

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:

1 Section 1. This act enacts into law major components of legislation
2 which are necessary to implement the state fiscal plan for the 2019-2020
3 state fiscal year. Each component is wholly contained within a Part
4 identified as Parts A through NN. The effective date for each particular
5 provision contained within such Part is set forth in the last section of
6 such Part. Any provision in any section contained within a Part,
7 including the effective date of the Part, which makes a reference to a
8 section "of this act", when used in connection with that particular
9 component, shall be deemed to mean and refer to the corresponding
10 section of the Part in which it is found. Section three of this act sets
11 forth the general effective date of this act.

12 PART A

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

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

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

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

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

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

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

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

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

52 ~~(c) [In the event that the commissioner and the manufacturer have~~
53 ~~previously agreed to a supplemental rebate for a drug pursuant to para-~~
54 ~~graph (b) of this subdivision or paragraph (e) of subdivision seven of~~
55 ~~section three hundred sixty-seven-a of the social services law, the drug~~
56 ~~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 (e)] of this subdivision [and shall take into consideration whether the manufacturer of the drug is providing significant discounts relative to other drugs covered by the Medicaid program].~~

~~(e)] (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

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

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

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

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

14 (ii) information supplied by the department relevant to the pricing of
15 the drug so long as any third party supplying information to the depart-
16 ment or the board does not receive funding from the pharmaceutical
17 industry or health insurance industry and did not receive such informa-
18 tion from a third party that receives funding from the pharmaceutical
19 industry or health insurance industry;

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

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

30 (v) the extent of utilization of the drug;

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

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

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

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

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

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

50 § 7. Intentionally omitted.

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

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

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

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

25 8. The commissioner shall report by [~~February~~] July first annually to
26 the drug utilization review board on savings achieved through the drug
27 cap in the last fiscal year. Such report shall provide data on what
28 savings were achieved through actions pursuant to subdivisions three,
29 five and seven of this section, respectively, and what savings were
30 achieved through other means and how such savings were calculated and
31 implemented.

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

34 10. (a) Any contract, contract renewal, or other arrangement entered
35 into by a health care plan for pharmacy benefit management services on
36 behalf of individuals enrolled in a managed care provider as defined in
37 section three hundred sixty-four-j of the social services law subsequent
38 to the effective date of this subdivision shall include provisions that
39 ensure the following:

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

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

50 (iii) The pharmacy benefit manager shall not retain any portion of
51 spread pricing. For purposes of this subdivision "spread pricing" means
52 any amount charged or claimed by the pharmacy benefit manager in excess
53 of the amount paid to pharmacies on behalf of the health care plan less
54 an administrative fee as described in this paragraph. Any such excess
55 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

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

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

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

13 p. the amendments [~~made~~] to subparagraph [~~(7)~~] 7 of paragraph (b) of
14 subdivision 1 of section 366 of the social services law made by section
15 one of this act shall expire and be deemed repealed October 1, [~~2019~~]
16 2021.

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

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

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

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

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

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

34 § 3. This act shall take effect immediately, provided, however, that
35 subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of
36 1973, as added by section one of this act, shall expire and be deemed
37 repealed June 30, [~~2019~~] 2021; and provided further, however, that the
38 expiration and repeal of such subdivision 15-a shall not affect or
39 impair in any manner any health facilities bonds issued, or any lease or
40 purchase of a health facility executed, pursuant to such subdivision
41 15-a prior to its expiration and repeal and that, with respect to any
42 such bonds issued and outstanding as of June 30, [~~2019~~] 2021, the
43 provisions of such subdivision 15-a as they existed immediately prior to
44 such expiration and repeal shall continue to apply through the latest
45 maturity date of any such bonds, or their earlier retirement or redemp-
46 tion, for the sole purpose of authorizing the issuance of refunding
47 bonds to refund bonds previously issued pursuant thereto.

