STATE OF NEW YORK

1507--B

IN SENATE

January 18, 2019

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

AN ACT to amend the social services law, in relation to reimbursement of transportation costs, reimbursement of emergency transportation services and supplemental transportation payments (Part A); to amend the public health law, in relation to extending and enhancing the Medicaid drug cap and to reduce unnecessary pharmacy benefit manager costs to the Medicaid program (Part B); to amend the social services law, in relation to the extension of the National Diabetes Prevention Program and the inclusion in standard coverage of medically tailored meals and medical nutrition therapy for certain persons and applied behavioral analysis treatment for those with autism spectrum disorder (Part C); to amend chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to extending the medicaid global cap (Part D); to amend chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to extending the provisions thereof; to amend chapter 56 of the laws of 2013, amending the social services law relating to eligibility conditions, in relation to extending the provisions thereof; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending the public health law relat-

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

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ing 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 public health law and the social services law, in relation to the payment of rates to

managed care plans and the service providers of such plans for long term care services; and requires the commissioner of health to convene a workgroup on case mix adjustments for residential health care facilities (Part G); to amend the public health law, in relation to waiver of certain regulations; and to repeal certain provisions of such law relating thereto (Part H); to amend the insurance law and the public health 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 intentionally omitted (Subpart F) (Part J); 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 insurance coverage of in vitro fertilization and other fertility preservation treatments (Part L); intentionally omitted (Part M); intentionally omitted (Part N); intentionally omitted (Part O); to amend the public health law and the executive law, in relation to elevated blood lead levels and testing for lead (Part P); to amend the public health law, in relation to the healthcare facility transformation program state III mandating certain awards and 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); intentionally omitted (Part S); to amend the public health law, in relation to codifying the creation of NY State of Health, the official Health Plan Marketplace within the department of health (Part T); to amend the elder law, in relation to the private pay program (Part U); intentionally omitted (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); intentionally omitted (Part AA); to amend the insurance law, in relation to mental health and substance use disorder health insurance parity; to amend the public health law, in relation to health maintenance organizations; and to repeal certain provisions of the insurance law relating thereto (Subpart A); to amend the public health law, in relation to general hospital policies for substance use disorder treatment (Subpart B); 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); amend the public health law, in relation to prescriber assistance in allowing unlicensed certified pharmacy technicians to assist in dispensing of drugs (Part CC); intentionally omitted (Part DD); to amend the social services law, in relation to denial of a claim based on lack of prior authorization (Part EE); to amend the social services law, in relation to establishing the home care asthma management program (Part FF); directing the department of health to submit a Medicaid state plan amendment to the centers for Medicare and Medicaid service to request authorization to establish and administer a methodology to provide supplemental reimbursement to certain eligible ground emergency medical transportation providers (Part GG); in relation to establishing the primary and preventive reproductive health care program; and making an appropriation therefor (Part HH); to amend the public health law, in relation to funding early intervention services; and to repeal certain provisions of the public health law and the insurance law relating thereto (Part II); to amend the public health law, in relation to expanding health department review of correctional health services (Part JJ); to amend the elder law, in relation to grants awarded for classic NORC programs (Part KK); to amend the mental hygiene law, in relation to establishing a credentialing pilot program for direct support professionals (Part LL); to amend the executive law, in relation to establishing the office of the advocate for people with disabilities (Part MM); and to amend the elder law, in relation to the program for elderly pharmaceutical insurance coverage (Part NN)

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

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2019-2020 state fiscal year. Each component is wholly contained within a Part identified as Parts A through NN. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, 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 Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to

transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for [~~enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law~~]: adult day health care programs located at a licensed residential health care facility as defined by section twenty-eight hundred one of the public health law or any approved extension site thereof; participants of a program designated as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by Federal Public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997; and enrollees of a managed long term care plan issued a certificate of authority under section forty-four hundred three-f of the public health law that elects to provide or arrange for transportation services directly. The commissioner shall offer managed long term care plans other than programs of all-inclusive care for the elderly, and adult day health care programs the option to arrange transportation directly or utilize a transportation manager or managers selected by the commissioner. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. This act shall take effect immediately.

PART B

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

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

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

(c) for state fiscal year two thousand nineteen--two thousand twenty, be limited to the ten-year rolling average of the medical component of

the consumer price index plus four percent and minus a pharmacy savings target of eighty-five million dollars[~~.~~]**; and**

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

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

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

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

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

~~further supplemental rebate for the duration of the previous rebate agreement.~~

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

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

§ 6-a. Subdivision 4 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:

4. In determining whether to recommend a target supplemental rebate for a drug, the drug utilization review board shall consider the actual cost of the drug to the Medicaid program, including federal and state rebates, and may consider, among other things:

(a) the drug's impact on the Medicaid drug spending growth target and the adequacy of capitation rates of participating Medicaid managed care plans, and the drug's affordability and value to the Medicaid program; or

(b) significant and unjustified increases in the price of the drug; or

(c) whether the drug may be priced disproportionately to its therapeutic benefits**, however, the drug utilization review board may not rely on assessments that utilize a measure that discounts the value of a life because of an individual's disability or age when recommending a target supplemental value**.

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

5. (a) If the drug utilization review board recommends a target rebate amount on a drug referred by the commissioner, the commissioner shall require a supplemental rebate to be paid by the drug's manufacturer in an amount not to exceed such target rebate amount. With respect to a rebate required in state fiscal year two thousand seventeen--two thousand eighteen, the rebate requirement shall apply beginning with the month of April, two thousand seventeen, without regard to the date the department enters into the rebate agreement with the manufacturer.

(b) The supplemental rebate required by paragraph (a) of this subdivision shall apply to drugs dispensed to enrollees of managed care providers pursuant to section three hundred sixty-four-j of the social services law and to drugs dispensed to Medicaid recipients who are not enrollees of such providers.

(c) If the drug utilization review board recommends a target rebate amount for a drug and the department is unable to negotiate a rebate from the manufacturer in an amount that is at least seventy-five percent of the target rebate amount, the commissioner is authorized to waive the provisions of paragraph (b) of subdivision three of section two hundred seventy-three of this article and the provisions of subdivisions twenty-five and twenty-five-a of section three hundred sixty-four-j of the social services law with respect to such drug; however, this waiver shall not be implemented in situations where it would prevent access by a Medicaid recipient to a drug which is the only treatment for a particular disease or condition. Under no circumstances shall the commissioner

be authorized to waive such provisions with respect to more than two drugs in a given time.

(d) Where the department and a manufacturer enter into a rebate agreement pursuant to this section, which may be in addition to existing rebate agreements entered into by the manufacturer with respect to the same drug, no additional rebates shall be required to be paid by the manufacturer to a managed care provider or any of a managed care provider's agents, including but not limited to any pharmacy benefit manager, while the department is collecting the rebate pursuant to this section.

(e) In formulating a recommendation concerning a target rebate amount for a drug, the drug utilization review board may consider:

(i) publicly available information relevant to the pricing of the drug;

(ii) information supplied by the department relevant to the pricing of the drug **so long as any third party supplying information to the department or the board does not receive funding from the pharmaceutical industry or health insurance industry and did not receive such information from a third party that receives funding from the pharmaceutical industry or health insurance industry**;

(iii) information relating to value-based pricing **however if the department or the board rely upon any third party to provide cost-effectiveness analysis or research related to value-based pricing, such analysis or research must: (A) be made available to the public, including any underlying methodologies and models; (B) disclose any assumptions or limitations of research findings in the context of the analysis or research; and (C) present results in a way that reflects any different outcomes for affected subpopulations**;

(iv) the seriousness and prevalence of the disease or condition that is treated by the drug;

(v) the extent of utilization of the drug;

(vi) the effectiveness of the drug in treating the conditions for which it is prescribed, or in improving a patient's health, quality of life, or overall health outcomes;

(vii) the likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(viii) the average wholesale price, wholesale acquisition cost, retail price of the drug, and the cost of the drug to the Medicaid program minus rebates received by the state;

(ix) in the case of generic drugs, the number of pharmaceutical manufacturers that produce the drug;

(x) whether there are pharmaceutical equivalents to the drug; and

(xi) information supplied by the manufacturer, if any, explaining the relationship between the pricing of the drug and the cost of development of the drug and/or the therapeutic benefit of the drug, or that is otherwise pertinent to the manufacturer's pricing decision; any such information provided shall be considered confidential and shall not be disclosed by the drug utilization review board in a form that identifies a specific manufacturer or prices charged for drugs by such manufacturer.

§ 7. Intentionally omitted.

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

(a) If, after taking into account all rebates and supplemental rebates received by the department, including rebates received to date pursuant to this section, total Medicaid drug expenditures are still projected to

exceed the annual growth limitation imposed by subdivision two of this section, the commissioner may: subject any drug of a manufacturer referred to the drug utilization review board under this section to prior approval in accordance with existing processes and procedures when such manufacturer has not entered into a supplemental rebate agreement as required by this section; [~~directing~~] direct managed care plans to remove from their Medicaid formularies those drugs that the drug utilization review board recommends a target rebate amount for and the manufacturer has failed to enter into a rebate agreement required by this section; [~~promoting~~] promote the use of cost effective and clinically appropriate drugs other than those of a manufacturer who has a drug that the drug utilization review board recommends a target rebate amount and the manufacturer has failed to enter into a rebate agreement required by this section; [~~allowing~~] allow manufacturers to accelerate rebate payments under existing rebate contracts; and such other actions as authorized by law. The commissioner shall provide written notice to the legislature thirty days prior to taking action pursuant to this paragraph, unless action is necessary in the fourth quarter of a fiscal year to prevent total Medicaid drug expenditures from exceeding the limitation imposed by subdivision two of this section, in which case such notice to the legislature may be less than thirty days.

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

8. The commissioner shall report by [~~February~~] July first annually to the drug utilization review board on savings achieved through the drug 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, contract renewal, 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 subsequent to the effective date of this subdivision 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) Upon entrance into a new contract, arrangement, or amendment of an existing pharmacy benefit manager contract, each health care plan shall report on a quarterly basis to the department any net savings to the health care plan which accrue based on the provisions of this subdivision. The department shall not adjust premiums to health care plans until after such plans submit reports to the department pursuant to this paragraph and the department shall not make any such premium adjustments unless such changes are deemed appropriate by its actuary. Any such premium adjustments shall be based on the reported net savings by health care plans resulting from the pharmacy benefit manager contract amendments made in compliance with this subdivision.

(c) Health care plans shall notify the department of the effective date of contracts, contract renewals or other arrangements related to services subject to the provisions of paragraph (a) of this subdivision at least fifteen days prior to entering into such contract, contract renewal or other arrangement. The department shall not adjust premiums to health care plans until such plans notify the department pursuant to this paragraph.

(d) The commissioner may promulgate regulations as necessary to implement the requirements of this subdivision, provided, however, that any such regulations shall apply to contracts, contract renewals, or other arrangements entered into subsequent to the effective date of such regulation.

§ 11. 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.

PART C

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

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

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

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

(gg) medically tailored meals and medical nutrition therapy. As used in this paragraph, "medically tailored meals and medical nutrition therapy" means nutritional assessment, nutritional therapy, and nutritional counseling provided by a certified dietician nutritionist, including the provision of any food indicated by the nutritional assessment and the delivery of such food, ordered by a health care professional acting within his or her lawful scope of practice under title eight of the education law, for the purpose of treating one or more chronic conditions for an individual who is limited in his or her daily activities of daily living; and provided that there is federal financial participation in the costs of services provided under this paragraph.

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

(hh) applied behavior analysis, as defined in section eighty-eight hundred one of the education law, where such service is provided by a licensed behavior analyst or certified behavior analyst assistant, licensed or certified under article one hundred sixty-seven of the education law, for the treatment of autism spectrum disorder.

§ 6. 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,~~] **2020-21** the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, **and the chairs of the senate finance and assembly ways and means committees,** 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~~] **and the chairs of the senate finance and assembly ways and means committees determine** 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. Subdivision 3 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, is amended by adding a new paragraph (e) to read as follows:

(e) The Medicaid savings allocation plan shall be submitted to the legislature for their consideration and approval prior to implementation of this plan.

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

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-six 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~~] 2021.

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

§ 11. This act shall take effect immediately and:

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

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

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

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

§ 3. This act shall take effect immediately, provided, however, that subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of 1973, as added by section one of this act, shall expire and be deemed repealed June 30, [~~2019~~] 2021; and provided further, however, that the expiration and repeal of such subdivision 15-a shall not affect or impair in any manner any health facilities bonds issued, or any lease or purchase of a health facility executed, pursuant to such subdivision 15-a prior to its expiration and repeal and that, with respect to any such bonds issued and outstanding as of June 30, [~~2019~~] 2021, the provisions of such subdivision 15-a as they existed immediately prior to such expiration and repeal shall continue to apply through the latest maturity date of any such bonds, or their earlier retirement or redemption, for the sole purpose of authorizing the issuance of refunding bonds to refund bonds previously issued pursuant thereto.

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

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

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

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

(f) section twenty-five of this act shall expire and be deemed repealed April 1, [~~2019~~] 2021;

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

(c) section fifty of this act shall take effect immediately and shall expire [~~six~~] eight 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~~] 2021;

§ 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-one such assessment shall be six percent**.

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

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

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

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

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, 2021**;

§ 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 amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019**, and on and after April 1, 2019 through March 31, 2021**.

§ 14. Section 4-a of part A of 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, as amended by section 5 of part T of chapter 57 of the laws of 2018, is amended to read as follows:

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

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

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

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal years beginning April first, two thousand ten and ending March thirty-first, two thousand [~~nineteen~~] twenty-one, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand [~~nineteen~~] twenty-one, based on consideration of rate appeals filed by residential health care facilities 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-one. 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-one, 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 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019**, and on and after April 1, 2019 through March 31, 2021**;

§ 18. Section 48-a of part A of 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, as amended by section 1 of part P of chapter 57 of the laws of 2017, is amended to read as follows:

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

of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~29~~] 1 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~] 2017 through March 31, [~~2020~~] 2021 for patients in the city of New York, for all rate periods on and after the effective date of section [~~29~~] 1 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~] 2017 through [~~March 31, 2020~~] March 31, 2021 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through [~~March 31, 2020~~] March 31, 2021, for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating 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 commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory 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 this chapter.

