prescribing health care provider  
4 in writing of the external appeal determination within two business days  
5 of rendering such determination.

6 (C) An external appeal agent shall make a determination on the  
7 external appeal and notify the insurer, 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 twenty-four hours following the  
10 external appeal agent's receipt of the request, if the original request  
11 was an expedited exception request under paragraph three of this  
12 subsection and the insured's prescribing health care provider attests  
13 that exigent circumstances exist. The external appeal agent shall notify  
14 the insurer, the insured or the insured's designee, and the insured's  
15 prescribing health care provider in writing of the external appeal  
16 determination within seventy-two hours of the external appeal agent's  
17 receipt of the external appeal.

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

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

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

37 § 4329. Prescription drug coverage. (a) Every corporation subject to  
38 the provisions of this article that issues a contract that provides  
39 coverage for prescription drugs shall, with respect to the prescription  
40 drug coverage, publish an up-to-date, accurate, and complete list of all  
41 covered prescription drugs on its formulary drug list, including any  
42 tiering structure that it has adopted and any restrictions on the manner  
43 in which a prescription drug may be obtained, in a manner that is easily  
44 accessible to insureds and prospective insureds. The formulary drug list  
45 shall clearly identify the preventive prescription drugs that are avail-  
46 able without annual deductibles or coinsurance, including co-payments.

47 (b) (1) Every contract issued by a corporation subject to the  
48 provisions of this article that provides coverage for prescription drugs  
49 shall include in the contract a process that allows an insured, the  
50 insured's designee, or the insured's prescribing health care provider to  
51 request a formulary exception. With respect to the process for such a  
52 formulary exception, a corporation shall follow the process and proce-  
53 dures specified in article forty-nine of this chapter and article  
54 forty-nine of the public health law, except as otherwise provided in  
55 paragraphs two, three, four and five of this subsection.

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

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

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

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

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

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

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

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

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

49     (B) An external appeal agent shall make a determination on the  
50 external appeal and notify the corporation, the insured or the insured's  
51 designee, and the insured's prescribing health care provider by tele-  
52 phone of its determination no later than seventy-two hours following the  
53 external appeal agent's receipt of the request, if the original request  
54 was a standard exception request under paragraph two of this subsection.  
55 The external appeal agent shall notify the corporation, the insured or  
56 the insured's designee and the insured's prescribing health care provid-

er in writing of the external appeal determination within two business days of rendering such determination.

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

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

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

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

#### SUBPART E

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

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

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

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

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

1 false pregnancy, termination of pregnancy, or recovery therefrom, child-  
2 birth or related medical conditions:

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

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

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

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

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

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

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

23 (8) engage in sexual stereotyping.

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

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

28 § 4330. Discrimination because of sex or marital status in hospital,  
29 surgical or medical expense insurance. (a) With regard to a contract  
30 issued by a corporation subject to the provisions of this article that  
31 provides hospital, surgical, or medical expense coverage or a contract  
32 of student accident and health insurance, as defined in subsection (a)  
33 of section three thousand two hundred forty of this chapter, no corpo-  
34 ration shall because of sex, marital status or based on pregnancy, false  
35 pregnancy, termination of pregnancy, or recovery therefrom, childbirth  
36 or related medical conditions:

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

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

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

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

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

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

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



1 (8) engage in sexual stereotyping.

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

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

8 SUBPART F

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

12 (B) transactions with respect to group life, group annuity, group  
13 accident and health or blanket accident and health insurance (other than  
14 any transaction with respect to a group annuity contract funding indi-  
15 vidual retirement accounts or individual retirement annuities, as  
16 defined in section four hundred eight of the Internal Revenue Code,  
17 funding annuities in accordance with subdivision (b) of section four  
18 hundred three of such code or providing a plan of retirement annuities  
19 under which the payments are derived wholly from funds contributed by  
20 the persons covered):

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

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

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

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

30 (cc) paragraphs (4), (5), (6), (7), (8), (9) [~~and~~] or (10)[+] :

31 (II) the following subparagraphs of paragraph (1) of subsection (c) of  
32 section four thousand two hundred thirty-five of this chapter:

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

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

45 (cc) subparagraphs (F)[+] and (G) [~~and (H)-~~] :

46 (III) section four thousand two hundred thirty-seven (except subpara-  
47 graph (B) for transactions with respect to an employer to whom the poli-  
48 cy is issued where the employer has its principal place of business in  
49 this state or the lesser of twenty-five percent of employees work in  
50 this state or twenty-five or more employees work in this state, (C),  
51 (E), or (F) of paragraph three of subsection (a) thereof) or four thou-  
52 sand two hundred thirty-eight (except paragraphs six and seven of  
53 subsection (b) thereof) of this chapter; and

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

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

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

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

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

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

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

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

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

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

1 jurisdiction where the insurer is authorized to do an insurance busi-  
2 ness.

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

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

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

31 (E)(i) With regard to any group life insurance certificate deemed to  
32 have been delivered in this state by virtue of subparagraph (B) or (C)  
33 of this paragraph, the superintendent shall [†(i)]: (I) require that the  
34 premiums charged be reasonable in relation to the benefits provided,  
35 except in cases where the policyholder pays the entire premium; [†(ii)]  
36 (II) have power to issue regulations prescribing the required, optional  
37 and prohibited provisions in such certificates; [†(iii)] and (III) estab-  
38 lish an accelerated certificate form approval procedure available to an  
39 insurer [which] that includes a statement in its policy form submission  
40 letter that it is the company's opinion that the certificate form or  
41 forms comply with applicable New York law and regulations. The super-  
42 intendent, upon receipt of such a filing letter, shall grant conditional  
43 approval of such certificate form or forms in reliance on the aforemen-  
44 tioned statement by the company upon the condition that the company will  
45 retroactively modify such certificate form or forms, to the extent  
46 necessary, if it is found by the superintendent that the certificate  
47 form fails to comply with applicable New York laws and regulations[†];

48 (ii) The superintendent may, with regard to the approval of any group  
49 life insurance certificate deemed to have been delivered in this state  
50 by virtue of subparagraph (B) or (C) of this paragraph, approve such  
51 certificate if the superintendent finds that the certificate affords  
52 insureds protections substantially similar to those [which] that have  
53 been provided by certificates delivered in this state[†]; and

54 (iii) Any regulations issued by the superintendent pursuant to this  
55 [paragraph] subparagraph may not impose stricter requirements than those

1 applicable to similar policies and certificates actually delivered in  
2 this state.

3 (F)(i) A group accident, group health, group accident and health,  
4 blanket accident, blanket health, or blanket accident and health insur-  
5 ance certificate deemed to have been delivered in this state pursuant to  
6 subparagraph (B) or (D) of this paragraph, shall be subject to the same  
7 provisions of this chapter as a certificate actually delivered or issued  
8 for delivery in this state.

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

13 (G) For purposes of this paragraph:

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

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

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

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

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

32 (i) Each association shall have:

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

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

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

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

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

41 (bb) the association collect dues or solicit contributions from  
42 members; and

43 (cc) the members have voting privileges and representation on the  
44 governing board and committees;

45 (ii) the premium ~~[is to be derived]~~ for the policy or contract shall  
46 be paid by the association or the trustees either wholly from funds  
47 contributed by the association or by the insured ~~[members and if the~~  
48 ~~opportunity to take such insurance is offered to all eligible]~~ individ-  
49 uals, or from funds contributed jointly by the association and insured  
50 ~~[members, then such]~~ individuals. A policy ~~[must cover not less than~~  
51 ~~seventy-five percent of any class or classes of members determined by~~  
52 ~~conditions pertaining to membership in the association]~~ or contract on  
53 which no part of the premium is to be derived from funds contributed by  
54 the insured individuals specifically for their insurance shall insure  
55 all eligible individuals, excluding any as to whom evidence of individ-

1 ual insurability is not satisfactory to the insurer to the extent  
2 permitted by law;

3 (iii) The amount of insurance under the policy or contract shall be  
4 based upon some plan precluding individual selection either by the  
5 insured individuals or by the association. However, with respect to an  
6 association, such a plan may permit a number of selections by the asso-  
7 ciation if the selections offered utilize consistent plans of insurance  
8 so that the resulting plans of coverage are reasonable. Furthermore,  
9 such a plan may permit a limited number of selections by insured indi-  
10 viduals if the selections offered utilize consistent plans of insurance  
11 for insured individuals so that the resulting plans of coverage are  
12 reasonable.

13 (iv) Except as provided in subsection (b) of this section, such policy  
14 or contract shall provide for the payment of benefits to the person  
15 insured or to some beneficiary or beneficiaries other than the associ-  
16 ation or any officials, representatives, trustees or agents thereof and  
17 shall provide for the issuance of a certificate to the association for  
18 delivery to the insured individual or such beneficiary, as evidence of  
19 such insurance.

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

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

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

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

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

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

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

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

44 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-  
45 sion, section or subpart of this act shall be adjudged by any court of  
46 competent jurisdiction to be invalid, such judgment shall not affect,  
47 impair, or invalidate the remainder thereof, but shall be confined in  
48 its operation to the clause, sentence, paragraph, subdivision, section  
49 or subpart thereof directly involved in the controversy in which such  
50 judgment shall have been rendered. It is hereby declared to be the  
51 intent of the legislature that this act would have been enacted even if  
52 such invalid provisions had not been included herein.

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



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

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

#### PART K

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

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

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

§ 2. Section 2999-i of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, subdivision 1 as amended by 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 applicable period shall cause to be deposited into the fund, subject to available appropriations, an amount equal to the difference between the amount appropriated to the fund in the preceding fiscal year, as increased by the adjustment factor defined in subdivision seven of this section, and the assets of the fund at the conclusion of that fiscal year.

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

(b) Whenever enrollment is suspended pursuant to paragraph (a) of this subdivision and until such time as enrollment resumes pursuant to such paragraph: (i) notice of such suspension shall be promptly posted on the

1 department's website [~~and on the website of the department of financial~~  
2 ~~services~~]; (ii) the fund administrator shall deny each application for  
3 enrollment that had been received but not accepted prior to the date of  
4 suspension and each application for enrollment received after the date  
5 of such suspension; and (iii) notification of each such denial shall be  
6 made to the plaintiff or claimant or persons authorized to act on behalf  
7 of such plaintiff or claimant and all defendants in regard to such  
8 plaintiff or claimant, to the extent they are known to the fund adminis-  
9 trator. Judgments and settlements for plaintiffs or claimants for whom  
10 applications are denied under this paragraph or who are not eligible for  
11 enrollment due to suspension pursuant to paragraph (a) of this subdivi-  
12 sion shall be satisfied as if this title had not been enacted.

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

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

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

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

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

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

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

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

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

51 6. (a) Every settlement agreement for claims arising out of a  
52 plaintiff's or claimant's birth related neurological injury subject to  
53 this title, and that provides for the payment of future medical expenses  
54 for the plaintiff or claimant, shall provide that [~~in the event the~~  
55 ~~administrator of the fund determines that the plaintiff or claimant is a~~  
56 ~~qualified plaintiff,~~] all payments for future medical expenses shall be

1 paid in accordance with this title[7] in lieu of that portion of the  
2 settlement agreement that provides for payment of such expenses. The  
3 plaintiff's or claimant's future medical expenses shall be paid in  
4 accordance with this title. When such a settlement agreement does not so  
5 provide, the court shall direct the modification of the agreement to  
6 include such term as a condition of court approval.

7 (b) In any case where the jury or court has made an award for future  
8 medical expenses arising out of a birth related neurological injury, any  
9 party to such action or person authorized to act on behalf of such party  
10 may make application to the court that the judgment reflect that, in  
11 lieu of that portion of the award that provides for payment of such  
12 expenses, [~~and upon a determination by the fund administrator that the~~  
13 ~~plaintiff is a qualified plaintiff,~~] the future medical expenses of the  
14 plaintiff shall be paid out of the fund in accordance with this title.  
15 Upon a finding by the court that the applicant has made a prima facie  
16 showing that the plaintiff is a qualified plaintiff, the court shall  
17 ensure that the judgment so provides.

18 7. A qualified plaintiff shall be enrolled when (a) such plaintiff or  
19 person authorized to act on behalf of such person, upon notice to all  
20 defendants, or any of the defendants in regard to the plaintiff's claim,  
21 upon notice to such plaintiff, makes an application for enrollment by  
22 providing the fund administrator with a certified copy of the judgment  
23 or of the court approved settlement agreement; and (b) the fund adminis-  
24 trator determines [~~upon the basis of such judgment or settlement agree-~~  
25 ~~ment and any additional information the fund administrator shall~~  
26 ~~request~~] that the relevant provisions of subdivision six of this section  
27 have been met [~~and that the plaintiff is a qualified plaintiff~~];  
28 provided that no enrollment shall occur when the fund is closed to  
29 enrollment pursuant to subdivision six of section twenty-nine hundred  
30 ninety-nine-i of this title.

31 9. Payments from the fund shall be made by the commissioner of taxa-  
32 tion and finance on the said certificate of the [~~superintendent of~~  
33 ~~financial services~~] commissioner. No payment shall be made by the  
34 commissioner of taxation and finance in excess of the amount certified.  
35 Promptly upon receipt of the said certificate of the [~~superintendent of~~  
36 ~~financial services~~] commissioner, the commissioner of taxation and  
37 finance shall pay the qualified plaintiff's health care provider or  
38 reimburse the qualified plaintiff the amount so certified for payment.

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

45 12. Health insurers (other than medicare and Medicaid) shall be the  
46 primary payers of qualifying health care costs of qualified plaintiffs.  
47 Such costs shall be paid from the fund only to the extent that health  
48 insurers or other collateral sources or other persons are not otherwise  
49 obligated to make payments therefor. Health insurers that make payments  
50 for qualifying health care costs to or on behalf of qualified plaintiffs  
51 shall have no right of recovery against and shall have no lien upon the  
52 fund or any person or entity nor shall the fund constitute an additional  
53 payment source to offset the payments otherwise contractually required  
54 to be made by such health insurers. The superintendent of financial  
55 services shall have the authority to enforce the provisions of this  
56 subdivision upon the referral of the commissioner.

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

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

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

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

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

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

2. All moneys received by the New York state medical indemnity fund pursuant to title four of article twenty-nine-D of the public health law from whatever source derived shall be deposited to the exclusive credit of such fund account. Said moneys shall be kept separate and shall not be commingled with any other moneys in the custody of the commissioner of taxation and finance.

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

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

#### PART L

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

(C) Coverage of diagnostic and treatment procedures, including prescription drugs, used in the diagnosis and treatment of infertility



1 as required by subparagraphs (A) and (B) of this paragraph shall be  
2 provided in accordance with the provisions of this subparagraph.

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

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

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

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

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

31 [~~(vi)~~] (v) The superintendent, in consultation with the commissioner  
32 of health, shall promulgate regulations which shall stipulate the guide-  
33 lines and standards which shall be used in carrying out the provisions  
34 of this subparagraph, which shall include:

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

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

46 (III) The identification of the required training, experience and  
47 other standards for health care providers for the provision of proce-  
48 dures and treatments for the diagnosis and treatment of infertility  
49 determined in accordance with the standards and guidelines established  
50 and adopted by the American College of Obstetricians and Gynecologists  
51 and the American Society for Reproductive Medicine; and

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

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

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

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

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

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

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

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

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

~~(E) Coverage~~ Except as provided in subparagraphs (F) and (G) of this paragraph, coverage shall not be required to include the diagnosis and treatment of infertility in connection with: (i) in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (ii) the reversal of elective sterilizations; (iii) sex

1 change procedures; (iv) cloning; or (v) medical or surgical services or  
2 procedures that are deemed to be experimental in accordance with clin-  
3 ical guidelines referenced in subparagraph ~~[(F)]~~ (E) of this paragraph.

4 ~~[(F)]~~ (E) The superintendent, in consultation with the commissioner of  
5 health, shall promulgate regulations which shall stipulate the guide-  
6 lines and standards which shall be used in carrying out the provisions  
7 of this paragraph, which shall include:

8 (i) The determination of "infertility" in accordance with the stand-  
9 ards and guidelines established and adopted by the American College of  
10 Obstetricians and Gynecologists and the American Society for Reproduc-  
11 tive Medicine;

12 (ii) The identification of experimental procedures and treatments not  
13 covered for the diagnosis and treatment of infertility determined in  
14 accordance with the standards and guidelines established and adopted by  
15 the American College of Obstetricians and Gynecologists and the American  
16 Society for Reproductive Medicine including "iatrogenic infertility",  
17 which means an impairment of fertility by surgery, radiation, chemother-  
18 apy or other medical treatment affecting reproductive organs or proc-  
19 esses;

20 (iii) The identification of the required training, experience and  
21 other standards for health care providers for the provision of proce-  
22 dures and treatments for the diagnosis and treatment of infertility  
23 determined in accordance with the standards and guidelines established  
24 and adopted by the American College of Obstetricians and Gynecologists  
25 and the American Society for Reproductive Medicine; and

26 (iv) The determination of appropriate medical candidates by the treat-  
27 ing physician in accordance with the standards and guidelines estab-  
28 lished and adopted by the American College of Obstetricians and Gynecol-  
29 ogists and/or the American Society for Reproductive Medicine.

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

36 (G) Every large group contract that provides medical, major medical or  
37 similar comprehensive-type coverage shall provide coverage for three  
38 cycles of in-vitro fertilization used in the treatment of infertility as  
39 defined in item (i) of subparagraph (E) of this paragraph. Coverage may  
40 be subject to annual deductibles and coinsurance, including copayments,  
41 as may be deemed appropriate by the superintendent and as are consistent  
42 with those established for other benefits within a given contract. For  
43 purposes of this subparagraph, a "cycle" is defined as either all treat-  
44 ment that starts when: preparatory medications are administered for  
45 ovarian stimulation for oocyte retrieval with the intent of undergoing  
46 in-vitro fertilization using a fresh embryo transfer; or medications are  
47 administered for endometrial preparation with the intent of undergoing  
48 in-vitro fertilization using a frozen embryo transfer. No corporation  
49 providing coverage under subparagraphs (F) or (G) of this paragraph  
50 shall discriminate based on an insured's expected length of life, pres-  
51 ent or predicted disability, degree of medical dependency, perceived  
52 quality of life, or other health conditions, nor based on personal char-  
53 acteristics, including age, sex, sexual orientation, marital status or  
54 gender identity.

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

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

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

(ii) No insurer providing coverage under this paragraph shall discriminate based on an insured's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.

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

#### PART M

Section 1. This act shall be known and may be cited as the "comprehensive contraception coverage act".

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

(16) (A) Every group or blanket policy which ~~[provides coverage for prescription drugs shall include coverage for the cost of contraceptive drugs or devices approved by the federal food and drug administration or generic equivalents approved as substitutes by such food and drug administration under the prescription of a health care provider legally authorized to prescribe under title eight of the education law. The coverage required by this section shall be included in policies and certificates only through the addition of a rider.~~

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

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

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

(II) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, the insurer shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing upon the recommendation of the insured's attending health care provider. An insurer shall defer to the

1 attending health care provider's determination of medical necessity.  
2 The superintendent may develop a standard exception form with  
3 instructions that an attending health care provider may use to recommend  
4 a particular contraceptive drug, device, or product based upon a deter-  
5 mination of medical necessity for an insured. The insurer shall accept  
6 the standard exception form submitted by the insured's attending health  
7 care provider;

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

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

15 (ii) Voluntary sterilization procedures for women;

16 (iii) Patient education and counseling on contraception; and

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

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

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

27 (D) Notwithstanding any other provision of this subsection, a reli-  
28 gious employer may request a contract without coverage for federal food  
29 and drug administration approved contraceptive methods that are contrary  
30 to the religious employer's religious tenets. If so requested, such  
31 contract shall be provided without coverage for contraceptive methods.  
32 This paragraph shall not be construed to deny an enrollee coverage of,  
33 and timely access to, contraceptive methods.

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

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

37 (b) The entity primarily employs persons who share the religious  
38 tenets of the entity.

39 (c) The entity serves primarily persons who share the religious tenets  
40 of the entity.

41 (d) The entity is a nonprofit organization as described in Section  
42 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

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

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

55 ~~[(i-i)]~~ (2) Where a group policyholder makes an election not to  
56 purchase coverage for contraceptive drugs or devices in accordance with



1 subparagraph [~~(A)~~] (D) of this paragraph, the insurer that provides such  
2 coverage shall provide written notice to certificateholders upon enroll-  
3 ment with the insurer of their right to directly purchase a rider for  
4 coverage for the cost of contraceptive drugs or devices. The notice  
5 shall also advise the certificateholders of the additional premium for  
6 such coverage.

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

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

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

17 (cc) (1) Every contract [~~which provides coverage for prescription~~  
18 ~~drugs shall include coverage for the cost of contraceptive drugs or~~  
19 ~~devices approved by the federal food and drug administration or generic~~  
20 ~~equivalents approved as substitutes by such food and drug administration~~  
21 ~~under the prescription of a health care provider legally authorized to~~  
22 ~~prescribe under title eight of the education law. The coverage required~~  
23 ~~by this section shall be included in contracts and certificates only~~  
24 ~~through the addition of a rider.~~

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

28 (A) All FDA-approved contraceptive drugs, devices, and other products.  
29 This includes all FDA-approved over-the-counter contraceptive drugs,  
30 devices, and products as prescribed or as otherwise authorized under  
31 state or federal law. Notwithstanding this paragraph, a corporation  
32 shall not be required to provide coverage of male condoms. The follow-  
33 ing applies to this coverage:

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

40 (ii) if the covered therapeutic and pharmaceutical equivalent versions  
41 of a drug, device, or product are not available or are deemed medically  
42 inadvisable, a corporation shall provide coverage for an alternate ther-  
43 apeutic and pharmaceutical equivalent version of the contraceptive drug,  
44 device, or product without cost-sharing upon the recommendation of the  
45 insured's attending health care provider. A corporation shall defer to  
46 the attending health care provider's determination of medical necessity.  
47 The superintendent may develop a standard exception form with  
48 instructions that an attending health care provider may use to recommend  
49 a particular contraceptive drug, device, or product based upon a deter-  
50 mination of medical necessity for an insured. The insurer shall accept  
51 the standard exception form submitted by the insured's attending health  
52 care provider;

53 (iii) this coverage shall include emergency contraception without  
54 cost-sharing when provided pursuant to a prescription, order under  
55 section sixty-eight hundred thirty-one of the education law, over-the-

1 counter, or when otherwise lawfully provided other than through a  
2 prescription; and

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

5 (B) Voluntary sterilization procedures for women;

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

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

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

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

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

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

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

27 (ii) The entity primarily employs persons who share the religious  
28 tenets of the entity.

29 (iii) The entity serves primarily persons who share the religious  
30 tenets of the entity.

31 (iv) The entity is a nonprofit organization as described in Section  
32 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

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

37 ~~[(2)]~~ (5) (A) Where a group contractholder makes an election not to  
38 purchase coverage for contraceptive drugs or devices in accordance with  
39 paragraph ~~[one]~~ four of this subsection, each enrollee covered under the  
40 contract issued to that group contractholder shall have the right to  
41 directly purchase the rider required by this subsection from the insurer  
42 or health maintenance organization which issued the group contract at  
43 the prevailing small group community rate for such rider whether or not  
44 the employee is part of a small group.

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

53 ~~[(3)]~~ (6) Nothing in this subsection shall be construed as authorizing  
54 a contract which provides coverage for prescription drugs to exclude  
55 coverage for prescription drugs prescribed for reasons other than  
56 contraceptive purposes.

~~1 [(4) Such coverage may be subject to reasonable annual deductibles and~~  
~~2 coinsurance as may be deemed appropriate by the superintendent and as~~  
~~3 are consistent with those established for other drugs or devices covered~~  
~~4 under the policy.]~~

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

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

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

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

23 (bb) if the covered therapeutic and pharmaceutical equivalent versions  
24 of a drug, device, or product are not available or are deemed medically  
25 inadvisable, the insurer shall provide coverage for an alternate thera-  
26 peutic and pharmaceutical equivalent version of the contraceptive drug,  
27 device, or product without cost-sharing. An insurer shall defer to the  
28 attending health care provider's determination of medical necessity.  
29 The superintendent may develop a standard exception form with  
30 instructions that an attending health care provider may use to recommend  
31 a particular contraceptive drug, device, procedure, service, or product  
32 based upon a determination of medical necessity for an insured. The  
33 insurer shall accept the standard exception form submitted by the  
34 insured's attending health care provider;

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

40 (dd) this coverage shall allow for the dispensing of twelve months-  
41 worth of a contraceptive at one time:

42 (II) Voluntary sterilization procedures for women;

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

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

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

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

54 § 5. Paragraph (d) of subdivision 3 of section 365-a of the social  
55 services law, as amended by chapter 909 of the laws of 1974 and as

relettered by chapter 82 of the laws of 1995, is amended to read as follows:

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

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

#### PART N

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

2. The universal access commission shall consist of independent health policy and insurance experts appointed by the commissioner and superintendent. The commission shall consult with the legislature and stakeholder groups and convene at least one meeting for members of the public to review and discuss options for achieving universal access to care.

3. The commissioner and superintendent shall select the chair of the commission from among the members of such commission and shall designate at least one employee from each department to assist the commission in the performance of its duties under this section. The commissioner and superintendent shall adopt rules for the governance of the commission, which shall meet as frequently as its business may require and at such other times as determined by the commissioner and superintendent to be necessary.

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

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

§ 2. This act shall take effect immediately.

#### PART O

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

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the core public health services identified in section six hundred two of this title, pursuant to an approved application for state aid, at a rate of no less than thirty-six per centum, except for the city of New York which shall receive no less than twenty per centum, of the difference between the amount of moneys expended by

the municipality for public health services required by section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services that are not eligible for state aid pursuant to this article.

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

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

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

#### PART P

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

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

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

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

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

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

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

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

2. The commissioner shall promulgate rules and regulations establishing minimum standards for the maintenance of lead safe residential rental properties. Such rules and regulations shall include:

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

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

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



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

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

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

§ 3. This act shall take effect immediately.

#### PART Q

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

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

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

§ 2. This act shall take effect immediately.

#### PART R

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

1 and social change that can help prevent maternal mortality. The same is  
2 true for severe maternal morbidity. Confidentiality is important to  
3 ensure that full information is made available in the review process to  
4 maximize protection of maternal health.

5 Section 3 of article 17 of the state constitution states: "The  
6 protection and promotion of the health of the inhabitants of the state  
7 are matters of public concern and provision therefor shall be made by  
8 the state and by such of its subdivisions and in such manner, and by  
9 such means as the legislature shall from time to time determine." The  
10 legislature finds that the creation of a state maternal mortality review  
11 board, and recognition and protection of any maternal mortality review  
12 board, including a New York city maternal mortality review board, are a  
13 matter of state concern and an important exercise of the legislature's  
14 constitutional mandate to protect the public health.

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

17 § 2509. Maternal mortality review board. 1. (a) There is hereby estab-  
18 lished in the department the maternal mortality review board for the  
19 purpose of reviewing maternal deaths and severe maternal morbidity and  
20 developing findings, recommendations, and best practices to the commis-  
21 sioner to contribute to the prevention of maternal mortality and severe  
22 maternal morbidity. The board shall assess the cause of death, factors  
23 leading to death and preventability for each maternal death reviewed  
24 and, at the discretion of the board, cases of severe maternal morbidity,  
25 and shall develop strategies for reducing the risk of maternal mortality  
26 and severe maternal morbidity, where cases of severe maternal morbidity  
27 were reviewed, taking into account factors such as racial, economic, or  
28 other disparities. The boards' findings, recommendations and best prac-  
29 tices shall be given to the commissioner for dissemination.

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

35 2. As used in this section:

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

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

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

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

48 3. (a) The members of the state board shall be comprised of multidis-  
49 ciplinary experts in the field of maternal mortality, women's health and  
50 public health, and shall include health care professionals and other  
51 experts who serve and are representative of the racial and ethnic diver-  
52 sity of the women and mothers of the state.

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

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

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

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

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

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

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

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

20 (j) The board is not subject to the open meetings law.