2. 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 or any such other fees established pursuant to the Medicaid state plan. 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~~] March 31, 2021, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title [~~one-A~~] 1-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

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

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [~~30~~] 2 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~] 2017 through March 31, [~~2020~~] 2021 for patients in the city of New York, for all rate periods on and after the effective date of section [~~30~~] 2 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~] 2017 through March 31, [~~2020~~] 2021 for patients outside the city of New York, and for all rate periods on and after the effective date of section [~~30~~] 2 of part [~~B~~] P of chapter [~~59~~] 57 of the laws of [~~2016~~] 2017 through March 31, [~~2020~~] 2021 for all services provided to persons

under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations 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~~] **2021**, 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, 2021**.

§ 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~~] **2021** provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

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

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019**, and for the state fiscal year beginning April 1, 2019 through March 31, 2021**, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpa-

tient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

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

PART F

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

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section,

purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [~~and~~] between July 1, 2018 and June 30, 2019**, and between July 1, 2019 and June 30, 2020** or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [~~and~~] between July 1, 2018 and June 30, 2019**, and between July 1, 2019 and June 30, 2020** for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an

individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

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

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and

between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [~~and~~] between July 1, 2018 and June 30, 2019**, and between July 1, 2019 and June 30, 2020** allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

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

July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, [~~and between~~] **to the period** July 1, 2016 and June 30, 2017, [~~and~~] to the period July 1, 2017 to June 30, 2018, [~~and~~] to the period July 1, 2018 to June 30, 2019**, and to the period July 1, 2019 to June 30, 2020**.

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

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, [~~and~~] during the period July 1, 2018 to June 30, 2019**, and during the period July 1, 2019 to June 30, 2020** allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering

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

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

superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019**, or covering the period July 1, 2019 to June 30, 2020** that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1,

2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019**, and to the period July 1, 2019 to June 30, 2020** received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019**, and covering the period July 1, 2019 to June 30, 2020** for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

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

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [~~2019;~~] **2020;** provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [~~2019,~~] **2020,** at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this

section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [~~2019~~] **2020** policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of 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, as amended by section 5 of part M of chapter 57 of the laws of 2018, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, [~~and~~] June 15, 2019**, and June 15, 2020** the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1,

2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019**, or July 1, 2019 to June 30, 2020** as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019**, or July 1, 2019 to June 30, 2020** as applicable.

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

§ 6. Section 20 of 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 thereto, as amended by section 6 of part M of chapter 57 of the laws of 2018, is amended to read as follows:

§ 20. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand [~~eighteen,~~] **nineteen,** shall be eligible to apply for such

coverage for the coverage period beginning the first of July, two thousand [~~eighteen;~~] **nineteen;** provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand [~~eighteen~~] **nineteen** exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [~~eighteen,~~] **nineteen,** then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [~~eighteen,~~] **nineteen,** as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [~~eighteen~~] **nineteen** and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [~~eighteen~~] **nineteen**.

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

PART G

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 5-a. Subdivision 8 of section 4403-f of the public health law, as amended by section 21 of part B of chapter 59 of the laws of 2016, is amended to read as follows:

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care shall comply with all applicable laws and regulations, state and federal, including regulations as to actuarial soundness for medicaid managed care. **Prior to each annual rate period and, to the extent practicable prior to the effective date of any change in law, regulation or other state or federal mandate impacting the cost of the managed care plans' operations or of the providers**

services, the commissioner shall provide an accounting of the component cost (including wage and related labor compliance) and total costs factored into the managed long term care plan rates, along with the commissioner's and the independent actuary's determination of the actuarial soundness and adequacy of such rates. Such accounting shall be provided to managed long term care plans at least sixty days prior to the start of the rate period and, for any changes during the rate period, at least sixty days prior to the effectiveness of such change, as practicable. The determinations of actuarial soundness and adequacy of the rates shall be further available to the plans' contracting providers. The commissioner shall provide for a streamlined and timely process to pay adjusted rates to managed care plans, and the plans' service providers, including increases for worker wages and related labor compliance; provided, however, that to the extent not expressly precluded by law, any new state requirement upon such plan or the plans' service providers which imposes new costs shall be implemented only on or after the determination made in this section that such rates comply with actuarial soundness and adequacy.

§ 5-b. The public health law is amended by adding a new section 3614-f to read as follows:

§ 3614-f. Payments for home and community based long term care services. The payment of claims submitted under contracts or agreements with insurers under the medical assistance program for home and community based long term care services provided under this article or by fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law shall provide that any funds appropriated to compensate for minimum wage pursuant to section six hundred fifty-two of the labor law shall be provided by insurers in amendments to existing contracts with home and community based long term care services providers under this article and to fiscal intermediaries operating pursuant to section three hundred sixty-five-f of the social services law at least ninety days prior to the effective date of any such law or regulation impacting wages. Insurers shall provide such funds in an amount that supplements any current contracts or agreements and shall not use such funds to supplant payments for existing services under the Medicaid program. Such insurers shall include but not be limited to Medicaid managed care plans and Medicaid managed long term care plans.

§ 5-c. Paragraph (b) of subdivision 10 of section 3614 of the public health law, as amended by section 5 of part C of chapter 109 of the laws of 2006, is amended and a new paragraph (e) is added to read as follows:

(b) Programs which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purposes of recruitment, training and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility. Such purpose shall include the recruitment, training and retention of non-supervisory home care services workers or any worker with direct patient care responsibility employed in licensed home care services agencies under contract with such agencies. Such agencies are prohibited from using such fund for any other purpose. For purposes of the long term home health care program, such payment shall be treated as supplemental payments and not effect any current cost cap requirement. For purposes of the managed long term care program, plans shall distribute such funds in their entirety using a reasonable methodology. Such payments shall be supplemental to reimbursement rates, and plans shall provide written notification to each contracted agency indicating the amount of funds disbursed

for the purpose of recruitment, training and retention of non-supervisory home care services workers or any personnel with direct patient care responsibility. Each such agency shall submit, at a time and in a manner determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment, training and retention of non-supervisory home health aides or any personnel with direct patient care responsibility. **When submitting attestations to the department, managed long term care plans shall include the methodology utilized in the disbursement of funds.** The commissioner is authorized to audit each such agency or program to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home health aides or other personnel with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(e) The department shall provide a report to the chairs of the senate finance committee, assembly ways and means committee, and senate health and assembly health committees. Such report shall be submitted on or before January first, two thousand twenty and shall include the distribution of monies by plan and provider of the funds set forth in this subdivision.

§ 5-d. Subdivision 12 of section 366-a of the social services law, as added by section 36-c of part B of chapter 57 of the laws of 2015, is amended to read as follows:

12. The commissioner shall develop expedited procedures for determining medical assistance eligibility for any medical assistance applicant with an immediate need for personal care or consumer directed personal assistance services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or section three hundred sixty-five-f of this title, respectively**, and hospice**. Such procedures shall require that a final eligibility determination be made within seven days of the date of a complete medical assistance application.

§ 5-e. Subdivision 31 of section 364-j of the social services law, as added by section 36-b of part B of chapter 57 of the laws of 2015, is amended to read as follows:

31. (a) The commissioner shall require managed care providers under this section, managed long-term care plans under section forty-four hundred three-f the public health law and other appropriate long-term service programs to adopt expedited procedures for approving personal care services for a medical assistance recipient who requires immediate personal care or consumer directed personal assistance services pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of this title or section three hundred sixty-five-f of this title, respectively, or other long-term care, **which shall include hospice,** and provide such care or services as appropriate, pending approval by such provider or program.

§ 5-f. Subparagraph (ii) of paragraph (k) of subdivision 3 of section 461-l of the social services law, as added by section 2 of part B of chapter 57 of the laws of 2018, is amended to read as follows:

(ii) Existing assisted living program providers licensed on or before April first, two thousand eighteen may submit applications under this paragraph beginning no later than June thirtieth, two thousand eighteen and until a deadline to be determined by the department of health. Existing assisted living program providers licensed on or before April first, two thousand [~~twenty~~] **nineteen** may submit such applications

beginning no later than June thirtieth, two thousand [~~twenty~~] nineteen and until a deadline to be determined by the department of health.

§ 5-g. Paragraph (m) of subdivision 3 of section 461-l of the social services law, as added by section 2 of part B of chapter 57 of the laws of 2018, is amended to read as follows:

(m) Beginning April first, two thousand [~~twenty-three,~~] twenty, additional assisted living program beds shall be approved on a case by case basis whenever the commissioner of health is satisfied that public need exists at the time and place and under circumstances proposed by the applicant.

§ 5-h. Workgroup on case mix adjustments for residential health care facilities. The commissioner of health shall convene and chair a workgroup on case mix adjustments to Medicaid rates of payment for residential health care facilities. The workgroup shall be comprised of residential health care facilities or representatives from such facilities, representatives from the statewide associations and other such experts on case mix as required by the commissioner. The workgroup shall review recent case mix data and related analyses conducted by the department, the department's Minimum Data Set (MDS) census collection process and case mix adjustments authorized under subdivision 2-c of section twenty-eight hundred eight of the public health law. Such review shall seek to promote a higher degree of accuracy in the MDS data, reduce audit findings and target abuses. The workgroup shall offer recommendations on how to improve accuracy in the MDS census collection process, reduce audit findings and reduce or eliminate abusive practices. In developing its recommendations, the workgroup shall ensure that the census collection process and case mix adjustment continues to recognize the need to adjust rates for residential health care facilities that serve high-need residents. The workgroup shall also consider any changes in federal law and regulations relating to nursing home reimbursement, including adoption of the patient driven payment model, and administrative complexity in revising the census collection and rate promulgation processes. The commissioner and department of health shall be prohibited from reducing or recouping case mix adjustments for periods prior to the implementation of the workgroup recommendations; provided, such limitation shall not apply to audits by the Office of the Medicaid Inspector General, audits conducted by the department of health, or in cases of fraud or abuse. The workgroup shall report its recommendations no later than July first, two thousand nineteen. Such recommendations shall be adopted by the commissioner on a prospective basis and rely on assessment data submitted no earlier than such adoption; however, any rate adjustments based on the recommendations of the workgroup shall be implemented only after such adjustments are approved by an independent actuary, and in no event shall such adjustments result in a reduction in rates of over $122 million in state-share funds.

§ 5-i. Subdivision 31 of section 364-j of the social services law is amended by adding a new paragraph (b) to read as follows:

(b) Prior to any managed long-term care payment reduction related to personal care services, the commissioner shall promulgate regulations allowing utilization management of personal care services in accordance with a recipient's plan of treatment that will realize corresponding cost reductions in personal care services. The regulations shall not be adopted, nor shall a related payment reduction occur, until it is determined by an independent actuary that the regulations will achieve cost reductions equal to the managed long-term care payment reduction.

§ 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that the amendments to subdivision 8 of section 4403-f of the public health law made by section five-a of this act shall not affect the repeal of such subdivision and shall be deemed to be repealed therewith; and provided further, however, that the amendments to subdivision 31 of section 364-j of the social services law made by sections five-e and five-i of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

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. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

§ 6. Intentionally omitted.

§ 7. This act shall take effect immediately.

PART I

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

ARTICLE 29

PHARMACY BENEFIT MANAGERS

Section 2901. Definitions.
2902. Acting without a registration.
2903. Registration requirements for pharmacy benefit managers.
2904. Reporting requirements for pharmacy benefit managers.
2905. Acting without a license.
2906. Licensing of a pharmacy benefit manager.
2907. Revocation or suspension of a registration or license of a pharmacy benefit manager.
2908. Penalties for violations.
2909. Stay or suspension of superintendent's determination.
2910. Revoked registrations or licenses.
2911. Change of address.
2912. Applicability of other laws.
2913. Assessments.
2914. Duty, accountability and transparency.

§ 2901. Definitions. For purposes of this article:

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

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

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

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

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

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

§ 2902. Acting without a registration. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefits manager prior to January first, two thousand twenty without having a valid registration as a pharmacy benefit manager filed with the superintendent in accordance with this article and any regulations promulgated thereunder.

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

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

§ 2903. Registration requirements for pharmacy benefit managers. (a) Every pharmacy benefit manager that performs pharmacy benefit management services prior to January first, two thousand twenty-one shall register with the superintendent in a manner acceptable to the superintendent, and shall pay a fee of two thousand dollars for each year or fraction of

a year in which the registration shall be valid. The superintendent, in consultation with the commissioner of health, may establish, by regulation, minimum registration standards required for a pharmacy benefit manager. The superintendent can reject a registration application filed by a pharmacy benefit manager that fails to comply with the minimum registration standards.

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

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

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

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

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

(2) The superintendent also may address to any pharmacy benefit manager or its officers any inquiry in relation to its provision of pharmacy benefit management services or any matter connected therewith. Every pharmacy benefit manager or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of the pharmacy benefit manager, as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

(b) In the event any pharmacy benefit manager or person does not submit the report required by paragraph one of subsection (a) of this section or does not provide a good faith response to an inquiry from the superintendent pursuant to paragraph two of subsection (a) of this section within a time period specified by the superintendent of not less than fifteen business days, the superintendent is authorized to levy a civil penalty, after notice and hearing, against such pharmacy benefit manager or person not to exceed one thousand dollars per day for each

day beyond the date the report is due or the date specified by the superintendent for response to the inquiry.

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

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

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

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

§ 2906. Licensing of a pharmacy benefit manager. (a) The superintendent may issue a pharmacy benefit manager's license to any person, firm, association or corporation who or that has complied with the requirements of this article, including regulations promulgated by the superintendent. The superintendent, in consultation with the commissioner of health, may establish, by regulation, minimum standards for the issuance of a license to a pharmacy benefit manager.

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

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

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

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

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

(5) protection of consumers.

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

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

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

(d)(1) Before a pharmacy benefit manager's license shall be issued or renewed, the prospective licensee shall properly file in the office of

the superintendent a written application therefor in such form or forms and supplements thereto as the superintendent prescribes, and pay a fee of two thousand dollars for each year or fraction of a year in which a 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 two 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, section two hundred eighty-a of the public health law, 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;

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

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

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

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

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

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

(7) been convicted of a felony;

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

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

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

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

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

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

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

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

(2) If any such registration or license held by a firm, association or corporation be revoked, no member of such firm or association and no officer or director of such corporation or any controlling person of the registrant or licensee shall be entitled to obtain any registration or

license, or to be named as a sub-licensee in any such license, under this article for the same period of time, unless the superintendent determines, after notice and hearing, that such member, officer or director was not personally at fault in the matter on account of which such registration or license was revoked.

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

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

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

(i) Within thirty days of the initial pretrial hearing date, a registrant or licensee subject to this article shall report to the superintendent any criminal prosecution of the registrant or licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

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

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

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

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

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

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

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

(1) if the superintendent determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other registrants or licensees, or the registrant or licensee proposing employment or appointment of such person; or

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

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

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

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

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

§ 2914. Duty, accountability and transparency. (a) The pharmacy benefit manager shall have a fiduciary relationship with and obligation to the health insurer and shall perform pharmacy benefit management services with care, skill, prudence, diligence, and professionalism.

(b) All funds received by the pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust for the health plan and shall be used or distributed only pursuant to the pharmacy benefit manager's contract, or other terms in the absence of a contract, with the health insurer or applicable law; except for any administrative fee or payment expressly provided for in the contract, or other terms in the absence of a contract, between the pharmacy benefit manager and the health insurer or provider to compensate the pharmacy benefit manager for its services.

(c) The pharmacy benefit manager shall periodically account to the health insurer for all funds received by the pharmacy benefit manager. The health plan or provider shall have access to all financial and utilization information of the pharmacy benefit manager in relation to pharmacy benefit management provided to the health plan or provider.

(d) The pharmacy benefit manager shall disclose in writing to the health insurer the terms and conditions of any contract or arrangement between the pharmacy benefit manager and any party relating to pharmacy benefit management services provided to the health insurer.

(e) The pharmacy benefit manager shall disclose in writing to the health insurer any activity, policy, practice, contract or arrangement of the pharmacy benefit manager that directly or indirectly presents any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the health insurer.

(f) Any information required to be disclosed by a pharmacy benefit manager to a health insurer under this section that is reasonable designated by the pharmacy benefit manager as proprietary or trade secret information shall be kept confidential by the health insurer, except as required or permitted by law, including disclosure necessary to prosecute or defend any legitimate legal claim or cause of action.

(g) The superintendent shall establish, by regulation, minimum standards for pharmacy benefit management services which shall address the elimination of conflicts of interest between pharmacy benefit managers and health insurers; and the elimination of deceptive practices, anti-competitive practices, and unfair claims practices.

§ 2. Section 280-a of the public health law is amended by adding a new subdivision 5 to read as follows:

5. A pharmacy benefit manager may not substitute or cause the substituting of one prescription drug for another in dispensing a prescription or alter or cause the altering of the term of a prescription, except with approval of the prescriber or as explicitly required or permitted by law.

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

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two,

section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two thousand one hundred two, two thousand one hundred seventeen, two thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, **two thousand nine hundred two, two thousand nine hundred five,** three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four thousand two hundred twenty-four, four thousand two hundred twenty-five, four thousand two hundred twenty-six, seven thousand eight hundred nine, seven thousand eight hundred ten, seven thousand eight hundred eleven, seven thousand eight hundred thirteen, seven thousand eight hundred fourteen and seven thousand eight hundred fifteen of this chapter; or section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one hundred five of the penal law.

§ 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.

PART J

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

SUBPART A

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

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

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

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

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

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

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

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

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

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

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

~~percent of such eligible employees or, if less, fifty or more~~] shall not require a minimum number or minimum percentage of such employees be insured when [~~such~~] the policy is providing coverage for group hospital, medical, major medical or similar comprehensive types of expense reimbursed insurance and, for all other types of group accident and health insurance, [~~must~~] the policy shall insure a minimum of fifty percent or five of such eligible employees, whichever is fewer.

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

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

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

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

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

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

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

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

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

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

(h) (1) On or after December thirty-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 December thirty-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 after such insurance shall have terminated, an individual conversion policy that contains the **essential health** benefits **package** described in paragraph [~~one~~] **three** of subsection [~~(b)~~] **(f)** of section [~~four thousand three hundred twenty-eight of this chapter. The insurer shall offer one policy at each level of coverage as defined in section 1302(d) of the affordable care act, 42 U.S.C. § 18022(d).~~] **three thousand two hundred**

seventeen-i of this article. The insurer shall offer one policy at each level of coverage as defined in subsection (c) of section three thousand two hundred seventeen-i of this article. The individual may choose any such policy offered by the insurer. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by an insurer for the insurer to satisfy the requirements of this subparagraph through the offering of policies that comply with this subparagraph by another insurer, corporation or health maintenance organization within the insurer's holding company system, as defined in article fifteen of this chapter. The conversion privilege afforded herein shall also be available upon the divorce or annulment of the marriage of the policyholder to the former spouse of such policyholder.

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

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

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

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

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

contain modified protein, or are amino acid based [~~which~~] that are medically necessary[~~, and such coverage for such modified solid food products for any calendar year or for any continuous period of twelve months for any insured individual shall not exceed two thousand five hundred dollars~~].

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

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

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

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

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

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

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

(10) pediatric services, including oral and vision care. If a stand-alone dental benefit plan offered through the health benefit exchange or outside of the health benefit exchange in the individual or small group market has certified to the State that the plan includes dental benefits meeting the requirements of the benchmark plan, a health plan shall not fail to meet the requirements of this section solely because the health plan does not include pediatric dental benefits otherwise offered through the stand-alone dental plan.

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

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

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

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

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

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

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

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

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

(e) The superintendent may require the use of model language describing the coverage requirements for medical, major medical or similar comprehensive type coverage insurance policy forms that are subject to the superintendent's approval pursuant to section three thousand two hundred one of this article.

(f) For purposes of this section:

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

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

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

(A) provides for essential health benefits;

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

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

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

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

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

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

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

§ 12. Subsection (h) 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:

(h) Every small group policy or association group policy delivered or issued for delivery in this state that provides coverage for hospital, medical or surgical expense insurance and is not a grandfathered health plan shall provide coverage for the essential health [~~benefit~~] 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)~~] three thousand two hundred seventeen-i of this article;

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

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

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

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

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

§ 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 elective ly. 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. Intentionally omitted.

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

(19) Every group or blanket accident and health insurance policy delivered or issued for delivery in this state [~~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**.

§ 17. Intentionally omitted.

§ 18. Intentionally omitted.

§ 19. Intentionally omitted.

§ 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 regu-~~

~~lations promulgated thereunder~~] the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(6); and

§ 23. Intentionally omitted.

§ 24. Intentionally omitted.

§ 25. Intentionally omitted.

§ 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. Intentionally omitted.

§ 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 (l) 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:

(l) [~~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. If a stand-alone dental benefit plan offered through the health benefit exchange or outside of the health benefit exchange in the individual or small group market has certified to the State that the plan includes dental benefits

meeting the requirements of the benchmark plan, a health plan shall not fail to meet the requirements of this section solely because the health plan does not include pediatric dental benefits otherwise offered through the stand-alone dental plan.

(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:

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

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

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

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

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

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

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

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

(f) For purposes of this section:

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

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

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

(A) provides for essential health benefits;
(B) limits cost-sharing for such coverage in accordance with subsection (d) of this section; and
(C) provides one of the levels of coverage described in subsection (c) of this section;
(4) "grandfathered health plan" means coverage provided by 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);
(5) "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and
(6) "student accident and health insurance" shall have the meaning set forth in subsection (a) of section three thousand two hundred forty of this chapter.

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

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

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

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

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

~~health benefit package as required in section 2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)~~]. The superintendent shall standardize the benefit package and cost sharing requirements of qualified group health insurance contracts consistent with coverage offered through the health benefit exchange established [~~pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031~~] by this state.

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

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

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

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

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

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

(3) Within the health benefit exchange established [~~pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031~~] by this state, a health maintenance organization may offer an individual enrollee direct payment contract that is a catastrophic health plan as defined in section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e), or any regulations promulgated thereunder.

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

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

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

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

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

SUBPART C

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

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

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

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

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

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

(ii) 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 policy issued to the religious employer. The rider shall clearly and conspicuously specify that the religious employer does not administer medically necessary abortion benefits, but that the insurer is issuing a rider for coverage of medically necessary abortions, and shall provide the insurer's contact information for questions; and

(iii) provides notice of the issuance of the policy and rider to the 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 forty-nine of this chapter and article forty-nine of the public health law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

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

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

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

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

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

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

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

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

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

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

(C) An external appeal agent shall make a determination on the external appeal and notify the insurer, 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 insurer, 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 or 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 insurer 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 insurer's denial of a standard exception request under paragraph two of this subsection, then the insurer shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills. If an external appeal agent overturns the insurer's denial of an expedited exception request under paragraph three of this subsection, then the insurer shall provide coverage of the non-formulary prescription drug for the duration of the exigent circumstances.

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

§ 4329. Prescription drug coverage. (a) Every corporation subject to the provisions of this article that issues a contract 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 contract issued by a corporation subject to the provisions of this article that provides coverage for prescription drugs shall include in the contract 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, a corporation shall follow the process and procedures specified in article forty-nine of this chapter and article forty-nine of the public health law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

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

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

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

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

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

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

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

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

(5) (A) If a corporation denies a request for an exception under paragraph two or three of this subsection, the insured, the insured's designee, or the insured's prescribing health care provider shall have the right to request that such denial be reviewed by an external appeal

agent certified by the superintendent pursuant to section four thousand nine hundred eleven of this chapter in accordance with article forty-nine of this chapter and article forty-nine of the public health law.

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

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

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

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

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

SUBPART E

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

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

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

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

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

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

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

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

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

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

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

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

(8) engage in sexual stereotyping.

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

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

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

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

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

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

(4) insert in the contract any condition, or make any stipulation, whereby the insured binds his or herself, or his or her heirs, execu-

tors, administrators or assigns, to accept any sum or service less than the full value or amount of such contract in case of a claim thereon except such conditions and stipulations as are imposed upon others in similar cases; and any such stipulation or condition so made or inserted shall be void;

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

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

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

(8) engage in sexual stereotyping.

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

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

SUBPART F

Intentionally Omitted

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

§ 3. Intentionally omitted.

§ 4. Legislative intent. It is hereby declared to be the intent of the legislature in enacting this act, that the laws of this state provide consumer and market protections at least as robust as those under the federal Patient Protection and Affordable Care Act, public law 111-148, as that law existed and was interpreted on January 19, 2017. 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. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 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. Intentionally omitted.

§ 6. This act shall take effect immediately.

PART L

Section 1. Paragraph 13 of subsection (i) of section 3216 of the insurance law is amended by adding three new subparagraphs (C), (D) and (E) to read as follows:

(C) Every policy delivered or issued for delivery in this state that provides coverage for hospital, surgical or medical care shall provide coverage for:

(i) in vitro fertilization used in the treatment of infertility; and

(ii) standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(D) (i) For the purposes of subparagraph (C) of this paragraph, "infertility" means a disease or condition characterized by the incapacity to impregnate another person or to conceive, as diagnosed or determined (I) by a physician licensed to practice medicine in this state, or (II) by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse, or after six months of regular, unprotected sexual intercourse in the case of a female thirty-five years of age or older.

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

(E) No insurer providing coverage under this paragraph shall discriminate based on a covered individual'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 6 of subsection (k) of section 3221 of the insurance law is amended by adding three new subparagraphs (E), (F) and (G) to read as follows:

(E) Every group policy delivered or issued for delivery in this state that provides hospital, surgical or medical coverage shall provide coverage for:

(i) in vitro fertilization used in the treatment of infertility; and

(ii) standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(F) (i) For the purposes of subparagraph (E) of this paragraph, "infertility" means a disease or condition characterized by the incapacity to impregnate another person or to conceive, as diagnosed or determined (I) by a physician licensed to practice medicine in this state, or (II) by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse, or after six months of regular, unprotected sexual intercourse in the case of a female thirty-five years of age or older.

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

(G) No insurer providing coverage under this paragraph shall discriminate based on a covered individual'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.

§ 3. 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 by adding three new paragraphs 5, 6 and 7 to read as follows:

(5) Every contract issued by a medical expense indemnity corporation, hospital service corporation or health service corporation for delivery in this state that provides hospital, surgical or medical coverage shall provide coverage for:

(A) in vitro fertilization used in the treatment of infertility; and

(B) standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person.

(6) (A) For the purposes of paragraph five of this subsection, "infertility" means a disease or condition characterized by the incapacity to impregnate another person or to conceive, as diagnosed or determined (i) by a physician licensed to practice medicine in this state, or (ii) by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse, or after six months of regular, unprotected sexual intercourse in the case of a female thirty-five years of age or older.

(B) For the purposes of paragraph five of this subsection, "iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

(7) No medical expense indemnity corporation, hospital service corporation or health service corporation providing coverage under this subsection shall discriminate based on a covered individual'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. 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 as required by subparagraphs (A) and (B) of this paragraph shall be provided in accordance with the provisions of this subparagraph.

(i) [~~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.~~

~~(ii)~~] 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 subparagraph.

[~~(iii)~~] (ii) 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.

[~~(iv) 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 subparagraph "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.~~

~~(v)~~] **(iii)** 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)~~] **(II)** sex change procedures; [~~(IV)~~] **(III)** cloning; or [~~(V)~~] **(IV)** medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in clause [~~(vi)~~] **(iv)** of this subparagraph.