21 4. (a) The commissioner shall receive upon request from any depart-  
22 ment, division, board, bureau, commission, local health departments or  
23 other agency of the state or political subdivision thereof or any public  
24 authority, as well as hospitals established pursuant to article twenty-  
25 eight of this chapter, birthing facilities, medical examiners, coroners  
26 and coroner physicians and any other facility providing services associ-  
27 ated with maternal mortality, such information, including, but not  
28 limited to, death records, medical records, autopsy reports, toxicology  
29 reports, hospital discharge records, birth records and any other infor-  
30 mation.

31 (b) The commissioner shall receive information, including oral or  
32 written statements, relating to any maternal death and case of severe  
33 maternal morbidity, from any family member or other interested party  
34 (including the patient in a case of severe maternal morbidity) relating  
35 to any case that may come before the board. Oral statements received  
36 under this paragraph shall be transcribed or summarized in writing. The  
37 commissioner and the city commissioner shall transmit that information  
38 to the board considering the case.

39 (c) Before transmitting any information to the board, the commission-  
40 er, or the city commissioner, shall remove all personal identifying  
41 information of the woman, health care practitioner or practitioners or  
42 anyone else individually named in such information, as well as the  
43 hospital or facility that treated the woman, and any other information  
44 such as geographic location that may inadvertently identify the woman,  
45 practitioner or facility. This paragraph shall not preclude the trans-  
46 mitting of information to the board that is reasonably necessary to  
47 enable the board to perform an appropriate review under this section.

48 5. Each board:

49 (a) shall make and report findings, recommendations and best practices  
50 to the commissioner regarding the cause of death, factors leading to  
51 death, and preventability of each maternal death case, and each case of  
52 severe maternal morbidity reviewed by the board, by reviewing relevant  
53 information for each case and consulting with experts as needed to eval-  
54 uate the information for each death; and shall provide such de-identi-  
55 fied findings and recommendations, including best practices and strate-  
56 gies for reducing the risk of maternal mortality and severe maternal

1 morbidity, to the advisory council; provided that material provided to  
2 the advisory council shall not include any information that would be  
3 confidential under this section;

4 (b) shall develop recommendations to the commissioner for areas of  
5 focus, including issues of severe maternal morbidity and issues of  
6 racial, economic or other disparities in maternal outcomes;

7 (c) may, in addition to the findings, recommendations, and best prac-  
8 tices made under this subdivision, and consistent with all applicable  
9 confidentiality protections, bring any particular matter to the atten-  
10 tion of the commissioner;

11 (d) the state board shall issue a report every other year to the  
12 commissioner on its findings, recommendations, and best practices, and  
13 it shall be a public document.

14 6. The commissioner and boards shall each keep confidential any infor-  
15 mation collected or received under this section that includes personal  
16 identifying information of the woman, health care practitioner or prac-  
17 tioners or anyone else individually named in such information, as well  
18 as the hospital or facility that treated the woman, and any other infor-  
19 mation such as geographic location that may inadvertently identify the  
20 woman, practitioner or facility, and shall use the information provided  
21 or received under this section solely for the purposes of improvement of  
22 the quality of health care of women and to prevent maternal mortality  
23 and severe maternal morbidity. This subdivision shall not preclude the  
24 transmitting of information to the board that is reasonably necessary to  
25 enable the board to perform an appropriate review under this section.  
26 All information and records received, meetings conducted, reports and  
27 records made and maintained and all books and papers obtained by the  
28 commissioner as well as the board shall be confidential and shall not be  
29 made open or available, including under article six of the public offi-  
30 cers law, and shall be limited to board members as well as those author-  
31 ized by the commissioner. Such information shall not be discoverable or  
32 admissible as evidence in any action in any court or before any other  
33 tribunal, board, agency or person.

34 7. (a) There is hereby established in the department an advisory coun-  
35 cil on maternal mortality and severe maternal morbidity.

36 (b) The advisory council:

37 (i) may review the findings, recommendations and best practices of the  
38 boards;

39 (ii) may use the boards findings, recommendations and best practices  
40 to develop recommendations on policies, best practices, and strategies  
41 to prevent maternal mortality and severe maternal morbidity;

42 (iii) may hold public hearings on those matters; and

43 (iv) may make findings and issue reports, including an annual report,  
44 on such matters;

45 (c) The advisory council shall consist of at least twenty members,  
46 representative of the racial and ethnic diversity of the women and moth-  
47 ers of the state to be determined by the commissioner. Ten of the  
48 members of the council shall be representative of the population and  
49 health care system of the city of New York. The commissioner shall  
50 appoint the chair of the council.

51 (d) The members of the council shall be comprised of multidisciplinary  
52 experts and lay persons knowledgeable in the field of maternal mortal-  
53 ity, women's health and public health and shall include members who  
54 serve and are representative of the diversity of the women and mothers  
55 in medically underserved areas of the state or areas of the state with

disproportionately high occurrences of maternal mortality or severe maternal morbidity.

(e) The terms of the council members shall be three years. The commissioner may choose to reappoint council members to additional three-year terms. Vacancies on the council shall be filled by appointment by the commissioner. A majority of the appointed membership of the council shall constitute a quorum. When any member of the council fails to attend three consecutive regular meetings, unless such absence is for good cause, that membership may be deemed vacant for purposes of the appointment of a successor.

(f) Meetings of the council shall be held at least twice a year.

(g) Members of the council shall be indemnified under section seventeen of the public officers law. Members of the council shall not be compensated for their participation on the council but shall receive reimbursement for their ordinary and necessary expenses of participation. Membership on the council shall not disqualify any person from holding any public office or employment.

§ 3. This act shall take effect immediately.

#### PART S

Section 1. Legislative intent. The legislature finds that comprehensive reproductive health care, including contraception and abortion, is a fundamental component of a woman's health, privacy and equality. The New York Constitution and United States Constitution protect a woman's fundamental right to access safe, legal abortion, courts have repeatedly reaffirmed this right and further emphasized that states may not place undue burdens on women seeking to access such right.

Moreover, the legislature finds, as with other medical procedures, the safety of abortion is furthered by evidence-based practices developed and supported by medical professionals. Abortion is one of the safest medical procedures performed in the United States; the goal of medical regulation should be to improve the quality and availability of health care services.

Furthermore, the legislature declares that it is the public policy of New York State that every individual possesses a fundamental right of privacy and equality with respect to their personal reproductive decisions and should be able to safely effectuate those decisions, including by seeking and obtaining abortion care, free from discrimination in the provision of health care.

Therefore, it is the intent of the legislature to prevent the enforcement of laws or regulations that are not in furtherance of a legitimate state interest in protecting a woman's health that burden abortion access.

§ 2. The public health law is amended by adding a new article 25-A to read as follows:

#### ARTICLE 25-A

#### REPRODUCTIVE HEALTH ACT

#### Section 2599-aa. Policy and purpose.

#### 2599-bb. Abortion.

§ 2599-aa. Policy and purpose. The legislature finds that comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality. Therefore, it is the policy of the state that:

1. Every individual has the fundamental right to choose or refuse contraception or sterilization.



2. Every individual who becomes pregnant has the fundamental right to choose to carry the pregnancy to term, to give birth to a child, or to have an abortion, pursuant to this article.

3. The state shall not discriminate against, deny, or interfere with the exercise of the rights set forth in this section in the regulation or provision of benefits, facilities, services or information.

§ 2599-bb. Abortion. 1. A health care practitioner licensed, certified, or authorized under title eight of the education law, acting within his or her lawful scope of practice, may perform an abortion when, according to the practitioner's reasonable and good faith professional judgment based on the facts of the patient's case: the patient is within twenty-four weeks from the commencement of pregnancy, or there is an absence of fetal viability, or the abortion is necessary to protect the patient's life or health.

2. This article shall be construed and applied consistent with and subject to applicable laws and applicable and authorized regulations governing health care procedures.

§ 3. Section 4164 of the public health law is REPEALED.

§ 4. Subdivision 8 of section 6811 of the education law is REPEALED.

§ 5. Sections 125.40, 125.45, 125.50, 125.55 and 125.60 of the penal law are REPEALED, and the article heading of article 125 of the penal law is amended to read as follows:

HOMICIDE[~~ABORTION~~] AND RELATED OFFENSES

§ 6. Section 125.00 of the penal law is amended to read as follows:

§ 125.00 Homicide defined.

Homicide means conduct which causes the death of a person [~~or an unborn child with which a female has been pregnant for more than twenty-four weeks~~] under circumstances constituting murder, manslaughter in the first degree, manslaughter in the second degree, or criminally negligent homicide[~~abortion in the first degree or self-abortion in the first degree~~].

§ 7. The section heading, opening paragraph and subdivision 1 of section 125.05 of the penal law are amended to read as follows:

Homicide[~~abortion~~] and related offenses; [~~definitions of terms~~]  
definition.

The following [~~definitions are~~] definition is applicable to this article:

[~~1.~~] "Person," when referring to the victim of a homicide, means a human being who has been born and is alive.

§ 7-a. Subdivisions 2 and 3 of section 125.05 of the penal law are REPEALED.

§ 8. Subdivision 2 of section 125.15 of the penal law is REPEALED.

§ 9. Subdivision 3 of section 125.20 of the penal law is REPEALED.

§ 10. Paragraph (b) of subdivision 8 of section 700.05 of the criminal procedure law, as amended by chapter 189 of the laws of 2018, is amended to read as follows:

(b) Any of the following felonies: assault in the second degree as defined in section 120.05 of the penal law, assault in the first degree as defined in section 120.10 of the penal law, reckless endangerment in the first degree as defined in section 120.25 of the penal law, promoting a suicide attempt as defined in section 120.30 of the penal law, strangulation in the second degree as defined in section 121.12 of the penal law, strangulation in the first degree as defined in section 121.13 of the penal law, criminally negligent homicide as defined in section 125.10 of the penal law, manslaughter in the second degree as defined in section 125.15 of the penal law, manslaughter in the first

1 degree as defined in section 125.20 of the penal law, murder in the  
2 second degree as defined in section 125.25 of the penal law, murder in  
3 the first degree as defined in section 125.27 of the penal law,  
4 ~~[abortion in the second degree as defined in section 125.40 of the penal~~  
5 ~~law, abortion in the first degree as defined in section 125.45 of the~~  
6 ~~penal law]~~ rape in the third degree as defined in section 130.25 of the  
7 penal law, rape in the second degree as defined in section 130.30 of the  
8 penal law, rape in the first degree as defined in section 130.35 of the  
9 penal law, criminal sexual act in the third degree as defined in section  
10 130.40 of the penal law, criminal sexual act in the second degree as  
11 defined in section 130.45 of the penal law, criminal sexual act in the  
12 first degree as defined in section 130.50 of the penal law, sexual abuse  
13 in the first degree as defined in section 130.65 of the penal law,  
14 unlawful imprisonment in the first degree as defined in section 135.10  
15 of the penal law, kidnapping in the second degree as defined in section  
16 135.20 of the penal law, kidnapping in the first degree as defined in  
17 section 135.25 of the penal law, labor trafficking as defined in section  
18 135.35 of the penal law, aggravated labor trafficking as defined in  
19 section 135.37 of the penal law, custodial interference in the first  
20 degree as defined in section 135.50 of the penal law, coercion in the  
21 first degree as defined in section 135.65 of the penal law, criminal  
22 trespass in the first degree as defined in section 140.17 of the penal  
23 law, burglary in the third degree as defined in section 140.20 of the  
24 penal law, burglary in the second degree as defined in section 140.25 of  
25 the penal law, burglary in the first degree as defined in section 140.30  
26 of the penal law, criminal mischief in the third degree as defined in  
27 section 145.05 of the penal law, criminal mischief in the second degree  
28 as defined in section 145.10 of the penal law, criminal mischief in the  
29 first degree as defined in section 145.12 of the penal law, criminal  
30 tampering in the first degree as defined in section 145.20 of the penal  
31 law, arson in the fourth degree as defined in section 150.05 of the  
32 penal law, arson in the third degree as defined in section 150.10 of the  
33 penal law, arson in the second degree as defined in section 150.15 of  
34 the penal law, arson in the first degree as defined in section 150.20 of  
35 the penal law, grand larceny in the fourth degree as defined in section  
36 155.30 of the penal law, grand larceny in the third degree as defined in  
37 section 155.35 of the penal law, grand larceny in the second degree as  
38 defined in section 155.40 of the penal law, grand larceny in the first  
39 degree as defined in section 155.42 of the penal law, health care fraud  
40 in the fourth degree as defined in section 177.10 of the penal law,  
41 health care fraud in the third degree as defined in section 177.15 of  
42 the penal law, health care fraud in the second degree as defined in  
43 section 177.20 of the penal law, health care fraud in the first degree  
44 as defined in section 177.25 of the penal law, robbery in the third  
45 degree as defined in section 160.05 of the penal law, robbery in the  
46 second degree as defined in section 160.10 of the penal law, robbery in  
47 the first degree as defined in section 160.15 of the penal law, unlawful  
48 use of secret scientific material as defined in section 165.07 of the  
49 penal law, criminal possession of stolen property in the fourth degree  
50 as defined in section 165.45 of the penal law, criminal possession of  
51 stolen property in the third degree as defined in section 165.50 of the  
52 penal law, criminal possession of stolen property in the second degree  
53 as defined by section 165.52 of the penal law, criminal possession of  
54 stolen property in the first degree as defined by section 165.54 of the  
55 penal law, trademark counterfeiting in the second degree as defined in  
56 section 165.72 of the penal law, trademark counterfeiting in the first