[~~(vi)~~] **(iv)** The superintendent, in consultation with the commissioner of health, shall promulgate regulations which shall stipulate the guidelines and standards which shall be used in carrying out the provisions of this subparagraph, which shall include:

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

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

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

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

§ 5. 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 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)~~] **(B)** 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)~~] (C) 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)~~] (ii) sex change procedures; [~~(iv)~~] (iii) cloning; or [~~(v)~~] (iv) medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in subparagraph [~~(F)~~] (D) of this paragraph.

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

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

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

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

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

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

PART M

Intentionally Omitted

PART N

Intentionally Omitted

PART O

Intentionally Omitted

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 to read 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.

§ 1-a. (a) Within 90 days after the date on which this act takes effect, the department of health shall adopt all necessary regulations to define "elevated lead levels" to mean a blood lead level greater than or equal to 5 micrograms per deciliter of whole blood, or such lower blood lead level as the department may establish, to be utilized in its lead poisoning prevention program. The department shall be authorized to promulgate regulations on an emergency basis to implement the provisions of this act.

(b) Within 6 months after the date on which the federal department of health and human services has published guidance recommending a lower concentration of lead in blood than the concentration established pursuant to section one of this act as the reference level for conducting an environmental intervention, the department of health shall publish a notice of proposed rule making and incorporating such guidance into its regulations.

§ 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. Subdivision 1 of section 383 of the executive law is amended by adding a new paragraph d to read as follows:

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

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

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

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

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

9. Information regarding the number, lengths, ages and locations of all the lead pipes located within the water system, as that term is defined in subdivision twenty-six of section two of the public service law.

§ 5. Section 1110 of the public health law, as added by chapter 296 of the laws of 2016, is amended to read as follows:

§ 1110. School and day care potable water testing and standards. 1. For the purposes of this section, "day care facilities" shall mean a child day care center, group family day care home, or a family day care home licensed or registered with the office of children and family services. The provisions of this section do not apply to child day care centers, group family day care homes, family day care homes, school-age child care programs and small day care centers that hold a permit issued by the New York City department of health and mental hygiene.

2. In addition to school districts already classified as a public water system under parts 141 and 142 of title 40 of the code of federal regulations, as such regulations may, from time to time, be amended, every school district [~~and~~], board of cooperative educational services**,** **and day care facility** shall conduct periodic first-drawn tap testing of potable water systems to monitor for lead contamination in each occupied school building under its jurisdiction as required by regulations promulgated pursuant to this section. The testing shall be conducted and the results analyzed by an entity or entities approved by the commissioner. **Such periodic first-drawn testing shall occur once every three years.**

[~~2.~~] **3.** Where a finding of lead contamination is made, the affected school district **or day care facility** shall: (a) continue first-drawn tap water testing pursuant to regulations promulgated pursuant to this section; (b) provide [~~school~~] occupants with an adequate supply of safe, potable water for drinking as required by rules and regulations of the department until future tests indicate lead levels pursuant to regulations promulgated pursuant to this section; and (c) provide parents or persons in parental relation to a child attending said school **or day care facility** with written notification of test results as well as posting such test results on the school district's website**; and notwithstanding any provision of law to the contrary, abate such contamination within ninety days**.

[~~3.~~] **4.** First-drawn tap testing shall not be required for school **or day care facility** buildings that have been deemed "lead-free" as defined by section 1417 of the federal safe drinking water act.

[~~4.~~] **5.** The commissioner, in consultation with the commissioner of education **and the commissioner of children and family services**, shall promulgate regulations to carry out the provisions of this section. Notwithstanding any other provision of law to the contrary, the regulations promulgated with regard to lead levels shall be consistent with the requirements for those school districts **or day care facilities** classified as a public water system under parts 141 and 142 of title 40 of the code of federal regulations as such regulations may, from time to time, be amended.

[~~5.~~] **6.** The commissioner **in consultation with the commissioner of children and family services,** may grant a waiver from the testing requirements of this section for certain school buildings, provided that, the school district **or day care facility** has substantially complied with the testing requirements and has been found to be below lead levels as determined by regulations promulgated pursuant to this section for such buildings.

[~~6.~~] **7.** Each school district [~~and~~], board of cooperative educational services**, and day care facility** conducting testing pursuant to subdivision one of this section and each school district classified as a public water system under parts 141 and 142 of title 40 of the code of federal regulations, as such regulations may, from time to time, be amended, shall make a copy of the results of all such testing and any lead remediation plans available to the public on its website and any additional means as chosen by such **school** district **or day care facility**. A copy of the results of all testing shall also be immediately transmitted to the department [~~and~~], state education department**, and office of children and family services** in a format to be determined by the commissioner and to the county department of health in the local jurisdiction of the school building. The commissioner of education **and the commissioner of children and family services**, in conjunction with the commissioner, shall publish

a report biennially based on the findings from the tap water testing conducted according to the provisions of this section. Such report shall be sent to the commissioner, the governor, the temporary president of the senate, and the speaker of the assembly and shall be made available on the department's [~~and~~], state education department's and office of children and family services' websites.

8. Subject to appropriation, the commissioner may provide financial assistance to assist day care facilities with compliance with this section when such compliance imposes an unreasonable financial hardship on the day care facility and such day care facilities are not eligible for building aid under sections nineteen fifty or thirty-six hundred two of the education law.

§ 6. The public health law is amended by adding a new section 1110-a to read as follows:

§ 1110-a. Park potable water testing and standards. 1. The person, officer, board or commission having the management and control of the potable water supply of any park shall conduct periodic first-drawn tap testing of potable water systems to monitor for lead contamination in each park under his or her jurisdiction as required by regulations promulgated pursuant to this section. The testing shall be conducted and the results analyzed by an entity or entities approved by the commissioner. Such periodic first-drawn tap testing shall occur at least once every three years.

2. Where a finding of lead contamination is made, the person, officer, board or commission having the management and control of the potable water supply of such park shall: (a) continue first-drawn tap water testing pursuant to regulations promulgated pursuant to this section; (b) provide park visitors with an adequate supply of safe, potable water for drinking as required by rules and regulations of the department until future tests indicate lead levels pursuant to regulations promulgated pursuant to this section; (c) conspicuously post warnings to park visitors the form and content of such warnings to be promulgated by the commissioner, as well as posting such warnings and test results on the park's website; (d) notwithstanding any provision of law to the contrary, abate such contamination within ninety days; and (e) immediately transmit a copy of the results of all such testing and any lead remediation plans to the commissioner of parks, recreation and historic preservation in a format to be determined by such commissioner.

3. The commissioner, in consultation with the commissioner of parks, recreation and historic preservation, shall promulgate regulations to carry out the provisions of this section.

4. The commissioner of parks, recreation and historic preservation shall make a copy of the results of all such testing and any lead remediation plans available to the public on the office of parks, recreation and historic preservation's website and any additional means as chosen by such commissioner. A copy of the results of all testing shall also be immediately transmitted to the department in a format to be determined by the commissioner. The commissioner of parks, recreation and historic preservation, in conjunction with the commissioner, shall publish a report biennially based on the findings from the tap water testing conducted according to the provisions of this section. Such report shall be sent to the commissioner, the governor, the temporary president of the senate, and the speaker of the assembly and shall be made available on the department's and office of parks, recreation and historic preservation's websites.

§ 7. This act shall take effect immediately; provided, however, that sections four, five and six of this act shall take effect on the one hundred eightieth day after it shall have become a law. 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 Q

Section 1. Subdivision 4 of section 2825-f of the public health law, as added by section 1 of part Q of chapter 57 of the laws of 2018, is amended and three new subdivisions 4-a, 4-b and 4-c are added to read as follows:

4. Notwithstanding any inconsistent subdivision of this section or any other provision of law to the contrary, the commissioner, with the approval of the director of the budget, [~~may expend up to~~] **shall award a minimum of** twenty million dollars of the funds appropriated for this program pursuant to subdivision three of this section, not including funds dedicated for community-based health care providers under paragraph (a) of such subdivision or for residential health care facilities under paragraph (b) of such subdivision, for awards made pursuant to paragraph (l) of subdivision three of section four hundred sixty-one-l of the social services law, provided that funding shall be prioritized for awards made pursuant to subparagraph (i) of such paragraph, with remaining funding available for awards made pursuant to subparagraphs (ii) and (iii) of such paragraph.

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 application number 17648 issued by the department on January eighth, two thousand eighteen pursuant to section twenty-eight hundred twenty-five-e of this article, with a minimum of thirty million dollars awarded to community-based healthcare providers as defined in subdivision three of section twenty-eight hundred twenty-five-e of this title. 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.

4-c. The commissioner shall release the request for applications for the remaining funds made available under this section by July first, two thousand nineteen and shall award such funds no later than January thirty-first, two thousand twenty.

§ 2. This act shall take effect immediately.

PART R

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

causes of maternal mortality, and those findings can lead to clinical and social change that can help prevent maternal mortality. The same is true for severe maternal morbidity. Confidentiality is important to ensure that full information is made available in the review process to maximize protection of maternal health.

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

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

§ 2509. Maternal mortality review board. 1. (a) There is hereby established in the department the maternal mortality review board for the purpose of reviewing maternal deaths and maternal morbidity and developing and disseminating findings, recommendations, and best practices to contribute to the prevention of maternal mortality and morbidity. The board shall assess the cause of death, factors leading to death and preventability for each maternal death reviewed and, in the discretion of the board, cases of severe maternal morbidity, and shall develop and disseminate strategies for reducing the risk of maternal mortality and morbidity, including risk resulting from racial, economic, or other disparities. The commissioner may delegate the authority to conduct maternal mortality reviews.

(b) The commissioner may enter into an agreement with the city of New York providing:

(i) that the functions of the state board relating to maternal deaths and severe maternal morbidity occurring within the city of New York shall be conducted by the city board;

(ii) the city board shall provide to the state board the results of its reviews, relevant information in the possession of the city board, and the recommendations of the city board; and

(iii) the department and the state board shall provide information and assistance to the city board for the performance of its functions.

(c) Nothing in this section shall prevent the city of New York from establishing, without an agreement with the commissioner, a board relating to maternal deaths and severe maternal morbidity occurring within the city of New York.

2. As used in this section, unless the context requires otherwise:

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

(b) "Board" means a maternal mortality review board established by this section, referred to in this section as the "state board", or a board operating under this section established by the city of New York, with or without an agreement with the commissioner, referred to in this section as the "city board".

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

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

(e) "City commissioner" means the commissioner of the New York city department of health and mental hygiene.

3. (a) The members of the state board shall be comprised of multidisciplinary experts in the field of maternal mortality, women's health and public health, and shall include health care professionals or other experts who serve and are representative of the diversity of the women and mothers in medically underserved areas of the state or areas of the state with disproportionately high occurrences of maternal mortality or morbidity.

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

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

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

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

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

(g) Members of the state and city boards shall be indemnified under section seventeen of the public officers law or section fifty-k of the general municipal law, as the case may be.

(h) Members of the state board shall not be compensated for their participation on the board but shall receive reimbursement for their ordinary and necessary expenses of participation.

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

4. (a) The commissioner and the city commissioner, as the case may be, may request and shall receive upon request from any department, division, board, bureau, commission, local health departments or other agency of the state or political subdivision thereof or any public authority, as well as hospitals established pursuant to article twenty-eight of this chapter, birthing facilities, medical examiners, coroners and coroner physicians and any other facility providing services associated with maternal mortality, such information, including, but not limited to, death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records and any other information that will help the department under this section to properly carry out its functions, powers and duties.

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

(c) Before transmitting any information to the board, the commissioner or the city commissioner shall remove all personal identifying information of the woman, health care practitioner or practitioners or anyone else individually named in such information, as well as the hospital or

facility that treated the woman, and any other information such as geographic location that may inadvertently identify the woman, practitioner or facility. This paragraph shall not preclude the transmitting of information to the board that is reasonably necessary to enable the board to perform an appropriate review under this section.

5. Each board:

(a) shall make and report findings and recommendations to the commissioner or city commissioner, as the case may be, regarding the cause of death, factors leading to death, and preventability of each maternal death case, and each case of severe maternal morbidity reviewed by the board, by reviewing relevant information for each case in the state or the city of New York, as the case may be, and consulting with experts as needed to evaluate the information for each death; and shall provide such findings and recommendations, including best practices and strategies for reducing the risk of maternal mortality and morbidity, to the advisory council; provided that material provided to the advisory council shall not include any information that would be confidential under this section;

(b) shall develop recommendations to the commissioner or city commissioner, as the case may be, for areas of focus, including issues of severe maternal morbidity and issues of racial, economic or other disparities in maternal outcomes;

(c) may, in addition to the findings and recommendations made under this subdivision, and consistent with all applicable confidentiality protections, bring any particular matter to the attention of the commissioner or the city commissioner;

(d) shall issue a report on its findings and recommendations every two years, and may also issue reports more frequently. The reports shall be public documents; and

(e) may request and shall receive the assistance of the commissioner and the city commissioner in carrying out its functions.

6. The commissioner and the city commissioner and the state and city boards shall each keep confidential any information collected or received under this section that includes personal identifying information of the woman, health care practitioner or practitioners or anyone else individually named in such information, as well as the hospital or facility that treated the woman, and any other information such as geographic location that may inadvertently identify the woman, practitioner or facility, and shall use the information provided or received under this section solely for the purposes of improvement of the quality of health care of women and to prevent maternal mortality and morbidity. This subdivision shall not preclude the transmitting of information to the board that is reasonably necessary to enable the board to perform an appropriate review under this section. All records received, meetings conducted, reports and records made and maintained and all books and papers obtained by the board shall be confidential and shall not be made open or available, including under article six of the public officers law, and shall be limited to board members as well as those authorized by the commissioner or city commissioner. Such information shall not be discoverable or admissible as evidence in any action in any court or before any other tribunal, board, agency or person.