1 degree as defined in section 165.73 of the penal law, forgery in the  
2 second degree as defined in section 170.10 of the penal law, forgery in  
3 the first degree as defined in section 170.15 of the penal law, criminal  
4 possession of a forged instrument in the second degree as defined in  
5 section 170.25 of the penal law, criminal possession of a forged instru-  
6 ment in the first degree as defined in section 170.30 of the penal law,  
7 criminal possession of forgery devices as defined in section 170.40 of  
8 the penal law, falsifying business records in the first degree as  
9 defined in section 175.10 of the penal law, tampering with public  
10 records in the first degree as defined in section 175.25 of the penal  
11 law, offering a false instrument for filing in the first degree as  
12 defined in section 175.35 of the penal law, issuing a false certificate  
13 as defined in section 175.40 of the penal law, criminal diversion of  
14 prescription medications and prescriptions in the second degree as  
15 defined in section 178.20 of the penal law, criminal diversion of  
16 prescription medications and prescriptions in the first degree as  
17 defined in section 178.25 of the penal law, residential mortgage fraud  
18 in the fourth degree as defined in section 187.10 of the penal law,  
19 residential mortgage fraud in the third degree as defined in section  
20 187.15 of the penal law, residential mortgage fraud in the second degree  
21 as defined in section 187.20 of the penal law, residential mortgage  
22 fraud in the first degree as defined in section 187.25 of the penal law,  
23 escape in the second degree as defined in section 205.10 of the penal  
24 law, escape in the first degree as defined in section 205.15 of the  
25 penal law, absconding from temporary release in the first degree as  
26 defined in section 205.17 of the penal law, promoting prison contraband  
27 in the first degree as defined in section 205.25 of the penal law,  
28 hindering prosecution in the second degree as defined in section 205.60  
29 of the penal law, hindering prosecution in the first degree as defined  
30 in section 205.65 of the penal law, sex trafficking as defined in  
31 section 230.34 of the penal law, sex trafficking of a child as defined  
32 in section 230.34-a of the penal law, criminal possession of a weapon in  
33 the third degree as defined in subdivisions two, three and five of  
34 section 265.02 of the penal law, criminal possession of a weapon in the  
35 second degree as defined in section 265.03 of the penal law, criminal  
36 possession of a weapon in the first degree as defined in section 265.04  
37 of the penal law, manufacture, transport, disposition and defacement of  
38 weapons and dangerous instruments and appliances defined as felonies in  
39 subdivisions one, two, and three of section 265.10 of the penal law,  
40 sections 265.11, 265.12 and 265.13 of the penal law, or prohibited use  
41 of weapons as defined in subdivision two of section 265.35 of the penal  
42 law, relating to firearms and other dangerous weapons, or failure to  
43 disclose the origin of a recording in the first degree as defined in  
44 section 275.40 of the penal law;

45 § 11. Subdivision 1 of section 673 of the county law, as added by  
46 chapter 545 of the laws of 1965, is amended to read as follows:

47 1. A coroner or medical examiner has jurisdiction and authority to  
48 investigate the death of every person dying within his county, or whose  
49 body is found within the county, which is or appears to be:

50 (a) A violent death, whether by criminal violence, suicide or casual-  
51 ty;

52 (b) A death caused by unlawful act or criminal neglect;

53 (c) A death occurring in a suspicious, unusual or unexplained manner;

54 (d) ~~A death caused by suspected criminal abortion,~~

55 ~~(e)]~~ A death while unattended by a physician, so far as can be discov-  
56 ered, or where no physician able to certify the cause of death as

provided in the public health law and in form as prescribed by the commissioner of health can be found;

~~[(f)]~~ (e) A death of a person confined in a public institution other than a hospital, infirmary or nursing home.

§ 12. Section 4 of the judiciary law, as amended by chapter 264 of the laws of 2003, is amended to read as follows:

§ 4. Sittings of courts to be public. The sittings of every court within this state shall be public, and every citizen may freely attend the same, except that in all proceedings and trials in cases for divorce, seduction, ~~[abortion]~~ rape, assault with intent to commit rape, criminal sexual act, bastardy or filiation, the court may, in its discretion, exclude therefrom all persons who are not directly interested therein, excepting jurors, witnesses, and officers of the court.

§ 13. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, that shall not affect the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act, which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 14. This act shall take effect immediately.

#### 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,

1 the purchase and sale of qualified health plans and/or other or addi-  
2 tional health plans certified by the Marketplace pursuant to this title,  
3 and shall continue to have the authority to operate a small business  
4 health options program ("SHOP") to assist eligible small employers in  
5 selecting qualified health plans and/or other or additional health plans  
6 certified by the Marketplace and to determine small employer eligibility  
7 for purposes of small employer tax credits. It is the intent of the  
8 legislature, by codifying the Marketplace in state statute, to continue  
9 to promote quality and affordable health coverage and care, reduce the  
10 number of uninsured persons, provide a transparent marketplace, educate  
11 consumers and assist individuals with access to coverage, premium  
12 assistance tax credits and cost-sharing reductions. In addition, the  
13 legislature declares the intent that the Marketplace continue to be  
14 properly integrated with insurance affordability programs, including  
15 Medicaid, child health plus and the basic health program, and such other  
16 health insurance programs as determined by the commissioner.

17 § 268-a. Definitions. For purposes of this title, the following defi-  
18 nitions shall apply:

19 1. "Commissioner" means the commissioner of health of the state of New  
20 York.

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

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

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

33 (a) accident insurance or disability income insurance, or any combina-  
34 tion thereof;

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

36 (c) liability insurance, including general liability insurance and  
37 automobile liability insurance;

38 (d) workers' compensation or similar insurance;

39 (e) automobile no-fault insurance;

40 (f) credit insurance;

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

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

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

52 (j) Medicare supplemental insurance as defined in section 1882(g)(1)  
53 of the federal social security act, coverage supplemental to the cover-  
54 age provided under chapter 55 of title 10 of the United States Code, or  
55 similar supplemental coverage provided under a group health plan if it



1 is offered as a separate policy, certificate or contract of insurance;  
2 or

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

5 5. "Insurer" means an insurance company subject to article forty-two  
6 or a corporation subject to article forty-three of the insurance law, or  
7 a health maintenance organization certified pursuant to article forty-  
8 four of the public health law that contracts or offers to contract to  
9 provide, deliver, arrange, pay or reimburse any of the costs of health  
10 care services.

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

14 7. "Qualified health plan" means a health plan that is issued pursuant  
15 to applicable law and certified by the Marketplace in accordance with  
16 section two hundred sixty-eight-d of this title, including a stand-alone  
17 dental plan.

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

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

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

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

28 (b) resides in this state;

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

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

34 11. "Secretary" means the secretary of the United States department of  
35 health and human services.

36 12. "SHOP" means the small business health options program operated by  
37 the Marketplace to assist eligible small employers in this state in  
38 selecting qualified health plans and/or other or additional health plans  
39 certified by the Marketplace and to determine small employer eligibility  
40 for purposes of small employer tax credits in accordance with applicable  
41 federal and state laws and regulations.

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

46 14. "Small group market" means the health insurance market under which  
47 individuals receive health insurance coverage on behalf of themselves  
48 and their dependents through a group health plan maintained by a small  
49 employer.

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

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

55 § 268-b. Establishment of NY State of Health, The Official Health Plan  
56 Marketplace. 1. There is hereby established an office within the depart-

1 ment of health to be known as the "NY State of Health, The official  
2 health plan Marketplace".

3 2. The purpose of the Marketplace is to facilitate enrollment in  
4 health coverage and the purchase and sale of qualified health plans and  
5 other health plans certified by the Marketplace; enroll individuals in  
6 coverage for which they are eligible in accordance with federal and  
7 state law; enable eligible individuals to receive premium tax credits,  
8 cost-sharing reductions, and to access insurance affordability programs  
9 and other health insurance programs as determined by the commissioner;  
10 assist eligible small employers in selecting qualified health plans  
11 and/or other, or additional health plans certified by the Marketplace  
12 and to qualify for small employer tax credits in accordance with appli-  
13 cable law; and to carry out other functions set forth in this title.

14 § 268-c. Functions of the Marketplace. The Marketplace shall:

15 1. (a) Perform eligibility determinations for federal and state insur-  
16 ance affordability programs including medical assistance in accordance  
17 with section three hundred sixty-six of the social services law, child  
18 health plus in accordance with section twenty-five hundred eleven of  
19 this chapter, the basic health program in accordance with section three  
20 hundred sixty-nine-gg of the social services law, premium tax credits  
21 and cost-sharing reductions and qualified health plans in accordance  
22 with applicable law and other health insurance programs as determined by  
23 the commissioner;

24 (b) certify and make available to qualified individuals, qualified  
25 health plans, including dental plans, certified by the Marketplace  
26 pursuant to applicable law, provided that coverage under such plans  
27 shall not become effective prior to certification by the Marketplace;  
28 and

29 (c) certify and/or make available to eligible individuals, health  
30 plans certified by the Marketplace pursuant to applicable law, and/or  
31 participating in an insurance affordability program pursuant to applica-  
32 ble law, provided that coverage under such plans shall not become effec-  
33 tive prior to certification by the Marketplace, and/or approval by the  
34 commissioner.

35 2. Assign an actuarial value to each Marketplace certified plan  
36 offered through the Marketplace in accordance with the criteria devel-  
37 oped by the secretary pursuant to federal law or the superintendent  
38 pursuant to the insurance law and/or requirements developed by the  
39 Marketplace, and determine each health plan's level of coverage in  
40 accordance with regulations issued by the secretary pursuant to federal  
41 law or the superintendent pursuant to the insurance law.

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

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

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

50 6. Implement procedures for the certification, recertification and  
51 decertification of health plans as qualified health plans or health  
52 plans approved for sale by the department of financial services or  
53 department of health and certified by the Marketplace, consistent with  
54 guidelines developed by the secretary pursuant to section 1311(c) of the  
55 federal act and requirements developed by the Marketplace.

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

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

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

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

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

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

21 13. Maintain an internet website through which enrollees and prospec-  
22 tive enrollees of qualified health plans and health plans certified by  
23 the Marketplace may obtain standardized comparative information on such  
24 plans and insurance affordability programs.

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

30 15. Operate a program under which the Marketplace awards grants to  
31 entities to serve as navigators in accordance with applicable federal  
32 law and regulations adopted thereunder, and/or a program under which the  
33 Marketplace awards grants to entities to provide community based enroll-  
34 ment assistance in accordance with requirements developed by the Market-  
35 place; and/or a program under which the Marketplace certifies New York  
36 state licensed producers to provide assistance to eligible individuals  
37 and/or small employers pursuant to federal or state law.

38 16. In accordance with applicable federal and state law, inform indi-  
39 viduals of eligibility requirements for the Medicaid program under title  
40 XIX of the social security act and the social services law, the chil-  
41 dren's health insurance program (CHIP) under title XXI of the social  
42 security act and this chapter, the basic health program under section  
43 three hundred sixty-nine-gg of the social services law, or any applica-  
44 ble state or local public health insurance program and if, through  
45 screening of the application by the Marketplace, the Marketplace deter-  
46 mines that such individuals are eligible for any such program, enroll  
47 such individuals in such program.

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

52 (a) there is no affordable health plan available covering the individ-  
53 ual, as defined by applicable law; or

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

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

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

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

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

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

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

25 24. Determine eligibility, provide notices, and provide opportunities  
26 for appeal and redetermination in accordance with the requirements of  
27 federal and state law.

28 § 268-d. Special functions of the Marketplace related to health plan  
29 certification and qualified health plan oversight. 1. Health plans  
30 certified by the Marketplace shall meet the following requirements:

31 (a) The insurer offering the health plan:

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

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

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

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

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

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

54 (A) the Marketplace has determined that at least one qualified dental  
55 plan or dental plan approved by the department of financial services or

1 the department is available to supplement the health plan's coverage;  
2 and

3 (B) the insurer makes prominent disclosure at the time it offers the  
4 health plan, in a form approved by the Marketplace, that the plan does  
5 not provide the full range of essential pediatric benefits, and that  
6 qualified dental plans or dental plans approved by the department of  
7 financial services or department of health providing those benefits and  
8 other dental benefits not covered by the plan are offered through the  
9 Marketplace;

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

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

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

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

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

31 (c) The Marketplace determines that making the health plan available  
32 through the Marketplace is in the interest of qualified individuals in  
33 this state.

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

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

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

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

41 3. The Marketplace shall require each insurer certified or seeking  
42 certification of a health plan as a qualified health plan or plan  
43 approved for sale by the department of financial services or the depart-  
44 ment to:

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

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

52 (A) claims payment policies and practices;

53 (B) periodic financial disclosures;

54 (C) data on enrollment and disenrollment;

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

56 (E) data on rating practices;



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

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

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

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

11 (c) provide to individuals, in a timely manner upon the request of the  
12 individual, the amount of cost-sharing, including deductibles, copay-  
13 ments, and coinsurance, under the individual's health plan or coverage  
14 that the individual would be responsible for paying with respect to the  
15 furnishing of a specific item or service by a participating provider. At  
16 a minimum, this information shall be made available to the individual  
17 through an internet website and through other means for individuals  
18 without access to the internet.

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

25 5. (a) The provisions of this article that apply to qualified health  
26 plans and plans approved for sale by the department of financial  
27 services and the department also shall apply to the extent relevant to  
28 qualified dental plans approved for sale by the department of financial  
29 services or the department, except as modified in accordance with the  
30 provisions of paragraphs (b) and (c) of this subdivision or otherwise  
31 required by the Marketplace.

32 (b) The qualified dental plan or dental plan approved for sale by the  
33 department of financial services and/or the department shall be limited  
34 to dental and oral health benefits, without substantially duplicating  
35 the benefits typically offered by health benefit plans without dental  
36 coverage, and shall include, at a minimum, the essential pediatric  
37 dental benefits prescribed by the secretary pursuant to section  
38 1302(b)(1)(J) of the federal act, and such other dental benefits as the  
39 Marketplace or secretary may specify in regulations.

40 (c) Insurers may jointly offer a comprehensive plan through the  
41 Marketplace in which an insurer provides the dental benefits through a  
42 qualified dental plan or plan approved by the department of financial  
43 services or the department and an insurer provides the other benefits  
44 through a qualified health plan, provided that the plans are priced  
45 separately and also are made available for purchase separately at the  
46 same price.

47 § 268-e. Appeals and appeal hearings; judicial review. 1. Any appli-  
48 cant or enrollee, or any individual authorized to act on behalf of any  
49 such applicant or enrollee, may appeal to the department from determi-  
50 nations of department officials or failures to make determinations upon  
51 grounds specified in subdivision four of this section. The department  
52 must review the appeal de novo and give such person an opportunity for  
53 an appeal hearing. The department may also, on its own motion, review  
54 any decision made or any case in which a decision has not been made by  
55 the Marketplace or a social services official within the time specified  
56 by law or regulations of the department. The department may make such

1 additional investigation as it may deem necessary, and the commissioner  
2 must make such determination as is justified and in accordance with  
3 applicable law.

4 2. Regarding any appeal pursuant to this section, with or without an  
5 appeal hearing, the commissioner may designate and authorize one or more  
6 appropriate members of his staff to consider and decide such appeals.  
7 Any staff member so designated and authorized will have authority to  
8 decide such appeals on behalf of the commissioner with the same force  
9 and effect as if the commissioner had made the decisions. Appeal hear-  
10 ings must be held on behalf of the commissioner by members of his staff  
11 who are employed for such purposes or who have been designated and  
12 authorized by the commissioner.

13 3. Persons entitled to appeal to the department pursuant to this  
14 section must include:

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

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

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

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

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

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

25 (B) eligibility for Medicaid;

26 (C) eligibility for Child Health Plus;

27 (D) eligibility for the Basic Health Program;

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

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

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

34 (ii) a re-determination of eligibility of the programs under this  
35 subdivision.

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

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

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

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

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

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

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

55 8. The department must include notice of the right to appeal as  
56 provided by subdivision four of this section and instructions regarding

1 how to file an appeal in any eligibility determination issued to the  
2 applicant or enrollee in accordance with applicable law. Such notice  
3 shall include:

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

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

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

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

13 (e) an explanation that an appeal decision for one household member  
14 may result in a change in eligibility for other household members and  
15 that such a change will be handled as a redetermination of eligibility  
16 for all household members in accordance with the standards specified in  
17 applicable law.

18 § 268-f. Marketplace advisory committee. 1. There is hereby created  
19 the marketplace advisory committee, which shall consider and advise the  
20 department and commissioner on matters concerning the provision of  
21 health care coverage through the NY State of Health or Marketplace.

22 2. The marketplace advisory committee shall consist of up to twenty-  
23 eight members appointed by the commissioner, representative of each  
24 geographic area of the state and including:

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

27 (i) health plan consumer advocates;

28 (ii) small business consumer representatives;

29 (iii) health care provider representatives;

30 (iv) representatives of the health insurance industry;

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

33 (i) licensed insurance producers; and

34 (ii) representatives of labor organizations.

35 3. The Marketplace shall select the chair of the advisory committee  
36 from among the members of such committee and shall designate an officer  
37 or employee of the department to assist the marketplace advisory commit-  
38 tee in the performance of its duties under this section. The Marketplace  
39 shall adopt rules for the governance of the advisory committee, which  
40 shall meet as frequently as its business may require and at such other  
41 times as determined by the Marketplace to be necessary.

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

46 § 268-g. Funding of the Marketplace. 1. The Marketplace shall be fund-  
47 ed by state and federal sources as authorized by applicable law, includ-  
48 ing but not limited to applicable law authorizing the respective insur-  
49 ance affordability programs available through the Marketplace.

50 2. The accounts of the Marketplace shall be subject to supervision of  
51 the comptroller and such accounts shall include receipts, expenditures,  
52 contracts and other matters which pertain to the fiscal soundness of the  
53 Marketplace.

54 3. Notwithstanding any law to the contrary, and in accordance with  
55 section four of the state finance law, upon request of the director of  
56 the budget, in consultation with the commissioner, the superintendent

1 and the executive director of the Marketplace, the comptroller is hereby  
2 authorized and directed to sub-allocate or transfer special revenue  
3 federal funds appropriated to the department for planning and implement-  
4 ing various healthcare and insurance reform initiatives authorized by  
5 applicable law. Marketplace moneys sub-allocated or transferred pursu-  
6 ant to this section shall be paid out of the fund upon audit and warrant  
7 of the state comptroller on vouchers certified or approved by the  
8 Marketplace.

9 § 268-h. Construction. Nothing in this article, and no action taken by  
10 the Marketplace pursuant hereto, shall be construed to:

11 1. preempt or supersede the authority of the superintendent or the  
12 commissioner; or

13 2. exempt insurers, insurance producers or qualified health plans from  
14 this chapter or the insurance law and any regulations promulgated there-  
15 under.

16 § 3. Severability. If any provision of this article, or the applica-  
17 tion thereof to any person or circumstances is held invalid or unconsti-  
18 tutional, that invalidity or unconstitutionality shall not affect other  
19 provisions or applications of this article that can be given effect  
20 without the invalid or unconstitutional provision or application, and to  
21 this end the provisions and application of this article are severable.

22 § 4. This act shall take effect immediately.

#### 23 PART U

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

26 12. The director is hereby authorized to implement private pay proto-  
27 cols for all programs administered by the office. These protocols may be  
28 implemented by area agencies on aging at their option and such protocols  
29 may not be applied to clients whose services are paid for with federal  
30 funds or funds designated as federal match. All private payments  
31 received directly by an area agency on aging or indirectly by one of its  
32 contractors shall be used to supplement, not supplant, funds by state,  
33 federal, or county appropriations. Private pay payments received under  
34 this subdivision shall be used by the area agency on aging to support  
35 and enhance services or programs provided by the area agency on aging.  
36 Participant payments under this subdivision shall not be required of  
37 individuals with incomes below four hundred percent of the federal  
38 poverty level. No participant, regardless of income, shall be required  
39 to pay for any service that they are receiving at the time these proto-  
40 cols are implemented by the area agency on aging. This subdivision shall  
41 not prevent cost sharing for the programs established pursuant to  
42 section two hundred fourteen of this title for individuals below four  
43 hundred percent of the federal poverty level.

44 § 2. This act shall take effect immediately.

#### 45 PART V

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

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

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

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

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

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

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

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

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

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

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

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

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

54     (b) A compliance program that meets Federal requirements for managed  
55 care provider compliance programs, as specified in the contract or  
56 contracts between the department and the Medicaid managed care provider



1 shall be deemed in compliance with the provisions in this section, so  
2 long as such programs adequately address medical assistance program risk  
3 areas and compliance issues. For purposes of this section, a managed  
4 care provider is as defined in paragraph (c) of subdivision one of  
5 section three hundred sixty-four-j of this chapter, and includes managed  
6 long term care plans.

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

14 § 5. Section 3613 of the public health law is amended by adding a new  
15 subdivision 1-a to read as follows:

16 1-a. Each home care services worker shall obtain an individual  
17 National Provider Identifier (NPI) number from the National Provider  
18 Plan and Provider Enumeration System (NPPES).

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

21 35. Recovery of overpayments from network providers. (a) Where the  
22 Medicaid inspector general during the course of an audit, investigation,  
23 or review, or the deputy attorney general for the Medicaid fraud control  
24 unit during the course of an investigation or prosecution for Medicaid  
25 fraud, identifies medical assistance overpayments made by a managed care  
26 provider or managed long term care plan to its subcontractor or subcon-  
27 tractors or provider or providers, the state shall have the right to  
28 recover the overpayment from the subcontractor or subcontractors,  
29 provider or providers, or the managed care provider or managed long term  
30 care plan.

31 (b) Where the state is unsuccessful in recovering an overpayment from  
32 the subcontractor or subcontractors or provider or providers, the Medi-  
33 caid inspector general may require the managed care provider or managed  
34 long term care plan to recover the medical assistance overpayment iden-  
35 tified in paragraph (a) of this subdivision on behalf of the state. The  
36 managed care provider or managed long term care plan shall remit to the  
37 state the full amount of the identified overpayment no later than six  
38 months after receiving notice of the overpayment from the state.

39 § 7. This act shall take effect immediately; provided, however, that  
40 the amendments to section 364-j of the social services law made by  
41 sections one, two, three, and six of this act shall not affect the  
42 repeal of such section and shall be deemed repealed therewith; provided  
43 further, that section three of this act shall apply to a contract or  
44 contracts in effect as of January 1, 2015 and any review period in  
45 section three of this act shall not begin before January 1, 2018.

46 PART W

47 Section 1. Section 1 of part D of chapter 111 of the laws of 2010  
48 relating to the recovery of exempt income by the office of mental health  
49 for community residences and family-based treatment programs, as amended  
50 by section 1 of part H of chapter 59 of the laws of 2016, is amended to  
51 read as follows:

52 Section 1. The office of mental health is authorized to recover fund-  
53 ing from community residences and family-based treatment providers  
54 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

Section 1. Subdivision 9 of section 730.10 of the criminal procedure law, as added by section 1 of part Q of chapter 56 of the laws of 2012, is amended to read as follows:

9. "Appropriate institution" means: (a) a hospital operated by the office of mental health or a developmental center operated by the office for people with developmental disabilities; ~~or~~ (b) a hospital licensed by the department of health which operates a psychiatric unit licensed by the office of mental health, as determined by the commissioner provided, however, that any such hospital that is not operated by the state shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner and the hospital; or (c) a mental health unit operating within a local correctional facility except those located within a city with a population of one million or more; provided however, that any such mental health unit operating within a local correctional facility shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner of mental health, director of community services and the sheriff for the respective locality. Nothing in this article shall be construed as requiring a hospital or local correctional facility to consent to providing care and treatment to an incapacitated person at such hospital or local correctional facility. The commissioner of mental health shall promulgate regulations for demonstration programs at no more than two counties to implement restoration to competency within a local correctional facility. Subject to annual appropriation, the commissioner of mental health may, at such commissioner's discretion, make funds available for state aid grants to any county that develops and operates a mental health unit within a local correctional facility pursuant to this section. Nothing in this article shall be construed as requiring a hospital or local correctional facility to consent to providing care and treatment to an incapacitated person at such hospital or local correctional facility.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that this act shall expire and be deemed repealed March 31, 2024; effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

#### 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]~~.

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

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

## PART Z

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

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those

1 teachings. No provision of this article or any other provision of law  
2 shall be construed to: (a) limit the volume of mental health ~~[or]~~,  
3 substance use disorder services or developmental disability services  
4 that can be provided by a provider of primary care services licensed  
5 under this article and authorized to provide integrated services in  
6 accordance with regulations issued by the commissioner in consultation  
7 with the commissioner of the office of mental health ~~[and]~~, the commis-  
8 sioner of the office of alcoholism and substance abuse services and the  
9 commissioner of the office for people with developmental disabilities,  
10 including regulations issued pursuant to subdivision seven of section  
11 three hundred sixty-five-1 of the social services law or part L of chap-  
12 ter fifty-six of the laws of two thousand twelve; (b) require a provider  
13 licensed pursuant to article thirty-one of the mental hygiene law or  
14 certified pursuant to article sixteen or article thirty-two of the  
15 mental hygiene law to obtain an operating certificate from the depart-  
16 ment if such provider has been authorized to provide integrated services  
17 in accordance with regulations issued by the commissioner in consulta-  
18 tion with the commissioner of the office of mental health ~~[and]~~, the  
19 commissioner of the office of alcoholism and substance abuse services  
20 and the commissioner of the office for people with developmental disa-  
21 bilities, including regulations issued pursuant to subdivision seven of  
22 section three hundred sixty-five-1 of the social services law or part L  
23 of chapter fifty-six of the laws of two thousand twelve.

24 § 2. Subdivision (f) of section 31.02 of the mental hygiene law, as  
25 added by section 2 of subpart B of part S of chapter 57 of the laws of  
26 2018, is amended to read as follows:

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

40 § 3. Subdivision (b) of section 32.05 of the mental hygiene law, as  
41 amended by section 3 of subpart B of part S of chapter 57 of the laws of  
42 2018, is amended to read as follow:

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

1 of law shall be construed to require a provider licensed pursuant to  
2 article twenty-eight of the public health law or article thirty-one of  
3 this chapter to obtain an operating certificate from the office of alco-  
4 holism and substance abuse services if such provider has been authorized  
5 to provide integrated services in accordance with regulations issued by  
6 the commissioner of alcoholism and substance abuse services in consulta-  
7 tion with the commissioner of the department of health ~~[and]~~, the  
8 commissioner of the office of mental health and the commissioner of the  
9 office for people with developmental disabilities, including regulations  
10 issued pursuant to subdivision seven of section three hundred sixty-  
11 five-1 of the social services law or part L of chapter fifty-six of the  
12 laws of two thousand twelve.

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

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

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

35 PART AA

36 Section 1. Paragraph (a) of subdivision 4 of section 488 of the social  
37 services law, as amended by section 2 of part MM of chapter 58 of the  
38 laws of 2015, is amended to read as follows:

39 (a) a facility or program in which services are provided and which is  
40 operated, licensed or certified by the office of mental health, the  
41 office for people with developmental disabilities or the office of alco-  
42 holism and substance abuse services, including but not limited to  
43 psychiatric centers, ~~[inpatient psychiatric units of a general hospi-~~  
44 ~~tal]~~ developmental centers, intermediate care facilities, community  
45 residences, group homes and family care homes, provided, however, that  
46 such term shall not include a secure treatment facility as defined in  
47 section 10.03 of the mental hygiene law, services defined in subpara-  
48 graph four of subdivision (a) of section 16.03 of the mental hygiene  
49 law, ~~[or]~~ services provided in programs or facilities that are operated  
50 by the office of mental health and located in state correctional facili-  
51 ties under the jurisdiction of the department of corrections and commu-  
52 nity supervision or services provided in a unit of a hospital, as  
53 defined in subdivision one of section twenty-eight hundred one of the



public health law that is licensed or certified by the office of mental health or the office of alcoholism and substance abuse services;

§ 2. Paragraphs (c), (d) and (e) of subdivision 4 of section 488 of the social services law, as added by section 1 of part B of chapter 501 of the laws of 2012, paragraph (d) as amended by chapter 126 of the laws of 2014, and paragraph (e) as amended by chapter 83 of the laws of 2013, are amended to read as follows:

(c) adult care facilities, which shall mean adult homes or enriched housing programs licensed pursuant to article seven of this chapter: (i) (A) that have a licensed capacity of eighty or more beds; and (B) in which at least twenty-five percent of the residents are persons with serious mental illness as defined by subdivision fifty-two of section 1.03 of the mental hygiene law; (ii) but not including an adult home or enriched housing program which is authorized to operate fifty-five percent or more of its total licensed capacity of beds as assisted living program beds pursuant to section four hundred sixty-one-1 of this chapter; or

(d) [~~any overnight, summer day and traveling summer day camps for children with developmental disabilities as defined in regulations promulgated by the commissioner of health, or~~

~~(e)]~~ the New York state school for the blind and the New York state school for the deaf, which operate pursuant to articles eighty-seven and eighty-eight of the education law; an institution for the instruction of the deaf and the blind which has a residential component and is subject to the visitation of the commissioner of education pursuant to article eighty-five of the education law with respect to its day and residential components; special act school districts serving students with disabilities; or in-state private schools which have been approved by the commissioner of education for special education services or programs, and which have a residential program.