7. The commissioner and the city commissioner, within their respective legal authority, may use the recommendations and findings of the boards to develop guidance and other actions relating to best practices, and shall disseminate information relating to that guidance and other actions to appropriate health care providers.

8. (a) There is hereby established in the department an advisory council on maternal mortality and morbidity.

(b) The advisory council:

(i) may review the findings of the boards;

(ii) may develop recommendations on policies, best practices, and strategies to prevent maternal mortality and morbidity;

(iii) may hold public hearings on those matters;

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

(v) may request and shall receive the assistance of the commissioner, the city commissioner, and the boards in carrying out its functions.

(c) The advisory council shall consist of at least twenty members, to be determined by the commissioner. The commissioner and the city commissioner shall each appoint half of the members of the council. The commissioner shall appoint the chair of the council.

(d) The members of the council shall be comprised of multidisciplinary experts and lay persons knowledgeable in the field of maternal mortality, women's health and public health and shall include members who serve and are representative of the diversity of the women and mothers in medically underserved areas of the state or areas of the state with disproportionately high occurrences of maternal mortality or morbidity.

(e) The terms of the council members shall be three years. The appointing official may choose to reappoint council members to additional three-year terms. Vacancies on the council shall be filled by appointment by the appointing official. 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

Intentionally Omitted

PART T

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

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

TITLE VII
NY STATE OF HEALTH

Section 268. Statement of policy and purposes.
268-a. Definitions.
268-b. Establishment of NY State of Health, The Official Health Plan Marketplace.
268-c. Functions of the Marketplace.

268-d. Special functions of the Marketplace related to health plan certification and qualified health plan oversight.
268-e. Appeals and appeal hearings; judicial review.
268-f. Marketplace advisory committee.
268-g. Funding of the Marketplace.
268-h. Construction.

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

§ 268-a. Definitions. For purposes of this title, the following definitions shall apply:

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

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

3. "Federal act" means the patient protection and affordable care act, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and any regulations or guidance issued thereunder.

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

(a) accident insurance or disability income insurance, or any combination thereof;

(b) coverage issued as a supplement to liability insurance;
(c) liability insurance, including general liability insurance and automobile liability insurance;
(d) workers' compensation or similar insurance;
(e) automobile no-fault insurance;
(f) credit insurance;
(g) other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
(h) limited scope dental or vision benefits, benefits for long-term care insurance, nursing home insurance, home care insurance, or any combination thereof, or such other similar, limited benefits health insurance as specified in federal regulations, if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan;
(i) coverage only for a specified disease or illness, hospital indemnity, or other fixed indemnity coverage;
(j) Medicare supplemental insurance as defined in section 1882(g)(1) of the federal social security act, coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, or similar supplemental coverage provided under a group health plan if it is offered as a separate policy, certificate or contract of insurance; or
(k) the New York state medical indemnity fund established pursuant to title four of article twenty-nine-D of the public health law.
5. "Insurer" means an insurance company subject to article forty-two or a corporation subject to article forty-three of the insurance law, or a health maintenance organization certified pursuant to article forty-four of the public health law that contracts or offers to contract to provide, deliver, arrange, pay or reimburse any of the costs of health care services.
6. "Stand-Alone dental plan" means a dental services plan that has been issued pursuant to applicable law and certified by the Marketplace in accordance with section two hundred sixty-eight-d of this title.
7. "Qualified health plan" means a health plan that is issued pursuant to applicable law and certified by the Marketplace in accordance with section two hundred sixty-eight-d of this title, including a stand-alone dental plan.
8. "Insurance affordability program" means Medicaid, child health plus, the basic health program and any other health insurance subsidy program designated as such by the commissioner.
9. "Eligible individual" means an individual, including a minor, who is eligible to enroll in an insurance affordability program or other health insurance program as determined by the commissioner.
10. "Qualified individual" means, with respect to qualified health plans, an individual, including a minor, who:
(a) is eligible to enroll in a qualified health plan offered to individuals through the Marketplace;
(b) resides in this state;
(c) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and
(d) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.
11. "Secretary" means the secretary of the United States department of health and human services.

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

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

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

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

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

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

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

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

1. (a) 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, premium tax credits and cost-sharing reductions and qualified health plans in accordance with applicable law and other health insurance programs as determined by the commissioner;

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

(c) certify and/or make available to eligible individuals, health plans certified by the Marketplace pursuant to applicable law, and/or participating in an insurance affordability program pursuant to applicable law, provided that coverage under such plans shall not become effective prior to certification by the Marketplace, and/or approval by the commissioner.

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

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

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

5. Maintain enrollment periods in the best interest of qualified individuals consistent with federal and state law.

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

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

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

9. Provide the minimum requirements an insurer shall meet to participate in the Marketplace, in the best interest of qualified individuals or eligible individuals;

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

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

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

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

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

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

state licensed producers to provide assistance to eligible individuals and/or small employers pursuant to federal or state law.

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

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

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

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

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

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

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

21. Meet program integrity requirements under applicable law, including keeping an accurate accounting of receipts and expenditures and providing reports to the secretary regarding Marketplace related activities in accordance with applicable law.

22. Submit information provided by Marketplace applicants for verification as required by section 1411(c) of the federal act and applicable state law.

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

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

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

(a) The insurer offering the health plan:

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

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

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

(iv) does not charge any cancellation fees or penalties for termination of coverage in violation of applicable law; and

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

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

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

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

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

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

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

(v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements; and

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

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

2. The Marketplace shall not exclude a health plan:

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

(b) through the imposition of premium price controls by the Marketplace; or

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

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

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

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

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment and disenrollment;

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

(E) data on rating practices;

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

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

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

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

(c) provide to individuals, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's health plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an internet website and through other means for individuals without access to the internet.

4. The Marketplace shall not exempt any insurer seeking certification of a health plan, regardless of the type or size of the insurer, from licensing or solvency requirements under the insurance law or this chapter, and shall apply the criteria of this section in a manner that ensures a level playing field for insurers participating in the Marketplace.

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

(b) The qualified dental plan or dental plan approved for sale by the department of financial services and/or the department shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental

coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the Marketplace or secretary may specify in regulations.

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

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

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

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

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

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

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

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

(i) An initial determination of eligibility, including:

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

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) an explanation that an appeal decision for one household member may result in a change in eligibility for other household members and that such a change will be handled as a redetermination of eligibility for all household members in accordance with the standards specified in applicable law.

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

2. The marketplace advisory committee shall consist of up to twenty-eight members appointed by the commissioner, representative of each geographic area of the state and including:

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

(i) health plan consumer advocates;

(ii) small business consumer representatives;

(iii) health care provider representatives;

(iv) representatives of the health insurance industry;

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

(i) licensed insurance producers; and

(ii) representatives of labor organizations.

3. The Marketplace shall select the chair of the advisory committee from among the members of such committee and shall designate an officer or employee of the department to assist the marketplace advisory committee in the performance of its duties under this section. The Marketplace shall adopt rules for the governance of the advisory committee, which shall meet as frequently as its business may require and at such other times as determined by the Marketplace to be necessary.

4. Members of the advisory committee 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.

§ 268-g. Funding of the Marketplace. 1. The Marketplace shall be funded by state and federal sources as authorized by applicable law, including but not limited to applicable law authorizing the respective insurance affordability programs available through the Marketplace.

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

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, upon request of the director of the budget, in consultation with the commissioner, the superintendent and the executive director of the Marketplace, the comptroller is hereby authorized and directed to sub-allocate or transfer special revenue federal funds appropriated to the department for planning and implementing various healthcare and insurance reform initiatives authorized by applicable law. Marketplace moneys sub-allocated or transferred pursuant to this section shall be paid out of the fund upon audit and warrant of the state comptroller on vouchers certified or approved by the Marketplace.

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

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

2. exempt insurers, insurance producers or qualified health plans from this chapter or the insurance law and any regulations promulgated thereunder.

§ 3. Severability. If any provision of this article, or the application thereof to any person or circumstances is held invalid or unconstitutional, that invalidity or unconstitutionality shall not affect other provisions or applications of this article that can be given effect without the invalid or unconstitutional provision or application, and to this end the provisions and application of this article are severable.

§ 4. This act shall take effect immediately.

PART U

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

12. The director is hereby authorized to implement private pay protocols for all programs administered by the office. These protocols may be implemented by area agencies on aging at their option and such protocols may not be applied to clients whose services are paid for with federal funds or funds designated as federal match. All private payments received directly by an area agency on aging or indirectly by one of its contractors shall be used to supplement, not supplant, funds by state,

federal, or county appropriations. Such private pay payments shall be set at a cost to the final recipient of not more than twenty percent above either the amount that the area agency on aging pays to its contractor to render the service or product, or the per unit wholesale cost to the area agency on aging if such area agency on aging renders the service or product directly to the final recipient. Private pay payments received under this subdivision shall be used by the area agency on aging to support and enhance services or programs provided by the area agency on aging. Participant payments under this subdivision shall not be required of individuals with incomes below four hundred percent of the federal poverty level. No participant, regardless of income, shall be required to pay for any service that they are receiving at the time these protocols are implemented by the area agency on aging. This subdivision shall not prevent cost sharing for the programs established pursuant to section two hundred fourteen of this title for individuals below four hundred percent of the federal poverty level. Individuals with incomes below four hundred percent of the federal poverty level shall remain the highest priority for receipt of services from the office and local area agencies on aging and their contractors; in the event that resources and services are limited, such resources and services may not be redirected from recipients under four hundred percent of the federal poverty level to those paying for services pursuant to the private pay protocols authorized by this subdivision.

§ 2. This act shall take effect immediately.

PART V

Intentionally Omitted

PART W

Section 1. Section 1 of part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, as amended by section 1 of part H of chapter 59 of the laws of 2016, is amended to read as follows:

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, [~~2019~~] 2022; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, [~~2019~~] 2022.

§ 2. This act shall take effect immediately.

PART X

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

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

PART Z

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

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

certified pursuant to **article sixteen or** article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health [~~and~~], the commissioner of the office of alcoholism and substance abuse services **and the commissioner of the office for people with developmental disabilities**, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

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

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

(b) (i) Methadone, or such other controlled substance designated by the commissioner of health as appropriate for such use, may be administered to an addict, as defined in section thirty-three hundred two of the public health law, by individual physicians, groups of physicians and public or private medical facilities certified pursuant to article twenty-eight or thirty-three of the public health law as part of a chemical dependence program which has been issued an operating certificate by the commissioner pursuant to subdivision (b) of section 32.09 of this article, provided, however, that such administration must be done in accordance with all applicable federal and state laws and regulations. Individual physicians or groups of physicians who have obtained authorization from the federal government to administer buprenorphine to addicts may do so without obtaining an operating certificate from the commissioner. (ii) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or article thirty-one of this chapter to obtain an operating certificate from the office of alcoholism and substance abuse services if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of alcoholism and substance abuse services in consultation with the commissioner of the department of health [~~and~~], the commissioner of the office of mental health **and the commissioner of the office for people with developmental disabilities**, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

(g) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article thirty-one or thirty-two of this chapter to obtain an operating certificate from the office for people with developmental disabilities if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of the office for people with developmental disabilities, in consultation with the commissioner of the department of health, the commissioner and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

PART AA

Intentionally Omitted

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

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

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

§ 3. Items (i) and (iii) of subparagraph (C) of paragraph 25 of subsection (i) of section 3216 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 certified pursuant to the behavior analyst certification board~~] person licensed, certified or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. [~~Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this 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.~~]

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

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

(I) The criteria for medical necessity determinations under the policy with respect to autism spectrum disorder benefits shall be made avail-

able 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-eight days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within [~~forty-eight hours~~] two business days of the admission. The facility shall perform daily clinical review of the patient, including [~~the~~] periodic consultation with the insurer at or just prior to the fourteenth day of the inpatient admission to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [~~fourteen~~] twenty-eight days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [~~fourteen~~] twenty-eight day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

(E) An insurer shall make available to any insured, prospective insured, or in-network provider, upon request, the criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits.

(F) For purposes of this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under

this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within [~~forty-eight hours~~] two business days. The facility shall perform clinical assessment of the patient at each visit, including [~~the~~] periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(G) For purposes of this paragraph:

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

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

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

(H) 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).

§ 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 office of mental health, or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

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

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

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

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

(E) For purposes of this paragraph:

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

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

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

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

(F) 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).

(G) This subparagraph shall apply to hospitals in this state that are licensed by the office of mental health that are participating in the insurer's provider network. Where the policy provides coverage for inpa-

tient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law provided to individuals who have not attained the age of eighteen shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first fourteen days of the inpatient admission, provided the facility notifies the insurer of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the patient, and participates in periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer which is approved by the office of mental health and appropriate to the age of the patient, to ensure that the inpatient care is medically necessary for the patient. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of alcoholism and substance abuse services, and any restrictions regarding the availability of the individual provider's services; and [~~in addition,~~] (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

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

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

(B) the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; [~~and~~]

(20) information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[~~.~~]; and

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

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

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

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

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

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

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state where the policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental[~~, nervous or emotional disorders and ailments~~] **health conditions**, however defined in such policy, by physicians, psychiatrists or psychologists, shall provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either: (i) three or more additional years experience in psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior that are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental

department, providing services for diagnosis or treatment of mental[~~, nervous or emotional disorders or ailments~~] **health conditions**; (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection (e) of this section, or (iii) a combination of the experience specified in items (i) and (ii) of this subparagraph totaling three years, satisfactory to the state board for social work.

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

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

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law[~~, which benefits may be limited to not less than thirty days of active treatment in any contract year, plan year or calendar year,~~] and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health[~~, which benefits may be limited to not less than twenty visits in any contract year, plan year or calendar year. Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day of treatment.~~] **or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and**

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

[~~(iii)~~] **(B)** Coverage required by this paragraph may be [~~provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the policy. Such coverage may be~~] subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. [~~In the event that a policy provides coverage for both inpatient hospital care and physician services, the aggregate of the benefits for outpatient care obtained under this paragraph may be limited to not less than twenty visits in any contract year, plan year or calendar year.~~

~~(iv) In this paragraph, "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.~~

~~(B) (i) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services, shall provide comparable coverage for adults and children with biologically based mental illness. Such group policies issued or delivered in this state shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the policy, including network limitations or variations, 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 (l) of section 3221 of the insurance law are REPEALED and five new subparagraphs (C), (D), (E), (F) and (G) are added to read as follows:

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

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

(E) For purposes of this paragraph:

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

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

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

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

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

(F) 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).

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

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

(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 depend-

ence treatment programs **and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located**.

(D) This subparagraph shall apply to facilities in this state **that are licensed,** certified **or otherwise authorized** by the office of alcoholism and substance abuse services that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first [~~fourteen~~] **twenty-eight** days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within [~~forty-eight hours~~] **two business days** of the admission. The facility shall perform daily clinical review of the patient, including [~~the~~] periodic consultation with the insurer **at or just prior to the fourteenth day of the inpatient admission** to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. **Prior to discharge, the facility shall provide the patient and the insurer with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the insurer whether services included in the discharge plan are secured or determined to be reasonably available.** Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [~~fourteen~~] **twenty-eight** days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [~~fourteen~~] **twenty-eight** day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(F) For purposes of this paragraph:

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

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

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to partic-

ipate 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 (l) 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 (l) of section 3221 of the insurance law, as added by section 4 of part MM of chapter 57 of the laws of 2018, is amended and three new subparagraphs (F), (G) and (H) are added to read as follows:

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage

provided under this paragraph shall not be subject to concurrent review for the first [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within [~~forty-eight hours~~] two business days. The facility shall perform clinical assessment of the patient at each visit, including [~~the~~] periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

(G) For purposes of this paragraph:

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

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

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

(H) 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).

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

(7-b) [~~(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~~] to 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 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.~~]

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

(B) Every group or blanket policy that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is

diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the group or blanket policy. [~~Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per policy or calendar year per covered individual.~~] This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the group or blanket policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as[~~,~~] case management[~~,~~] and other managed care provisions.

§ 20. Items (i) and (iii) of subparagraph (C) of paragraph 17 of subsection (l) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

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

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

§ 21. Paragraph 17 of subsection (l) of section 3221 of the insurance law is amended by adding four new subparagraphs (H), (I), (J) and (K) to read as follows:

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

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

(J) For purposes of this paragraph:

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

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

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

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

§ 22. Paragraphs 1, 2, and 3 of subsection (g) of section 4303 of the insurance law, as amended by chapter 502 of the laws of 2007, are amended to read as follows:

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

[~~(A)~~]

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

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

~~(C) Such coverage may be provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the contract.~~] or for out-patient care provided in other states, to similarly certified facilities; and

(2) where the contract provides coverage for physician services benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subsection (n) of this section, a nurse practitioner licensed to practice on this state, or professional corporation or university faculty practice corporation thereof.

(3) Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract.

Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the contract.

[~~(D) For the purpose of this subsection, "active treatment" means treatment furnished in conjunction with in-patient confinement for mental, nervous or emotional disorders or ailments that meet such standards as shall be prescribed pursuant to the regulations of the commissioner of mental health.~~

~~(E) In the event the group remittance group or contract holder is provided coverage under this subsection and under paragraph one of subsection (h) of this section from the same health service corporation, or under a contract that is jointly underwritten by two health service corporations or by a health service corporation and a medical expense indemnity corporation, the aggregate of the benefits for outpatient care obtained under subparagraph (B) of this paragraph and paragraph one of subsection (h) of this section may be limited to not less than twenty visits in any contract year, plan year or calendar year.~~

~~(2) (A) A hospital service corporation or a health service corporation, which provides group, group remittance or school blanket coverage for inpatient hospital care, shall provide comparable coverage for adults and children with biologically based mental illness. Such hospital service corporation or health service corporation shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the contract, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a contract provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the contract is written under one license or two licenses.~~

~~(B) For purposes of this subsection, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, anorexia, and bulimia.~~

~~(3) For purposes of this subsection, the term "children with serious emotional disturbances" means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:~~

~~(A) serious suicidal symptoms or other life-threatening self-destructive behaviors;~~

~~(B) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);~~

~~(C) behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or~~

~~(D) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.~~]

§ 23. Paragraphs 4 and 5 of subsection (g) of section 4303 of the insurance law are REPEALED and five new paragraphs 4, 5, 6, 7 and 8 are added to read as follows:

(4) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(5) The criteria for medical necessity determinations under the contract with respect to mental health benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(6) For purposes of this subsection:

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

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

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

(D) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

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

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

obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

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

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

(i) A medical expense indemnity corporation or health service corporation [~~which~~] that provides coverage for physicians, psychiatrists or psychologists for psychiatric or psychological services or for the diagnosis and treatment of [~~mental, nervous or emotional disorders and ailments~~] mental health conditions, however defined in such contract, [~~must~~] shall make available and if requested by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, provide the same coverage for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection. Such coverage shall be made available at the inception of all new contracts and, with respect to all other contracts, at any anniversary date subject to evidence of insurability. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract and annually thereafter, except that this notice shall not be required where a [~~policy~~] contract covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

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

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

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

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent

and that are consistent with those imposed on other benefits within a given contract.

(4) This paragraph shall apply to facilities in this state [~~certified~~] **that are licensed, certified or otherwise authorized** by the office of alcoholism and substance abuse services that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall also not be subject to concurrent utilization review during the first [~~fourteen~~] **twenty-eight** days of the inpatient admission provided that the facility notifies the corporation of both the admission and the initial treatment plan within [~~forty-eight hours~~] **two business days** of the admission. The facility shall perform daily clinical review of the patient, including [~~the~~] periodic consultation with the corporation **at or just prior to the fourteenth day of the inpatient admission** to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. **Prior to discharge, the facility shall provide the patient and the corporation with a written discharge plan which shall describe arrangements for additional services needed following discharge from the inpatient facility as determined using the evidence-based and peer-reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. Prior to discharge, the facility shall indicate to the corporation whether services included in the discharge plan are secured or determined to be reasonably available.** Any utilization review of treatment provided under this paragraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [~~fourteen~~] **twenty-eight** days of such inpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial [~~fourteen~~] **twenty-eight** day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

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

(6) For purposes of this subsection:

(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.

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

§ 27. Paragraphs 1 and 2 of subsection (l) of section 4303 of the insurance law, as amended by chapter 41 of the laws of 2014, are amended and a new paragraph 3-a is added to read as follows:

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

(2) Coverage under this subsection 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~~] 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.

(3-a) A contract that provides large group coverage that provides coverage for outpatient substance use disorder services under this subsection may not impose copayments or coinsurance for outpatient substance use disorder services that exceed 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.

§ 28. Paragraph 5 of subsection (l) of section 4303 of the insurance law, as added by section 5 of part MM of chapter 57 of the laws of 2018, is amended and three new paragraphs 6, 7 and 8 are added to read as follows:

(5) This paragraph shall apply to facilities in this state [~~certified~~] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment

that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within [~~forty-eight hours~~] two business days. The facility shall perform clinical assessment of the patient at each visit, including [~~the~~] periodic consultation with the corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, of such outpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. A subscriber shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

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

(7) For purposes of this subsection:

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

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

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to 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 (l-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:

(l-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 maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection.

§ 31. Paragraph 2 of subsection (ee) of section 4303 of the insurance law, as amended by section 40 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(2) Every contract that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the contract because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. [~~Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per contract or calendar year per covered individual.~~] This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the contract, provided however that such contract shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as[~~,~~] case management[~~,~~] and other managed care provisions.

§ 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of section 4303 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

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

(C) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided [~~or supervised~~] by a [~~behavior analyst certified pursuant to the behavior analyst certification board~~] **person that is licensed, certified or otherwise authorized to provide applied behavior analysis**, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. [~~Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this subsection shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.~~]

§ 33. Subsection (ee) of section 4303 of the insurance law is amended by adding four new paragraphs 8, 9, 10, and 11 to read as follows:

(8) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(9) The criteria for medical necessity determinations under the contract with respect to autism spectrum disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(10) 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; and

(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.

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

§ 34. Paragraphs 17, 20 and 21 of subsection (a) of section 4324 of the insurance law, paragraph 17 as amended and paragraphs 20 and 21 as added by section 8 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph 22 is added to read as follows:

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, [~~and in addition,~~] **and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of alcoholism and substance abuse services, and any restrictions regarding the availability of the individual provider's services; (C)** in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

(20) with respect to out-of-network coverage:

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

(B) a description of the amount that the corporation will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; [~~and~~]

(21) information in writing and through an internet website that reasonably permits a subscriber or prospective subscriber to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the corporation will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[~~.~~]**; and**

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

§ 35. Subsection (b) of section 4325 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) No corporation organized under this article shall by contract, written policy [~~or~~]**,** written procedure **or practice** prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such corporation which the provider believes may negatively impact upon the quality of or access to patient care. **Nor shall a corporation organized under this article take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such corporation which may violate this chapter including subsection (g), (k), (1), (1-1) or (1-2) of section forty-three hundred three of this article.**

§ 36. Subparagraph (C) of paragraph 1 of subsection (b) of section 4900 of the insurance law, as added by chapter 41 of the laws of 2014, is amended and a new subparagraph (D) is added to read as follows:

(C) for purposes of a determination involving substance use disorder treatment:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; [~~and~~] or

(D) for purposes of a determination involving treatment for a mental health condition:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses or treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

§ 37. Paragraph 9 of subsection (a) of section 4902 of the insurance law, as amended by section 1 of part A of chapter 69 of the laws of 2016, is amended to read as follows:

(9) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review [~~tools designated by the office of alcoholism and substance abuse services that are appropriate to the age of the patient and consistent with the treatment service levels within the office of alcoholism and substance abuse services system~~] tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

§ 38. Subsection (a) of section 4902 of the insurance law is amended by adding a new paragraph 12 to read as follows:

(12) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

§ 39. Paragraph (b) of subdivision 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 (1-2) 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 law to the contrary, nothing in this act shall limit the rights accruing to employees pursuant to a collective bargaining agreement with any state or local government employer for the unexpired term of such agreement where such agreement is in effect on the effective date of this act and so long as such agreement remains in effect thereafter or the eligibility of any member of an employee organization to join a health insurance plan open to him or her pursuant to such a collectively negotiated agreement.

SUBPART B

Section 1. Subdivision 1 of section 2803-u of the public health law, as added by section 1 of part C of chapter 70 of the laws of 2016, is amended to read as follows:

1. The office of alcoholism and substance abuse services, in consultation with the department, shall develop or utilize existing educational materials to be provided to general hospitals to disseminate to individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder during discharge planning pursuant to section twenty-eight hundred three-i of this [~~chapter~~] article. Such materials shall include information regarding the various types of treatment and recovery services, including but not limited to: inpatient, outpatient, and medication-assisted treatment; how to recognize the need for treatment services; information for individuals to determine what type and level of treatment is most appropriate and what resources are available to them; and any other information the commissioner deems appropriate. General hospitals shall include in their policies and procedures treatment protocols, consistent with medical standards, to be utilized by the emergency departments in general hospitals

for the appropriate use of medication-assisted treatment, including buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department of a general hospital is not feasible.

§ 2. This act shall take effect immediately.

SUBPART C

Section 1. Subparagraph (v) of paragraph (a) of subdivision 2 of section 3343-a of the public health law is REPEALED and subparagraphs (vi), (vii), (viii), (ix) and (x) are renumbered subparagraphs (v), (vi), (vii), (viii) and (ix).

§ 2. This act shall take effect only upon certification from the commissioner of health that all emergency departments in general hospitals can access the prescription monitoring program registry through their electronic health record software. Such commissioner is authorized to apply for any federal grants to assist emergency departments in updating their electronic health record software to interface with the prescription monitoring program registry; provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in section one of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

SUBPART D

Section 1. Paragraph (r) of subdivision 4 of section 364-j of the social services law, as amended by section 39 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(r) A managed care provider shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal social security act, provided that services for a substance use disorder shall be provided by a program licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services.

§ 2. This act shall take effect immediately; provided, however that the amendments to paragraph (r) of subdivision 4 of section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed to be repealed therewith.

SUBPART E

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-y1)-N-phenylbutyramide. Other name: Butyryl Fentanyl.

(59) N-[~~1-[2-hydroxy-2-(thiophen-2-yl)ethyl~~]piperidin-4-y1]-N-phenylpropionamide. Other name: Beta-Hydroxythiofentanyl.

(60) N-(1-phenethylpiperidin-4-y1)-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-y1)-N-phenylacrylamide. Other names: Acryl Fentanyl or Acryloylfentanyl.

(63) N-(4-fluoropheny1)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl.

(64) N-(2-fluoropheny1)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

(65) N-(1-phenethylpiperidin-4-y1)-N-phenyltetrahydrofuran-2-carboxamide. Other name: tetrahydrofuranyl fentanyl.

(66) 2-methoxy-N-(1-phenethylpiperidin-4-y1)-N-phenylacetamide. Other name: methoxyacetyl fentanyl.

(67) N-(1-phenethylpiperidin-4-y1)-N-phenylcyclopropanecarboxamide. Other name: cyclopropyl fentanyl.

(68) N-(1-phenethylpiperidin-4-y1)-N-phenylpentanamide. Other name: Valeryl fentanyl.

(69) N-(4-fluoropheny1)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-fluorobutyrylfentanyl.

(70) N-(4-methoxypheny1)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-methoxybutyryl fentanyl.

(71) N-(4-chloropheny1)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other name: para-chloroisobutyryl fentanyl.

(72) N-(1-phenethylpiperidin-4-y1)-N-phenylisobutyramide. Other name: isobutyryl fentanyl.