§ 3. This act shall take effect August 1, 2019 and shall apply to reports of abuse or neglect made on or after such date; provided that, any reports of abuse or neglect reported to the justice center prior to the effective date of this act shall be completed by the justice center.

#### PART BB

Section 1. This part enacts into law major components of legislation which are necessary to effectuate provisions relating to mental health and substance use disorder treatment. Each component is wholly contained within a Subpart identified as Subparts A through E. 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 three of this Part sets forth the general effective date of this Part.

#### SUBPART A

Section 1. Paragraph 4 of subsection (i) of section 3216 of the insurance law is amended to read as follows:

(4) If a policy provides for reimbursement for psychiatric or psychological 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:

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

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

(J) For purposes of this paragraph:

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

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

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

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

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

(30)(A) Every policy 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 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.

(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-one days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within ~~[forty-eight hours]~~ two business days of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first ~~[fourteen]~~ twenty-one days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial ~~[fourteen]~~ twenty-one day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(E) An insurer shall make available to any insured, prospective insured, or in-network provider, upon request, the criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits.

(F) For purposes of this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review



1 for the first [~~two~~] three weeks of continuous treatment, not to exceed  
2 [~~fourteen~~] twenty-one visits, provided the facility notifies the insurer  
3 of both the start of treatment and the initial treatment plan within  
4 [~~forty-eight hours~~] two business days. The facility shall perform clinical  
5 assessment of the patient at each visit, including the periodic  
6 consultation with the insurer to ensure that the facility is using the  
7 evidence-based and peer reviewed clinical review tool utilized by the  
8 insurer which is designated by the office of alcoholism and substance  
9 abuse services and appropriate to the age of the patient, to ensure that  
10 the outpatient treatment is medically necessary for the patient. Any  
11 utilization review of the treatment provided under this subparagraph may  
12 include a review of all services provided during such outpatient treatment,  
13 including all services provided during the first [~~two~~] three weeks  
14 of continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, of  
15 such outpatient treatment. Provided, however, the insurer shall only  
16 deny coverage for any portion of the initial [~~two~~] three weeks of  
17 continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, for  
18 outpatient treatment on the basis that such treatment was not medically  
19 necessary if such outpatient treatment was contrary to the evidence-  
20 based and peer reviewed clinical review tool utilized by the insurer  
21 which is designated by the office of alcoholism and substance abuse  
22 services. An insured shall not have any financial obligation to the  
23 facility for any treatment under this subparagraph other than any copay-  
24 ment, coinsurance, or deductible otherwise required under the policy.

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

29 (G) For purposes of this paragraph:

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

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

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

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

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

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

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

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

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

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

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

~~(iv) serious disfigurement of such person, or~~

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

~~(C) Coverage provided under this paragraph may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the policy, provided, however, no policy shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This subparagraph shall not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]~~

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

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

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the

1 office of mental health, or, for care provided in other states, to simi-  
2 larly licensed or certified hospitals or facilities; and

3 (ii) where the policy provides coverage for physician services, bene-  
4 fits for outpatient care provided by a psychiatrist or psychologist  
5 licensed to practice in this state, a licensed clinical social worker  
6 who meets the requirements of subparagraph (D) of paragraph four of  
7 subsection (1) of section three thousand two hundred twenty-one of this  
8 article, a nurse practitioner licensed to practice in this state, or a  
9 professional corporation or university faculty practice corporation  
10 thereof.

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

15 (C) Coverage under this paragraph shall not apply financial require-  
16 ments or treatment limitations to mental health benefits that are more  
17 restrictive than the predominant financial requirements and treatment  
18 limitations applied to substantially all medical and surgical benefits  
19 covered by the policy.

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

24 (E) For purposes of this paragraph:

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

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

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

43 (iv) "mental health condition" means any mental health disorder as  
44 defined in the most recent edition of the diagnostic and statistical  
45 manual of mental disorders or the most recent edition of another gener-  
46 ally recognized independent standard of current medical practice such as  
47 the international classification of diseases.

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

51 (G) This subparagraph shall apply to hospitals in this state that are  
52 licensed by the office of mental health that are participating in the  
53 insurer's provider network. Where the policy provides coverage for inpa-  
54 tient hospital care, benefits for inpatient hospital care in a hospital  
55 as defined by subdivision ten of section 1.03 of the mental hygiene law  
56 provided to individuals who have not attained the age of eighteen shall

1 not be subject to preauthorization. Coverage provided under this para-  
2 graph shall also not be subject to concurrent utilization review during  
3 the first fourteen days of the inpatient admission, provided the facili-  
4 ty notifies the insurer of both the admission and the initial treatment  
5 plan within two business days of the admission, performs daily clinical  
6 review of the patient, and participates in periodic consultation with  
7 the insurer to ensure that the facility is using the evidence-based and  
8 peer reviewed clinical review criteria utilized by the insurer which is  
9 approved by the office of mental health and appropriate to the age of  
10 the patient, to ensure that the inpatient care is medically necessary  
11 for the patient. All treatment provided under this subparagraph may be  
12 reviewed retrospectively. Where care is denied retrospectively, an  
13 insured shall not have any financial obligation to the facility for any  
14 treatment under this subparagraph other than any copayment, coinsurance,  
15 or deductible otherwise required under the policy.

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

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

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

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

37 (B) the amount that the insurer will reimburse under the methodology  
38 for out-of-network health care services set forth as a percentage of the  
39 usual and customary cost for out-of-network health care services; and

40 (C) examples of anticipated out-of-pocket costs for frequently billed  
41 out-of-network health care services; ~~[and]~~

42 (20) information in writing and through an internet website that  
43 reasonably permits an insured or prospective insured to estimate the  
44 anticipated out-of-pocket cost for out-of-network health care services  
45 in a geographical area or zip code based upon the difference between  
46 what the insurer will reimburse for out-of-network health care services  
47 and the usual and customary cost for out-of-network health care  
48 services~~[,]~~; and

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

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

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

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

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

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

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state where the policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental~~[, nervous or emotional disorders and ailments]~~ health conditions, however defined in such policy, by physicians, psychiatrists or psychologists, shall provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either: (i) three or more additional years experience in psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior that are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental~~[, nervous or emotional disorders or ailments]~~ health conditions; (ii)



1 three or more additional years experience in psychotherapy under the  
2 supervision, satisfactory to the state board for social work, of a  
3 psychiatrist, a licensed and registered psychologist or a licensed clin-  
4 ical social worker qualified for reimbursement pursuant to subsection  
5 (e) of this section, or (iii) a combination of the experience specified  
6 in items (i) and (ii) of this subparagraph totaling three years, satis-  
7 factory to the state board for social work.

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

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

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

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

41 [~~(iii)~~] (B) Coverage required by this paragraph may be [~~provided on a~~  
42 ~~contract year, plan year or calendar year basis and shall be consistent~~  
43 ~~with the provision of other benefits under the policy. Such coverage may~~  
44 ~~be]~~ subject to annual deductibles, co-pays and coinsurance as may be  
45 deemed appropriate by the superintendent and shall be consistent with  
46 those imposed on other benefits under the policy. [~~In the event that a~~  
47 ~~policy provides coverage for both inpatient hospital care and physician~~  
48 ~~services, the aggregate of the benefits for outpatient care obtained~~  
49 ~~under this paragraph may be limited to not less than twenty visits in~~  
50 ~~any contract year, plan year or calendar year.~~

51 (iv) ~~In this paragraph, "active treatment" means treatment furnished~~  
52 ~~in conjunction with inpatient confinement for mental, nervous or~~  
53 ~~emotional disorders or ailments that meet standards prescribed pursuant~~  
54 ~~to the regulations of the commissioner of mental health.~~

55 (B) (i) ~~Every insurer delivering a group or school blanket policy or~~  
56 ~~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 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

1 (iv) "mental health condition" means any mental health disorder as  
2 defined in the most recent edition of the diagnostic and statistical  
3 manual of mental disorders or the most recent edition of another gener-  
4 ally recognized independent standard of current medical practice such as  
5 the international classification of diseases.

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

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

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

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

49 (B) Coverage provided under this paragraph may be limited to facili-  
50 ties in New York state ~~[which are certified]~~ that are licensed, certi-  
51 fied or otherwise authorized by the office of alcoholism and substance  
52 abuse services and, in other states, to those which are accredited by  
53 the joint commission as alcoholism, substance abuse or chemical depend-  
54 ence treatment programs and are similarly licensed, certified, or other-  
55 wise 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-one days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within ~~[forty-eight hours]~~ two business days of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first ~~[fourteen]~~ twenty-one days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial ~~[fourteen]~~ twenty-one day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(E) 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 may 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 only 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]~~ three weeks of continuous treatment, not to exceed ~~[fourteen]~~ twenty-one visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within ~~[forty-eight hours]~~ two business days. The facility shall perform clinical assessment of the patient at each visit, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any



1 utilization review of the treatment provided under this subparagraph may  
2 include a review of all services provided during such outpatient treat-  
3 ment, including all services provided during the first [~~two~~] three weeks  
4 of continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, of  
5 such outpatient treatment. Provided, however, the insurer shall only  
6 deny coverage for any portion of the initial [~~two~~] three weeks of  
7 continuous treatment, not to exceed [~~fourteen~~] twenty-one visits, for  
8 outpatient treatment on the basis that such treatment was not medically  
9 necessary if such outpatient treatment was contrary to the evidence-  
10 based and peer reviewed clinical review tool utilized by the insurer  
11 which is designated by the office of alcoholism and substance abuse  
12 services. An insured shall not have any financial obligation to the  
13 facility for any treatment under this subparagraph other than any copay-  
14 ment, coinsurance, or deductible otherwise required under the policy.

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

19 (G) For purposes of this paragraph:

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

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

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

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

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

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

49 (7-b) [~~(A)~~] Every policy that provides medical, major medical or simi-  
50 lar comprehensive-type coverage and provides coverage for prescription  
51 drugs for medication for the treatment of a substance use disorder shall  
52 include immediate access, without prior authorization, [~~to a five-day~~  
53 ~~emergency supply~~] to the formulary forms of prescribed medications  
54 covered under the policy for the treatment of substance use disorder  
55 [~~where an emergency condition exists~~], including a prescribed drug or  
56 medication associated with the management of opioid withdrawal and/or

1 stabilization, except where otherwise prohibited by law. Further, cover-  
2 age ~~[of an emergency supply]~~ without prior authorization shall include  
3 formulary forms medication for opioid overdose reversal otherwise  
4 covered under the policy prescribed or dispensed to an individual  
5 covered by the policy.

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

12 ~~(i) placing the health of the person afflicted with such condition in~~  
13 ~~serious jeopardy, or in the case of a behavioral condition, placing the~~  
14 ~~health of such person or others in serious jeopardy;~~

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

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

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

18 ~~(v) a condition described in clause (i), (ii), or (iii) of section~~  
19 ~~1867(e)(1)(A) of the Social Security Act.~~

20 ~~[(C) Coverage provided under this paragraph may be subject to copay-~~  
21 ~~ments, coinsurance, and annual deductibles that are consistent with~~  
22 ~~those imposed on other benefits within the policy; provided, however, no~~  
23 ~~policy shall impose an additional copayment or coinsurance on an insured~~  
24 ~~who received an emergency supply of medication and then received up to a~~  
25 ~~thirty day supply of the same medication in the same thirty day period~~  
26 ~~in which the emergency supply of medication was dispensed. This subpara-~~  
27 ~~graph shall not preclude the imposition of a copayment or coinsurance on~~  
28 ~~the initial emergency supply of medication in an amount that is less~~  
29 ~~than the copayment or coinsurance otherwise applicable to a thirty day~~  
30 ~~supply of such medication, provided that the total sum of the copayments~~  
31 ~~or coinsurance for an entire thirty day supply of the medication does~~  
32 ~~not exceed the copayment or coinsurance otherwise applicable to a thirty~~  
33 ~~day supply of such medication.]~~

34 § 19. Subparagraph (B) of paragraph 17 of subsection (1) of section  
35 3221 of the insurance law, as amended by section 39 of part D of chapter  
36 56 of the laws of 2013, is amended to read as follows:

37 (B) Every group or blanket policy that provides physician services,  
38 medical, major medical or similar comprehensive-type coverage shall  
39 provide coverage for the screening, diagnosis and treatment of autism  
40 spectrum disorder in accordance with this paragraph and shall not  
41 exclude coverage for the screening, diagnosis or treatment of medical  
42 conditions otherwise covered by the policy because the individual is  
43 diagnosed with autism spectrum disorder. Such coverage may be subject to  
44 annual deductibles, copayments and coinsurance as may be deemed appro-  
45 priate by the superintendent and shall be consistent with those imposed  
46 on other benefits under the group or blanket policy. ~~[Coverage for~~

47 ~~applied behavior analysis shall be subject to a maximum benefit of six~~  
48 ~~hundred eighty hours of treatment per policy or calendar year per~~  
49 ~~covered individual.]~~ This paragraph shall not be construed as limiting

50 the benefits that are otherwise available to an individual under the  
51 group or blanket policy, provided however that such policy shall not  
52 contain any limitations on visits that are solely applied to the treat-  
53 ment of autism spectrum disorder. No insurer shall terminate coverage or  
54 refuse to deliver, execute, issue, amend, adjust, or renew coverage to  
55 an individual solely because the individual is diagnosed with autism  
56 spectrum disorder or has received treatment for autism spectrum disorder.

der. 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 (l) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

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

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

§ 21. Paragraph 17 of subsection (l) of section 3221 of the insurance law is amended by adding four new subparagraphs (H), (I), (J) and (K) to read as follows:

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

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

(J) For purposes of this paragraph:

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

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

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

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

§ 22. Paragraphs 1, 2, and 3 of subsection (g) of section 4303 of the insurance law, as amended by chapter 502 of the laws of 2007, are amended to read as follows:

~~[(1)]~~ A medical expense indemnity corporation, hospital service corporation or a health service corporation, ~~[which]~~ that provides group, group remittance or school blanket coverage for inpatient hospital care~~[7]~~ or coverage for physician services shall provide as part of its contract ~~[broad-based]~~ coverage for the diagnosis and treatment of mental~~[, nervous or emotional disorders or ailments, however defined in such contract, at least equal to the coverage provided for other]~~ health conditions and ~~[shall include]~~:

~~[(A)]~~

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

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

~~(C) Such coverage may be provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the contract.]~~ or for out-patient care provided in other states, to similarly certified facilities; and

(2) where the contract provides coverage for physician services benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subsection (n) of this section, a nurse practitioner licensed to practice on this state, or professional corporation or university faculty practice corporation thereof.

(3) Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the contract.

~~[(D) For the purpose of this subsection, "active treatment" means treatment furnished in conjunction with in-patient confinement for mental, nervous or emotional disorders or ailments that meet such standards as shall be prescribed pursuant to the regulations of the commissioner of mental health.~~

~~(E) In the event the group remittance group or contract holder is provided coverage under this subsection and under paragraph one of subsection (h) of this section from the same health service corporation, or under a contract that is jointly underwritten by two health service~~

~~corporations or by a health service corporation and a medical expense indemnity corporation, the aggregate of the benefits for outpatient care obtained under subparagraph (B) of this paragraph and paragraph one of subsection (h) of this section may be limited to not less than twenty visits in any contract year, plan year or calendar year.~~

~~(2) (A) A hospital service corporation or a health service corporation, which provides group, group remittance or school blanket coverage for inpatient hospital care, shall provide comparable coverage for adults and children with biologically based mental illness. Such hospital service corporation or health service corporation shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the contract, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a contract provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the contract is written under one license or two licenses.~~

~~(B) For purposes of this subsection, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, anorexia, and bulimia.~~

~~(3) For purposes of this subsection, the term "children with serious emotional disturbances" means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:~~

~~(A) serious suicidal symptoms or other life-threatening self-destructive behaviors;~~

~~(B) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);~~

~~(C) behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or~~

~~(D) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.]~~

§ 23. Paragraphs 4 and 5 of subsection (g) of section 4303 of the insurance law are REPEALED and five new paragraphs 4, 5, 6, 7 and 8 are added to read as follows:

(4) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(5) The criteria for medical necessity determinations under the contract with respect to mental health benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(6) For purposes of this subsection:

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



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

4 (C) "treatment limitation" means limits on the frequency of treatment,  
5 number of visits, days of coverage, or other similar limits on the  
6 scope or duration of treatment and includes nonquantitative treatment  
7 limitations such as: medical management standards limiting or excluding  
8 benefits based on medical necessity, or based on whether the treatment  
9 is experimental or investigational; formulary design for prescription  
10 drugs; network tier design; standards for provider admission to partic-  
11 ipate in a network, including reimbursement rates; methods for deter-  
12 mining usual, customary, and reasonable charges; fail-first or step  
13 therapy protocols; exclusions based on failure to complete a course of  
14 treatment; and restrictions based on geographic location, facility type,  
15 provider specialty, and other criteria that limit the scope or duration  
16 of benefits for services provided under the contract; and

17 (D) "mental health condition" means any mental health disorder as  
18 defined in the most recent edition of the diagnostic and statistical  
19 manual of mental disorders or the most recent edition of another gener-  
20 ally recognized independent standard of current medical practice such as  
21 the international classification of diseases.

22 (7) A corporation shall provide coverage under this paragraph, at a  
23 minimum, consistent with the federal Paul Wellstone and Pete Domenici  
24 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
25 1185a).

26 (8) This subparagraph shall apply to hospitals in this state that are  
27 licensed by the office of mental health that are participating in the  
28 corporation's provider network. Where the contract provides coverage for  
29 inpatient hospital care, benefits for inpatient hospital care in a  
30 hospital as defined by subdivision ten of section 1.03 of the mental  
31 hygiene law provided to individuals who have not attained the age of  
32 eighteen shall not be subject to preauthorization. Coverage provided  
33 under this paragraph shall also not be subject to concurrent utiliza-  
34 tion review during the first fourteen days of the inpatient admission,  
35 provided the facility notifies the corporation of both the admission and  
36 the initial treatment plan within two business days of the admission,  
37 performs daily clinical review of the patient, and participates in peri-  
38 odic consultation with the corporation to ensure that the facility is  
39 using the evidence-based and peer reviewed clinical review criteria  
40 utilized by the corporation which is approved by the office of mental  
41 health and appropriate to the age of the patient, to ensure that the  
42 inpatient care is medically necessary for the patient. All treatment  
43 provided under this subparagraph may be reviewed retrospectively. Where  
44 care is denied retrospectively, an insured shall not have any financial  
45 obligation to the facility for any treatment under this subparagraph  
46 other than any copayment, coinsurance, or deductible otherwise required  
47 under the contract.

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

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

51 (i) A medical expense indemnity corporation or health service corpo-  
52 ration ~~[which]~~ that provides coverage for physicians, psychiatrists or  
53 psychologists for psychiatric or psychological services or for the diag-  
54 nosis and treatment of ~~[mental, nervous or emotional disorders and~~  
55 ~~ailments]~~ mental health conditions, however defined in such contract,  
56 ~~[must]~~ shall make available and if requested by all persons holding

1 individual contracts in a group whose premiums are paid by a remitting  
2 agent or by the contract holder in the case of a group contract issued  
3 pursuant to section four thousand three hundred five of this article,  
4 provide the same coverage for such services when performed by a licensed  
5 clinical social worker, within the lawful scope of his or her practice,  
6 who is licensed pursuant to article one hundred fifty-four of the educa-  
7 tion law. The state board for social work shall maintain a list of all  
8 licensed clinical social workers qualified for reimbursement under this  
9 subsection. Such coverage shall be made available at the inception of  
10 all new contracts and, with respect to all other contracts, at any anni-  
11 versary date subject to evidence of insurability. Written notice of the  
12 availability of such coverage shall be delivered to the group remitting  
13 agent or group contract holder prior to inception of such contract and  
14 annually thereafter, except that this notice shall not be required where  
15 a ~~[policy]~~ contract covers two hundred or more employees or where the  
16 benefit structure was the subject of collective bargaining affecting  
17 persons who are employed in more than one state.

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

21 (k)(1) Every contract that provides hospital, major medical or similar  
22 comprehensive coverage ~~[must]~~ shall provide inpatient coverage for the  
23 diagnosis and treatment of substance use disorder, including detoxifica-  
24 tion and rehabilitation services. Such inpatient coverage shall include  
25 unlimited medically necessary treatment for substance use disorder  
26 treatment services provided in residential settings ~~[as required by the~~  
27 ~~Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §~~  
28 ~~1185a)]~~. Further, such inpatient coverage shall not apply financial  
29 requirements or treatment limitations, including utilization review  
30 requirements, to inpatient substance use disorder benefits that are more  
31 restrictive than the predominant financial requirements and treatment  
32 limitations applied to substantially all medical and surgical benefits  
33 covered by the contract. ~~[Further, such coverage shall be provided~~  
34 ~~consistent with the federal Paul Wellstone and Pete Domenici Mental~~  
35 ~~Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a)].~~

36 (2) Coverage provided under this subsection may be limited to facili-  
37 ties in New York state ~~[which are certified]~~ that are licensed, certi-  
38 fied or otherwise authorized by the office of alcoholism and substance  
39 abuse services and, in other states, to those which are accredited by  
40 the joint commission as alcoholism, substance abuse, or chemical depend-  
41 ence treatment programs and are similarly licensed, certified or other-  
42 wise authorized in the state in which the facility is located.

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

47 (4) This paragraph shall apply to facilities in this state ~~[certified]~~  
48 that are licensed, certified or otherwise authorized by the office of  
49 alcoholism and substance abuse services that are participating in the  
50 corporation's provider network. Coverage provided under this subsection  
51 shall not be subject to preauthorization. Coverage provided under this  
52 subsection shall also not be subject to concurrent utilization review  
53 during the first ~~[fourteen]~~ twenty-one days of the inpatient admission  
54 provided that the facility notifies the corporation of both the admis-  
55 sion and the initial treatment plan within ~~[forty-eight hours]~~ two busi-  
56 ness days of the admission. The facility shall perform daily clinical

1 review of the patient, including the periodic consultation with the  
2 corporation to ensure that the facility is using the evidence-based and  
3 peer reviewed clinical review tool utilized by the corporation which is  
4 designated by the office of alcoholism and substance abuse services and  
5 appropriate to the age of the patient, to ensure that the inpatient  
6 treatment is medically necessary for the patient. Any utilization review  
7 of treatment provided under this paragraph may include a review of all  
8 services provided during such inpatient treatment, including all  
9 services provided during the first [~~fourteen~~] twenty-one days of such  
10 inpatient treatment. Provided, however, the corporation shall only deny  
11 coverage for any portion of the initial [~~fourteen~~] twenty-one day inpa-  
12 tient treatment on the basis that such treatment was not medically  
13 necessary if such inpatient treatment was contrary to the evidence-based  
14 and peer reviewed clinical review tool utilized by the corporation which  
15 is designated by the office of alcoholism and substance abuse services.  
16 An insured shall not have any financial obligation to the facility for  
17 any treatment under this paragraph other than any copayment, coinsu-  
18 rance, or deductible otherwise required under the contract.

19 (5) The criteria for medical necessity determinations under the  
20 contract with respect to inpatient substance use disorder benefits  
21 shall be made available by the corporation to any insured, prospective  
22 insured or in-network provider upon request.

23 (6) For purposes of this subsection:

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

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

29 (C) "treatment limitation" means limits on the frequency of treatment,  
30 number of visits, days of coverage, or other similar limits on the  
31 scope or duration of treatment and includes nonquantitative treatment  
32 limitations such as: medical management standards limiting or excluding  
33 benefits based on medical necessity, or based on whether the treatment  
34 is experimental or investigational; formulary design for prescription  
35 drugs; network tier design; standards for provider admission to partic-  
36 ipate in a network, including reimbursement rates; methods for deter-  
37 mining usual, customary, and reasonable charges; fail-first or step  
38 therapy protocols; exclusions based on failure to complete a course of  
39 treatment; and restrictions based on geographic location, facility type,  
40 provider specialty, and other criteria that limit the scope or duration  
41 of benefits for services provided under the contract; and

42 (D) "substance use disorder" shall have the meaning set forth in the  
43 most recent edition of the diagnostic and statistical manual of mental  
44 disorders or the most recent edition of another generally recognized  
45 independent standard of current medical practice such as the interna-  
46 tional classification of diseases.

47 (7) A corporation shall provide coverage under this paragraph, at a  
48 minimum, consistent with the federal Paul Wellstone and Pete Domenici  
49 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
50 1185a).

51 § 27. Paragraphs 1 and 2 of subsection (1) of section 4303 of the  
52 insurance law, as amended by chapter 41 of the laws of 2014, are amended  
53 and a new paragraph 3-a is added to read as follows:

54 (1) Every contract that provides medical, major medical or similar  
55 comprehensive-type coverage [~~must~~] shall provide outpatient coverage for  
56 the diagnosis and treatment of substance use disorder, including detoxi-

1 fication and rehabilitation services. Such coverage shall not apply  
2 financial requirements or treatment limitations to outpatient substance  
3 use disorder benefits that are more restrictive than the predominant  
4 financial requirements and treatment limitations applied to substantial-  
5 ly all medical and surgical benefits covered by the contract. [~~Further,~~  
6 ~~such coverage shall be provided consistent with the federal Paul Well-~~  
7 ~~stone and Pete Domenici Mental Health Parity and Addiction Equity Act of~~  
8 ~~2008 (29 U.S.C. § 1185a).~~]

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

18 (3-a) A contract that provides large group coverage that provides  
19 coverage for outpatient substance use disorder services under this  
20 subsection may not impose copayments or coinsurance for outpatient  
21 substance use disorder services that exceed the copayment or coinsurance  
22 imposed for a primary care office visit. Provided that only one such  
23 copayment may be imposed for all services provided in a single day by a  
24 facility licensed, certified or otherwise authorized by the office of  
25 alcoholism and substance abuse services to provide outpatient substance  
26 use disorder services.

27 § 28. Paragraph 5 of subsection (1) of section 4303 of the insurance  
28 law, as added by section 5 of part MM of chapter 57 of the laws of 2018,  
29 is amended and three new paragraphs 6, 7 and 8 are added to read as  
30 follows:

31 (5) This paragraph shall apply to facilities in this state [~~certified~~  
32 that are licensed, certified or otherwise authorized] by the office of  
33 alcoholism and substance abuse services for the provision of outpatient,  
34 intensive outpatient, outpatient rehabilitation and opioid treatment  
35 that are participating in the corporation's provider network. Coverage  
36 provided under this subsection shall not be subject to preauthorization.  
37 Coverage provided under this subsection shall not be subject to concur-  
38 rent review for the first [~~two~~] three weeks of continuous treatment, not  
39 to exceed [~~fourteen~~] twenty-one visits, provided the facility notifies  
40 the corporation of both the start of treatment and the initial treatment  
41 plan within [~~forty-eight hours~~] two business days. The facility shall  
42 perform clinical assessment of the patient at each visit, including the  
43 periodic consultation with the corporation to ensure that the facility  
44 is using the evidence-based and peer reviewed clinical review tool  
45 utilized by the corporation which is designated by the office of alco-  
46 holism and substance abuse services and appropriate to the age of the  
47 patient, to ensure that the outpatient treatment is medically necessary  
48 for the patient. Any utilization review of the treatment provided under  
49 this paragraph may include a review of all services provided during such  
50 outpatient treatment, including all services provided during the first  
51 [~~two~~] three weeks of continuous treatment, not to exceed [~~fourteen~~]  
52 twenty-one visits, of such outpatient treatment. Provided, however, the  
53 corporation shall only deny coverage for any portion of the initial  
54 [~~two~~] three weeks of continuous treatment, not to exceed [~~fourteen~~]  
55 twenty-one visits, for outpatient treatment on the basis that such  
56 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 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) "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.