(73) N-(1-phenethylpiperidin-4-y1)-N-phenylcyclopentanecarboxamide. Other name: cyclopentyl fentanyl.

(74) N-(2-fluoropheny1)-2-methoxy-N-(1-phenethylpiperidin-4-yl) acetamide. Other name: Ocfentanil.

(75) 1-cyclohexy1-4-(1,2-diphenylethyl)piperazine. Other name: MT-45.

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

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

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

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

(C) Substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino or nitro groups;

(D) Replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; and/or

(E) Replacement of the N-propionyl group by another acyl group.

§ 2. Intentionally omitted.

§ 3. This act shall take effect on the ninetieth day after it shall have become a law.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It has hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

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

PART CC

Section 1. The public health law is amended by adding a new section 280-d to read as follows:

§ 280-d. Prescriber assistance. 1. Unlicensed assistants may be employed in licensed pharmacies for purposes other than the practice of pharmacy, including at least two unlicensed persons per pharmacist to assist in the dispensing of drugs, provided, however, that a pharmacist may obtain the assistance of up to four additional unlicensed persons where such additional unlicensed persons are certified as pharmacy technicians by a nationally accredited pharmacy technician certification program. Proof of certification for such individuals employed by a pharmacy shall be maintained by the pharmacy and provided to state agencies upon request. The department and state board of pharmacy shall consider and may establish regulations permitting a pharmacist to obtain the assistance of a greater number of unlicensed persons.

2. (a) The compounding, preparation, labeling, or dispensing of drugs, in accordance with article one hundred thirty-seven of the education law, in facilities licensed in accordance with article twenty-eight of this chapter shall be performed by: (i) a licensed pharmacist, as defined in article one hundred thirty-seven of the education law; (ii) a pharmacy intern, under the direct supervision of a licensed pharmacist as defined in article one hundred thirty-seven of the education law; or (iii) under the direct supervision of a licensed pharmacist an individual who has received certification from a nationally accredited pharmacy technician certification program may assist in the preparation and dispensing of drugs including weighing, mixing, and measuring when properly trained. Proof of certification and training for such individuals employed by a facility shall be maintained by the facility and provided to state agencies upon request.

(b) A person employed in a facility licensed in accordance with article twenty-eight of this chapter who directly assists licensed pharmacists to dispense prescriptions in such facility on the effective date of this section shall be exempt from the certification requirement in paragraph (a) of this subdivision if he or she submits evidence to, and verified by, his or her employer, of a minimum of five (5) years of employment in good standing in a pharmacy within the previous eight (8) years, including eighteen consecutive months with a single employer. Such evidence and verification shall be documented and maintained by the facility and provided to state agencies upon request. Such individual shall not be permitted to assist in the compounding of medications.

§ 2. This act shall take effect immediately.

PART DD

Intentionally Omitted

PART EE

Section 1. Paragraph (b) of subdivision 2 of section 367-a of the social services law, as amended by section 116 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(b) Any inconsistent provision of this chapter or other law notwithstanding, upon furnishing assistance under this title to any applicant or recipient of medical assistance, the local social services district or the department shall be subrogated, to the extent of the expenditures by such district or department for medical care furnished, to any rights such person may have to medical support or reimbursement from liable third parties, including but not limited to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. For purposes of this section, the term medical support shall mean the right to support specified as support for the purpose of medical care by a court or administrative order. The right of subrogation does not attach to insurance benefits paid or provided under any health insurance policy prior to the receipt of written notice of the exercise of subrogation rights by the carrier issuing such insurance, nor shall such right of subrogation attach to any benefits which may be claimed by a social services official or the department, by agreement or other established procedure, directly from an insurance carrier. No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the exercise of such subrogation right is received by the carrier within three years from the date services for which benefits are provided under the policy or contract are rendered. Liable third parties shall not deny a claim made by a social services official or the department in conformance with this paragraph solely on the basis of the date of submission of the claim, the type or format of the claim form, **lack of prior authorization,** or a failure to present proper documentation at the point-of-sale that is the basis of the claim. The local social services district or the department shall also notify the carrier when the exercise of subrogation rights has terminated because a person is no longer receiving assistance under this title. Such carrier shall establish mechanisms to maintain the confidentiality of all individually identifiable information or records. Such carrier shall limit the use of such information or record to the specific purpose for which such disclosure is made, and shall not further disclose such information or records.

§ 2. This act shall take effect immediately.

PART FF

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

(r-1) asthma management services furnished by a home care agency in accordance with the program requirements established pursuant to section three hundred sixty-five-o of this title, provided, however, that the provisions of this paragraph shall not take effect until all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of asthma management services provided pursuant to this paragraph.

§ 2. The social services law is amended by adding a new section 365-o to read as follows:

§ 365-o. Home care asthma management program. 1. Purpose and intent. The home care asthma management program is intended to target asthma management, health maintenance and promotion, prevention of hospitalizations and emergency episodes, and coordination and collaboration of

services and providers. In implementing such program, the department shall consider the advice of experts in asthma management, home care and other relevant sectors in the continuum of care.

2. Eligibility. The department shall provide notice to all eligible individuals of the availability of the home care asthma management program, and shall have the opportunity to apply for participation in the program. For the purposes of this section, an "eligible individual" is a person who has been diagnosed with asthma and is eligible for medical assistance.

3. Participating providers. All home care agencies certified or licensed under article thirty-six of the public health law who elect to provide services as described in subdivision four of this section to eligible individuals may participate in the program.

4. Department guidelines. The department shall promulgate guidelines for referral of individuals diagnosed with asthma to home care agencies certified or licensed under article thirty-six of the public health law and participating in the home care asthma management program for follow-up services, including but not limited to:

(i) a home-based health assessment of the individual and home environment for asthma trigger reduction;

(ii) use of available telehealth and clinical technology to assist in asthma management;

(iii) patient and family education and training in asthma self-management; such asthma self-management education would include but not be limited to basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms, asthma control, and using written asthma action plans;

(iv) periodic follow-up services, in particular after emergency room or hospital visits occur, providing patients with root cause analysis and steps for prevention of future episodes; and

(v) coordination of home and community-based services, including collaboration with the patient's primary care, managed care, health home and specialty providers, as applicable.

5. Adjustment of rates. The commissioner shall adjust the rates of payment to home care agencies certified under article thirty-six of the public health law that participate in the home care asthma management program.

6. Effectiveness. The provisions of this section shall not take effect until all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of the home care asthma management program provided pursuant to this section.

§ 3. This act shall take effect immediately; provided that the department of social services shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in sections one and two of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART GG

Section 1. The department of health shall submit a Medicaid state plan amendment to the centers for Medicare and Medicaid services of the United States department of health and human services to request author-

ization to establish and administer a methodology to provide supplemental reimbursement to eligible ground emergency medical transportation providers that provide ground emergency medical transportation services to Medicaid beneficiaries. For the purposes of this section, "eligible ground emergency medical transportation provider" means a provider who provides ground emergency medical transportation services to Medicaid beneficiaries and is enrolled as a Medicaid provider during the period being claimed.

§ 2. This act shall take effect immediately.

PART HH

Section 1. Primary and preventive reproductive health care program. Notwithstanding any other provision of law to the contrary, the commissioner of health shall ensure the availability of the full range of reproductive services through a primary and preventive care reproductive health program. The program shall provide sixteen million dollars in grants to not-for-profit organizations with demonstrated experience providing primary and preventive reproductive health care, including organizations that have at least thirty-five years of family planning experience and demonstrated expertise in contracting and grants management. Notwithstanding section 112 or 163 of the state finance law or contrary provisions of law, such distributions shall be made without a competitive bid or request for proposal process. Notwithstanding any inconsistent provision of law, the department of health may provide such grants by interchange, suballocation or transfer from any appropriation, fund or account with the approval of the director of the budget.

§ 2. This act shall take effect upon a determination by the commissioner of health that there is a need to establish a primary and preventive reproductive health care program; provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in section one of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of New York in further of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.

PART II

Section 1. The public health law is amended by adding a new section 2807-o to read as follows:

§ 2807-o. Early intervention services pool. 1. Definitions. The following words or phrases as used in this section shall have the following meanings:

(a) "Early intervention services" shall mean services delivered to an eligible child, pursuant to an individualized family service plan under the early intervention program.

(b) "Early intervention program" shall mean the early intervention program for toddlers with disabilities and their families as created by title two-A of article twenty-five of this chapter.

(c) "Municipality" shall mean any county outside of the city of New York or the city of New York.

2. Payments for early intervention services. (a) The commissioner shall, from funds allocated for such purpose under paragraph (g) of subdivision six of section twenty-eight hundred seven-s of this article,

make payments to municipalities and the state for the delivery of early intervention services.

(b) Payments under this subdivision shall be made to municipalities and the state by the commissioner. Each municipality and the state of New York shall receive a share of such payments equal to its proportionate share of the total approved statewide dollars not reimbursable by the medical assistance program paid to providers of early intervention services by the state and municipalities on account of early intervention services in the last complete state fiscal year for which such data is available.

§ 2. Subdivision 6 of section 2807-s of the public health law is amended by adding two new paragraphs (g) and (h) to read as follows:

(g) A further gross statewide amount for the state fiscal year two thousand twenty and each state fiscal year thereafter shall be fifteen million dollars.

(h) The amount specified in paragraph (g) of this subdivision shall be allocated under section twenty-eight hundred seven-o of this article among the municipalities and the state of New York based on each municipality's share and the state's share of early intervention program expenditures not reimbursable by the medical assistance program for the latest twelve month period for which such data is available.

§ 3. Subdivision 7 of section 2807-s of the public health law is amended by adding a new paragraph (d) to read as follows:

(d) funds shall be added to the funds collected by the commissioner for distribution in accordance with section twenty-eight hundred seven-o of this article, in the following amount: fifteen million dollars for the period beginning April first, two thousand twenty, and continuing each state fiscal year thereafter.

§ 4. Subdivision 1 of section 2557 of the public health law, as amended by section 4 of part C of chapter 1 of the laws of 2002, is amended to read as follows:

1. The approved costs for an eligible child who receives an evaluation and early intervention services pursuant to this title shall be a charge upon the municipality wherein the eligible child resides or, where the services are covered by the medical assistance program, upon the social services district of fiscal responsibility with respect to those eligible children who are also eligible for medical assistance. All approved costs shall be paid in the first instance and at least quarterly by the appropriate governing body or officer of the municipality upon vouchers presented and audited in the same manner as the case of other claims against the municipality. Notwithstanding the insurance law or regulations thereunder relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made pursuant to this title. Notwithstanding the insurance law or any other law or agreement to the contrary, benefits under this title shall be considered secondary to [~~any plan of insurance or state government benefit~~] the medical assistance program under which an eligible child may have coverage. [~~Nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of this title.~~]

§ 5. Subdivision 2 of section 2557 of the public health law, as amended by section 9-a of part A of chapter 56 of the laws of 2012, is amended to read as follows:

2. The department shall reimburse the approved costs paid by a municipality for the purposes of this title, other than those reimbursable by the medical assistance program [~~or by third party payors~~], in an amount

of fifty percent of the amount expended in accordance with the rules and regulations of the commissioner; provided, however, that in the discretion of the department and with the approval of the director of the division of the budget, the department may reimburse municipalities in an amount greater than fifty percent of the amount expended. Such state reimbursement to the municipality shall not be paid prior to April first of the year in which the approved costs are paid by the municipality, provided, however that, subject to the approval of the director of the budget, the department may pay such state aid reimbursement to the municipality prior to such date.

§ 6. The section heading of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

[~~Third party insurance and medical~~] **Medical** assistance program payments.

§ 7. Subdivision 3 of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, paragraphs (a), (c) and (d) as amended by section 11 of part A of chapter 56 of the laws of 2012 and paragraph (b) as further amended by section 104 of part A of chapter 62 of the laws of 2011, is amended to read as follows:

3. (a) [~~Providers of evaluations and early intervention services, hereinafter collectively referred to in this subdivision as "provider" or "providers", shall in the first instance and where applicable, seek payment from all third party payors including governmental agencies prior to claiming payment from a given municipality for evaluations conducted under the program and for services rendered to eligible children, provided that, the obligation to seek payment shall not apply to a payment from a third party payor who is not prohibited from applying such payment, and will apply such payment, to an annual or lifetime limit specified in the insured's policy.~~

~~(i) Parents shall provide the municipality and service coordinator information on any insurance policy, plan or contract under which an eligible child has coverage.~~

~~(ii)~~] Parents shall provide the municipality and the service coordinator with a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of early intervention services.

[~~(iii) providers~~] **(b) Providers** shall utilize the department's fiscal agent and data system for claiming payment for evaluations and services rendered under the early intervention program.

[~~(b) The commissioner, in consultation with the director of budget and the superintendent of financial services, shall promulgate regulations providing public reimbursement for deductibles and copayments which are imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.~~

~~(c) Payments made for early intervention services under an insurance policy or health benefit plan, including payments made by the medical assistance program or other governmental third party payor, which are provided as part of an IFSP pursuant to section twenty-five hundred forty-five of this title shall not be applied by the insurer or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan, pursuant to section eleven of the chapter of the laws of nineteen hundred ninety-two which added this title.~~

~~(d)~~] **(c)** A municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or

for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from [~~third party reimbursement~~] **the medical assistance program**. The provider shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided [~~under any health insurance policy or health benefits plan~~] prior to receipt of written notice of the exercise of subrogation rights [~~by the insurer or plan administrator providing such benefits~~]. **Notwithstanding any inconsistent provision of this title, except as provided for herein, no third party payor other than the medical assistance program shall be required to reimburse for early intervention services provided under this title.**

§ 8. Subdivision 3 of section 2543 of the public health law is REPEALED.

§ 9. Section 3235-a of the insurance law is REPEALED.

§ 10. Subparagraph (F) of paragraph 25 of subsection (i) of section 3216 of the insurance law is REPEALED.

§ 11. Subparagraph (F) of paragraph 17 of subsection (1) of section 3221 of the insurance law is REPEALED.

§ 12. Paragraph 6 of subsection (ee) of section 4303 of the insurance law is REPEALED.

§ 13. This act shall take effect January 1, 2020; provided, however, that the amendments to section 2807-s of the public health law made by sections two and three of this act shall not affect the expiration of such section and shall be deemed to expire therewith. 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 by the commissioner of health, on or before such effective date.

PART JJ

Section 1. Subdivision 26 of section 206 of the public health law, as amended by section 127-t of subpart B of part C of chapter 62 of the laws of 2011, is amended and a new subdivision 26-a is added to read as follows:

26. **(a)** The commissioner [~~is hereby authorized and directed to~~]**, in consultation with the commissioner of alcoholism and substance use services in relation to subparagraph (viii) of this paragraph, shall** review any policy or practice instituted in facilities operated by the department of corrections and community supervision, and in all local correctional facilities, as defined in subdivision sixteen of section two of the correction law, regarding**:**

(i) human immunodeficiency virus (HIV)[~~,~~] **and** acquired immunodeficiency syndrome (AIDS), [~~and~~] **including the prevention and transmission of HIV and the treatment of AIDS;**

(ii) hepatitis C (HCV) including the prevention of the transmission of [~~HIV and HCV and the treatment of AIDS, HIV and~~] HCV [~~among inmates~~]**;**

(iii) women's health;

(iv) transgender health;

(v) chronic health conditions including but not limited to asthma, diabetes, and heart disease;

(vi) health care services for individuals fifty years of age or older;

(vii) discharge planning of health care services including planning for discharges requiring residential placement or long-term care services; and

(viii) substance use disorders.

(b) Such [~~review~~] reviews shall be performed annually and shall focus on whether such [~~HIV, AIDS or HCV policy~~] policies or [~~practice is~~] practices are consistent with current, generally accepted medical standards and procedures [~~used to prevent the transmission of HIV and HCV and to treat AIDS, HIV and HCV among the general public~~]. In performing such reviews, in order to determine the quality and adequacy of care and treatment provided, department personnel are authorized to enter correctional facilities and inspect policy and procedure manuals and medical protocols, interview health services providers and inmate-patients, review medical grievances, and inspect a representative sample of medical records of inmates [~~known to be infected with HIV or HCV or have AIDS~~]. Prior to initiating a review of a correctional system, the commissioner shall inform the public, including patients, their families and patient advocates, of the scheduled review and invite them to provide the commissioner with relevant information.

(c) Upon the completion of such review, the department shall, in writing, approve such policy or practice as instituted in facilities operated by the department of corrections and community supervision, and in any local correctional facility, or, based on specific, written recommendations, direct the department of corrections and community supervision, or the authority responsible for the provision of medical care to inmates in local correctional facilities to prepare and implement a corrective plan to address deficiencies in areas where such policy or practice fails to conform to current, generally accepted medical standards and procedures. The commissioner shall monitor the implementation of such corrective plans and shall conduct such further reviews as the commissioner deems necessary to ensure that identified deficiencies in [~~HIV, AIDS and HCV~~] policies and practices are corrected. All written reports pertaining to reviews provided for in this subdivision shall not contain individual patient identifying information and shall be [~~maintained, under such conditions as the commissioner shall prescribe, as~~] public information [~~available for public inspection~~] and shall be posted on the department's website.

26-a. (a) The department, in consultation with the department of corrections and community supervision, shall biennially study health care staffing in facilities operated by the department of corrections and community supervision and in local correctional facilities as defined in subdivision sixteen of section two of the correction law. The study shall examine:

(i) adequacy of staffing, including in specialties such as women's, transgender, and geriatric health care;

(ii) potential challenges such as salary adequacy or geographic factors; and

(iii) impact of staffing levels on availability of services.

(b) The first such study shall be completed and submitted to the governor, the temporary president of the senate, and the speaker of the assembly no later than one year after the effective date of this subdivision.

§ 2. This act shall take effect immediately.

PART KK

Section 1. Subdivision 5 of section 209 of the elder law, as amended by section 1 of part S of chapter 59 of the laws of 2016, is amended to read as follows:

5. Within amounts specifically appropriated therefor and consistent with the criteria developed and required pursuant to this section the director shall approve grants to eligible applicants. Individual grants awarded for classic NORC programs shall be in amounts not to exceed [~~two~~] three hundred thousand ([~~$200,000~~] $300,000) dollars and for neighborhood NORCs not less than sixty thousand ($60,000) dollars in any twelve month period.

§ 2. This act shall take effect immediately.

PART LL

Section 1. The mental hygiene law is amended by adding a new section 13.44 to read as follows:

§ 13.44 Direct support professional credential pilot program.

(a) Subject to appropriations, the office shall implement a professional credentialing pilot program to assist and enhance the field of direct care support.

(b) The pilot program participants shall be selected by the commissioner, in consultation with the regional offices under his or her jurisdiction and the regional centers for workforce transformation. Such pilot program participants shall include individuals employed by state-operated facilities under the auspices of the office and not-for-profit providers licensed and/or certified by the office. Pilot program participants shall be geographically disbursed throughout the state, and as determined by the commissioner, in regions of the state with the greatest need.

(c) (1) When implementing the pilot program, the office shall focus on assisting individuals in the field of direct support by advancing initiatives that: (i) promote direct support work as a career, with a focus on creating opportunities for career advancement within the profession, (ii) further professionalize the field by developing advanced skills and competencies, (iii) promote the health, safety and well-being of the people being served, and (iv) enhance workforce recruitment and retention efforts, with a focus on direct support professional positions.

(2) Such initiatives shall include but not be limited to:

(i) a credentialing and education program for direct support professionals which shall utilize best practices including but not limited to New York state direct support professional competencies, certification programs offered by institutions of higher learning, and direct support professional credentialing and education initiatives in other states; and

(ii) a comprehensive training program which may include on-line training, mentorships, and support group components. To develop the training program, the pilot may utilize national direct support professional competency programs or credentialing standards and trainings.

(d) (1) There is hereby established within the office an advisory council for direct support professional credentialing, which shall advise, oversee and assist with the implementation of the pilot program established pursuant to this section.

(2) (i) The council shall consist of the commissioner or his or her designee, who shall chair the council and twenty-one additional members. Seven members shall be appointed upon the recommendation of the commis-

sioner, seven members shall be appointed upon the recommendation of the temporary president of the senate and seven members shall be appointed upon the recommendation of the speaker of the assembly. (ii) The composition of the council shall be as follows:

(A) five individuals from the direct support professional credential technical report advisory group, at least two of whom shall be not-for-profit providers of services;

(B) five individuals from the direct support professional credential technical report advisory group project staff identified by the commissioner, at least one of whom is from an institute of higher learning;

(C) six individuals from the office's regional center for workforce transformation; each individual shall represent one of the six regions covered by the regional center for workforce transformation;

(D) four direct support professionals, of whom two shall be credentialed direct support professionals; and

(E) a self-advocate or a representative of a self-advocacy association for individuals with intellectual or developmental disabilities.

(3) Members of the taskforce shall serve without compensation, but may be reimbursed for actual costs incurred for participation on such taskforce.

(4) The council shall meet at least four times in each full calendar year or at the request of the chair or commissioner.

(5) The council may establish committees as it deems necessary to particular subjects of importance related to the implementation of the pilot program.

(6) The council may consider any matter relating to initiatives advanced as part of the pilot program and shall advise and provide recommendations to the office on any such matter, including, but not limited to:

(i) ensuring the program is person-centered, accessible, applicable and relevant for people and families who reside in the state of New York; and

(ii) providing recommendations and assistance to the office to: (A) seek approval from the federal centers for Medicare and Medicaid services for the statewide credentialing program to be included in the state's 1115 demonstration waiver, as approved by the commissioner; (B) collaborate with managed care organizations to ensure the statewide credentialing program is incorporated into managed care contracts for long term services and supports; and (C) develop the report required pursuant to subdivision (e) of this section.

(e) The office in consultation with the participants of the pilot program and the advisory council established pursuant to this section, shall issue a report no later than November fifteenth, two thousand twenty-two to the governor, the temporary president of the senate, the speaker of the assembly, the assembly chair of the committee on mental health, and the senate chair of the committee on mental health and developmental disabilities, detailing the progress of the pilot program, all relevant data and information taking into consideration any privacy concerns or confidential restrictions to share such information, and recommendations which shall include but not be limited to:

(1) rate of recruitment and retention for direct support professionals of providers participating in the pilot program compared to the rate for non-participating providers;

(2) number of direct support professionals credentialed;

(3) enhancement of quality supports and services to individuals with developmental disabilities;

(4) correlation between how wage increases for credentialed individuals demonstrates commitment to the profession, leadership qualities, retention in the field, improved supports and services, and family and individual satisfaction;

(5) identified barriers to meeting the pilot programs goals and objectives and recommendations on how to eliminate such barriers; and

(6) any recommendation related to achieving a successful implementation of a statewide credentialing program including but not limited to continuing and/or expanding the operation of the credentialing pilot program or additional investment of resources required by the state.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law. 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 MM

Section 1. The executive law is amended by adding a new article 19-E to read as follows:

ARTICLE 19-E

OFFICE OF THE ADVOCATE FOR PEOPLE WITH DISABILITIES

Section 460. Legislative intent.
461. Definitions.
462. Office of the advocate for people with disabilities.
463. Director; general responsibilities.

§ 460. Legislative intent. Persons with disabilities comprise a major segment of the state of New York's population and their particular needs and concerns must be considered as an integral part of the planning and implementation of all state programs and services affecting their lives and well-being. The office of the advocate for people with disabilities shall advocate on behalf of persons with disabilities and assure that persons with disabilities are afforded the opportunity to exercise all of the rights and responsibilities accorded to citizens of this state.

§ 461. Definitions. For purposes of this article:

(a) "Persons with disabilities" shall mean any person who has a disability as defined in subdivision twenty-one of section two hundred ninety-two of this chapter.

(b) "State agency" or "state agencies" shall mean any state department, board, bureau, division, commission, committee, public authority, public corporation, council, office or other governmental entity performing a governmental or proprietary function for the state, except the judiciary or the state legislature.

§ 462. Office of the advocate for people with disabilities. (a) There is hereby established within the department of the state, an office of the advocate for people with disabilities. The office of the advocate for people with disabilities shall advise and assist state agencies in developing policies designed to help meet the needs of persons with disabilities.

(b) The office of the advocate for people with disabilities shall: (i) be the state's coordinator for the implementation of the Americans with Disabilities Act; (ii) coordinate state activities to ensure that state programs do not discriminate against and are accessible to persons with disabilities; (iii) ensure that such programs provide services to individuals with disabilities in the most integrated setting appropriate to their needs; and (iv) work with state agencies to develop legislation

and potential regulatory changes to help effectuate the duties and responsibilities required in this article, and any other changes that may significantly affect the lives of persons with disabilities in the state.

(c) The office of the advocate for people with disabilities shall, to the extent practicable, review and report to the governor upon proposed legislation and regulations. The office of the advocate for people with disabilities shall submit comments, where appropriate, to the state agency which referred such proposed legislation and regulations evaluating: (i) the impact of the proposed legislation or regulation upon persons with disabilities; (ii) the relationship and impact of such proposed legislation or regulation on existing programs affecting persons with disabilities; and (iii) any modifications that would help persons with disabilities or aid in the implementation of the new proposal. All state agencies shall cooperate with the office of the advocate for people with disabilities to ensure that the office is able to fulfill the requirements under this article.

§ 463. Director; general responsibilities. The head of the office of the advocate for people with disabilities shall be the director, who shall be appointed by the governor and receive a salary to be fixed by the governor within the amounts appropriated therefor. The director, subject to rules prescribed by the governor, may appoint and fix the compensation of employees of the office within the amounts appropriated therefor.

§ 2. Subdivisions 1 and 2 of section 702 of the executive law, as added by chapter 551 of the laws of 2002, are amended to read as follows:

1. The most integrated setting coordinating council is hereby created within the executive department to have and exercise the functions, powers and duties provided by the provisions of this article and any other provision of law. The council shall be comprised of the commissioners of: the department of health, the office of mental retardation and developmental disabilities, the office of mental health, the department of transportation, the office of children and family services, the office of alcohol and substance abuse services, the department of education, and the division of housing and community renewal. In addition, the council shall consist of the director of the office for the aging, [~~a representative from~~] the director of the office of the advocate for [~~persons~~] people with disabilities, [~~a representative from the commission on quality of care for the mentally disabled,~~] three consumers of services for individuals with disabilities, one to be appointed by the governor, one to be appointed by the temporary president of the senate, and one to be appointed by the speaker of the assembly, three individuals with expertise in the field of community services for people of all ages with disabilities, one to be appointed by the governor, one to be appointed by the temporary president of the senate, and one to be appointed by the speaker of the assembly, and three individuals with expertise in or recipients of services available to senior citizens with disabilities, one to be appointed by the governor, one to be appointed by the temporary president of the senate, and one to be appointed by the speaker of the assembly.

2. The [~~commissioners of the department of health, the office of mental health, the office of mental retardation and developmental disabilities, and the director of the office for the aging~~] director of the office of the advocate for people with disabilities shall [~~rotate~~] serve as chairperson of the council [~~on a quarterly basis~~].

§ 3. This act shall take effect April 1, 2020.

PART NN

Section 1. Subdivision 2 of section 242 of the elder law, as amended by section 12 of part A of chapter 60 of the laws of 2014, is amended to read as follows:

2. Persons eligible for catastrophic coverage under section two hundred forty-eight of this title shall include:

(a) any unmarried resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand one, is more than twenty thousand and less than or equal to [~~seventy-five thousand~~] **one hundred one thousand two hundred fifty** dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

(b) any married resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person's spouse beginning on or after January first, two thousand one, is more than twenty-six thousand dollars and less than or equal to one hundred **thirty-five** thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

§ 2. This act shall take effect immediately.

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

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