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

§ 29. Subsection (1-2) of section 4303 of the insurance law, as added by section 3 of part B of chapter 69 of the laws of 2016, is amended to read as follows:

(1-2) ~~[(1)]~~ Every contract that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall include immediate access, without prior authorization, to ~~[a five-day emergency supply]~~ the formulary forms of prescribed medications covered under the contract for the treatment of substance use disorder ~~[where an emergency condition exists]~~, including a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, except where otherwise prohibited by law. Further, coverage ~~[of an emergency supply]~~ without prior authorization shall include formulary forms of medication for opioid overdose reversal otherwise covered under the contract prescribed or dispensed to an individual covered by the contract.

~~[(2) For purposes of this paragraph, an "emergency condition" means a substance use disorder condition that manifests itself by acute symptoms~~



~~of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:~~

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

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

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

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

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

~~(3) Coverage provided under this subsection may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the contract; provided, however, no contract shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This paragraph shall not preclude the imposition of a copayment or coinsurance on the initial limited supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]~~

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

(n) In addition to the requirements of subsection (i) of this section, every health service or medical expense indemnity corporation issuing a group contract pursuant to this section or a group remittance contract for delivery in this state which contract provides reimbursement to subscribers or physicians, psychiatrists or psychologists for psychiatric or psychological services or for the diagnosis and treatment of ~~[mental, nervous or emotional disorders and ailments,]~~ mental health conditions, however defined in such contract, must provide the same

coverage to persons covered under the group contract for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either (i) three or more additional years experience in psychotherapy, which for the purposes of this subsection shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior which are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of ~~[mental, nervous or emotional disorders or ailments,]~~ mental health conditions,

or (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection (i) of this section, or (iii) a combination of the experience specified in paragraphs (i) and (ii) totaling three years, satisfactory to the state board for social work. The state board for social work shall

1 maintain a list of all licensed clinical social workers qualified for  
2 reimbursement under this subsection.

3 § 31. Paragraph 2 of subsection (ee) of section 4303 of the insurance  
4 law, as amended by section 40 of part D of chapter 56 of the laws of  
5 2013, is amended to read as follows:

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

29 § 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of  
30 section 4303 of the insurance law, as amended by chapter 596 of the laws  
31 of 2011, are amended to read as follows:

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

37 (C) "behavioral health treatment" means counseling and treatment  
38 programs, when provided by a licensed provider, and applied behavior  
39 analysis, when provided [~~or supervised~~] by a [~~behavior analyst certified~~  
40 ~~pursuant to the behavior analyst certification board~~] person that is  
41 licensed, certified or otherwise authorized to provide applied behavior  
42 analysis, that are necessary to develop, maintain, or restore, to the  
43 maximum extent practicable, the functioning of an individual. [~~Individ-~~  
44 ~~uals that provide behavioral health treatment under the supervision of a~~  
45 ~~certified behavior analyst pursuant to this subsection shall be subject~~  
46 ~~to standards of professionalism, supervision and relevant experience~~  
47 ~~pursuant to regulations promulgated by the superintendent in consulta-~~  
48 ~~tion with the commissioners of health and education.~~]

49 § 33. Subsection (ee) of section 4303 of the insurance law is amended  
50 by adding four new paragraphs 8, 9, 10, and 11 to read as follows:

51 (8) Coverage under this paragraph shall not apply financial require-  
52 ments or treatment limitations to autism spectrum disorder benefits that  
53 are more restrictive than the predominant financial requirements and  
54 treatment limitations applied to substantially all medical and surgical  
55 benefits covered by the policy.

1 (9) The criteria for medical necessity determinations under the  
2 contract with respect to autism spectrum disorder benefits shall be made  
3 available by the corporation to any insured, prospective insured, or  
4 in-network provider upon request.

5 (10) For purposes of this subsection:

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

8 (B) "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 (C) "treatment limitation" means limits on the frequency of treatment,  
12 number of visits, days of coverage, or other similar limits on the scope  
13 or duration of treatment and includes nonquantitative treatment limita-  
14 tions such as: medical management standards limiting or excluding bene-  
15 fits based on medical necessity, or based on whether the treatment is  
16 experimental or investigational; formulary design for prescription  
17 drugs; network tier design; standards for provider admission to partic-  
18 ipate in a network, including reimbursement rates; methods for determin-  
19 ing usual, customary, and reasonable charges; fail-first or step therapy  
20 protocols; exclusions based on failure to complete a course of treat-  
21 ment; and restrictions based on geographic location, facility type,  
22 provider specialty, and other criteria that limit the scope or duration  
23 of benefits for services provided under the contract.

24 (11) 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 § 34. Paragraphs 17, 20 and 21 of subsection (a) of section 4324 of  
29 the insurance law, paragraph 17 as amended and paragraphs 20 and 21 as  
30 added by section 8 of part H of chapter 60 of the laws of 2014, are  
31 amended and a new paragraph 22 is added to read as follows:

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

46 (20) with respect to out-of-network coverage:

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

49 (B) a description of the amount that the corporation will reimburse  
50 under the methodology for out-of-network health care services set forth  
51 as a percentage of the usual and customary cost for out-of-network  
52 health care services; and

53 (C) examples of anticipated out-of-pocket costs for frequently billed  
54 out-of-network health care services; [~~and~~]

55 (21) information in writing and through an internet website that  
56 reasonably permits a subscriber or prospective subscriber to estimate

1 the anticipated out-of-pocket cost for out-of-network health care  
2 services in a geographical area or zip code based upon the difference  
3 between what the corporation will reimburse for out-of-network health  
4 care services and the usual and customary cost for out-of-network health  
5 care services[~~+~~]; and

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

11 § 35. Subsection (b) of section 4325 of the insurance law, as added by  
12 chapter 705 of the laws of 1996, is amended to read as follows:

13 (b) No corporation organized under this article shall by contract,  
14 written policy [~~ex~~], written procedure or practice prohibit or restrict  
15 any health care provider from filing a complaint, making a report or  
16 commenting to an appropriate governmental body regarding the policies or  
17 practices of such corporation which the provider believes may negatively  
18 impact upon the quality of or access to patient care. Nor shall a corpo-  
19 ration organized under this article take any adverse action, including  
20 but not limited to refusing to renew or execute a contract or agreement  
21 with a health care provider as retaliation against a health care provid-  
22 er for filing a complaint, making a report or commenting to an appropri-  
23 ate governmental body regarding policies or practices of such corpo-  
24 ration which may violate this chapter including subsection (g), (k),  
25 (1), (1-1) or (1-2) of section forty-three hundred three of this arti-  
26 cle.

27 § 36. Subparagraph (C) of paragraph 1 of subsection (b) of section  
28 4900 of the insurance law, as added by chapter 41 of the laws of 2014,  
29 is amended and a new subparagraph (D) is added to read as follows:

30 (C) for purposes of a determination involving substance use disorder  
31 treatment:

32 (i) a physician who possesses a current and valid non-restricted  
33 license to practice medicine and who specializes in behavioral health  
34 and has experience in the delivery of substance use disorder courses of  
35 treatment; or

36 (ii) a health care professional other than a licensed physician who  
37 specializes in behavioral health and has experience in the delivery of  
38 substance use disorder courses of treatment and, where applicable,  
39 possesses a current and valid non-restricted license, certificate or  
40 registration or, where no provision for a license, certificate or regis-  
41 tration exists, is credentialed by the national accrediting body appro-  
42 priate to the profession; [~~and~~] or

43 (D) for purposes of a determination involving treatment for a mental  
44 health condition:

45 (i) a physician who possesses a current and valid non-restricted  
46 license to practice medicine and who specializes in behavioral health  
47 and has experience in the delivery of mental health courses or treat-  
48 ment; or

49 (ii) a health care professional other than a licensed physician who  
50 specializes in behavioral health and has experience in the delivery of  
51 mental health courses of treatment and, where applicable, possesses a  
52 current and valid non-restricted license, certificate, or registration  
53 or, where no provision for a license, certificate or registration  
54 exists, is credentialed by the national accrediting body appropriate to  
55 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 tool that is appropriate to the age of the patient. ~~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~~ When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

§ 38. Subsection (a) of section 4902 of the insurance law is amended by adding a new paragraph 12 to read as follows:

(12) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

§ 39. Paragraph (b) of subsection 5 of section 4403 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) The following criteria shall be considered by the commissioner at the time of a review: (i) the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disability Act to assure access to health care for the enrollee population; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; ~~and~~ (iii) the availability of appropriate and timely care that is in compliance with the standards of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance and regulations issued under those Acts, which shall include an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services; and (iv) with the exception of initial licensure, the number of grievances filed by enrollees relating to waiting times for appointments, appropriateness of referrals and other indicators of plan capacity.

§ 40. Subdivision 3 of section 4406-c of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

3. No health care plan shall by contract, written policy ~~or~~, written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such health



care plan which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall a health care plan take any adverse action, including but not limited to refusing to renew 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 organization's website and the health maintenance organization shall update the website within fifteen days of the addition or termination of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation;

(t) with respect to out-of-network coverage:

(i) a clear description of the methodology used by the health maintenance organization to determine reimbursement for out-of-network health care services;

(ii) the amount that the health maintenance organization 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;

(iii) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; ~~[and]~~

(u) information in writing and through an internet website that reasonably permits an enrollee or prospective enrollee 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 health maintenance organization will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services~~[-]; and~~

(v) the most recent comparative analysis performed by the health maintenance organization to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Dominici 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.

§ 42. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 4900 of the public health law, as added by chapter 41 of the laws of 2014, is amended and a new subparagraph (iv) is added to read as follows:

(iii) for purposes of a determination involving substance use disorder treatment:

(A) 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

(B) 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

(iv) for purposes of a determination involving treatment for a mental health condition:

(A) 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

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of a 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

§ 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

1 law to the contrary, nothing in this act shall limit the rights accruing  
2 to employees pursuant to a collective bargaining agreement with any  
3 state or local government employer for the unexpired term of such agree-  
4 ment where such agreement is in effect on the effective date of this act  
5 and so long as such agreement remains in effect thereafter or the eligi-  
6 bility of any member of an employee organization to join a health insur-  
7 ance plan open to him or her pursuant to such a collectively negotiated  
8 agreement.

9 SUBPART B

10 Section 1. Subdivision 1 of section 2803-u of the public health law,  
11 as added by section 1 of part C of chapter 70 of the laws of 2016, is  
12 amended to read as follows:

13 1. The office of alcoholism and substance abuse services, in consulta-  
14 tion with the department, shall develop or utilize existing educational  
15 materials to be provided to general hospitals to disseminate to individ-  
16 uals with a documented substance use disorder or who appear to have or  
17 be at risk for a substance use disorder during discharge planning pursu-  
18 ant to section twenty-eight hundred three-i of this [~~chapter~~] article.  
19 Such materials shall include information regarding the various types of  
20 treatment and recovery services, including but not limited to: inpa-  
21 tient, outpatient, and medication-assisted treatment; how to recognize  
22 the need for treatment services; information for individuals to deter-  
23 mine what type and level of treatment is most appropriate and what  
24 resources are available to them; and any other information the commis-  
25 sioner deems appropriate. General hospitals shall include in their poli-  
26 cies and procedures treatment protocols, consistent with medical stand-  
27 ards, to be utilized by the emergency departments in general hospitals  
28 for the appropriate use of medication-assisted treatment, including  
29 buprenorphine, prior to discharge, or referral protocols for evaluation  
30 of medication-assisted treatment when initiation in an emergency depart-  
31 ment of a general hospital is not feasible.

32 § 2. This act shall take effect immediately.

33 SUBPART C

34 Section 1. Subparagraph (v) of paragraph (a) of subdivision 2 of  
35 section 3343-a of the public health law is REPEALED and subparagraphs  
36 (vi), (vii), (viii), (ix) and (x) are renumbered subparagraphs (v),  
37 (vi), (vii), (viii) and (ix).

38 § 2. This act shall take effect immediately.

39 SUBPART D

40 Section 1. Paragraph (r) of subdivision 4 of section 364-j of the  
41 social services law, as amended by section 39 of part A of chapter 56 of  
42 the laws of 2013, is amended to read as follows:

43 (r) A managed care provider shall provide services to participants  
44 pursuant to an order of a court of competent jurisdiction, provided  
45 however, that such services shall be within such provider's or plan's  
46 benefit package and are reimbursable under title xix of the federal  
47 social security act, provided that services for a substance use disorder  
48 shall be provided by a program licensed, certified or otherwise author-  
49 ized 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (C) Substitution in or on the piperidine ring with alkyl, alkenyl,  
2 alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino or nitro groups;

3 (D) Replacement of the aniline ring with any aromatic monocycle wheth-  
4 er or not further substituted in or on the aromatic monocycle; and/or

5 (E) Replacement of the N-propionyl group by another acyl group.

6 § 2. Section 3308 of the public health law is amended by adding a new  
7 subdivision 7 to read as follows:

8 7. The commissioner may, by regulation, classify as a Schedule I  
9 controlled substance in section three thousand three hundred six of this  
10 article any substance listed in Schedule I of the federal schedules of  
11 controlled substances in 21 USC §812 or 21 CFR §1308.11.

12 § 3. This act shall take effect on the ninetieth day after it shall  
13 have become a law.

14 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-  
15 sion, section or part of this act shall be adjudged by any court of  
16 competent jurisdiction to be invalid, such judgment shall not affect,  
17 impair, or invalidate the remainder thereof, but shall be confined in  
18 its operation to the clause, sentence, paragraph, subdivision, section  
19 or part thereof directly involved in the controversy in which such judg-  
20 ment shall have been rendered. It has hereby declared to be the intent  
21 of the legislature that this act would have been enacted even if such  
22 invalid provisions had not been included herein.

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

26 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-  
27 sion, section or part of this act shall be adjudged by any court of  
28 competent jurisdiction to be invalid, such judgment shall not affect,  
29 impair, or invalidate the remainder thereof, but shall be confined in  
30 its operation to the clause, sentence, paragraph, subdivision, section  
31 or part thereof directly involved in the controversy in which such judg-  
32 ment shall have been rendered. It is hereby declared to be the intent of  
33 the legislature that this act would have been enacted even if such  
34 invalid provisions had not been included herein.

35 § 3. This act shall take effect immediately provided, however, that  
36 the applicable effective date of Parts A through BB of this act shall be  
37 as specifically set forth in the last section of such Parts.