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

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

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

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

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

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

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

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

28 (i) the amendments to paragraph (b) and subparagraph (i) of paragraph
29 (g) of subdivision 7 of section 4403-f of the public health law made by
30 section forty-one-b of this act shall expire and be repealed April 1,
31 [~~2019~~] 2021;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of such ambulatory behavioral health fees to providers available under
2 this section shall be for all rate periods on and after the effective
3 date of section ~~[29]~~ 1 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of
4 ~~[2016]~~ 2017 through March 31, ~~[2020]~~ 2021 for patients in the city of
5 New York, for all rate periods on and after the effective date of
6 section ~~[29]~~ 1 of part ~~[B]~~ P of chapter ~~[59]~~ 57 of the laws of ~~[2016]~~
7 2017 through ~~[March 31, 2020]~~ March 31, 2021 for patients outside the
8 city of New York, and for all rate periods on and after the effective
9 date of such chapter through ~~[March 31, 2020]~~ March 31, 2021, for all
10 services provided to persons under the age of twenty-one; provided,
11 however, the commissioner of health, in consultation with the commis-
12 sioner of alcoholism and substance abuse services and the commissioner
13 of mental health, may require, as a condition of approval of such ambu-
14 latory behavioral health fees, that aggregate managed care expenditures
15 to eligible providers meet the alternative payment methodology require-
16 ments as set forth in attachment I of the New York state medicaid
17 section one thousand one hundred fifteen medicaid redesign team waiver
18 as approved by the centers for medicare and medicaid services. The
19 commissioner of health shall, in consultation with the commissioner of
20 alcoholism and substance abuse services and the commissioner of mental
21 health, waive such conditions if a sufficient number of providers, as
22 determined by the commissioner, suffer a financial hardship as a conse-
23 quence of such alternative payment methodology requirements, or if he or
24 she shall determine that such alternative payment methodologies signif-
25 icantly threaten individuals access to ambulatory behavioral health
26 services. Such waiver may be applied on a provider specific or industry
27 wide basis. Further, such conditions may be waived, as the commissioner
28 determines necessary, to comply with federal rules or regulations
29 governing these payment methodologies. Nothing in this section shall
30 prohibit managed care organizations and providers from negotiating
31 different rates and methods of payment during such periods described
32 above, subject to the approval of the department of health. The depart-
33 ment of health shall consult with the office of alcoholism and substance
34 abuse services and the office of mental health in determining whether
35 such alternative rates shall be approved. The commissioner of health
36 may, in consultation with the commissioner of alcoholism and substance
37 abuse services and the commissioner of the office of mental health,
38 promulgate regulations, including emergency regulations promulgated
39 prior to October 1, 2015 to establish rates for ambulatory behavioral
40 health services, as are necessary to implement the provisions of this
41 section. Rates promulgated under this section shall be included in the
42 report required under section 45-c of part A of this chapter.

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

behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through ~~March 31, 2020~~ March 31, 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

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

34 b. Notwithstanding any contrary provision of law, the fees paid by
35 managed care organizations licensed under article 44 of the public
36 health law or under article 43 of the insurance law, to providers
37 licensed pursuant to article 28 of the public health law or article 31
38 or 32 of the mental hygiene law, for ambulatory behavioral health
39 services provided to patients enrolled in the child health insurance
40 program pursuant to title ~~[one-A]~~ 1-A of article 25 of the public health
41 law, shall be in the form of fees for such services which are equivalent
42 to the payments established for such services under the ambulatory
43 patient group (APG) rate-setting methodology. The commissioner of health
44 shall consult with the commissioner of alcoholism and substance abuse
45 services and the commissioner of the office of mental health in deter-
46 mining such services and establishing such fees. Such ambulatory behav-
47 ioral health fees to providers available under this section shall be for
48 all rate periods on and after the effective date of this chapter through
49 March 31, ~~[2020]~~ 2021, provided, however, that managed care organiza-
50 tions and providers may negotiate different rates and methods of payment
51 during such periods described above, subject to the approval of the
52 department of health. The department of health shall consult with the
53 office of alcoholism and substance abuse services and the office of
54 mental health in determining whether such alternative rates shall be
55 approved. The report required under section 16-a of part C of chapter
56 60 of the laws of 2014 shall also include the population of patients

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

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

9 § 2. This act shall take effect immediately and shall be deemed to
10 have been in full force and effect on and after April 1, 2010, and shall
11 expire on ~~[January 1, 2018]~~ March 31, 2021.

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

17 § 10. This act shall take effect immediately and shall be deemed to
18 have been in full force and effect on and after July 1, 1996; provided,
19 however, that sections one, two and three of this act shall expire and
20 be deemed repealed on March 31, ~~[2020]~~ 2021 provided, however that the
21 amendments to section 364-j of the social services law made by section
22 four of this act shall not affect the expiration of such section and
23 shall be deemed to expire therewith and provided, further, that the
24 provisions of subdivisions 8, 9 and 10 of section 4401 of the public
25 health law, as added by section one of this act; section 4403-d of the
26 public health law as added by section two of this act and the provisions
27 of section seven of this act, except for the provisions relating to the
28 establishment of no more than twelve comprehensive HIV special needs
29 plans, shall expire and be deemed repealed on July 1, 2000.

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

34 (a) Notwithstanding any inconsistent provision of law or regulation to
35 the contrary, effective beginning August 1, 1996, for the period April
36 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,
37 1998 through March 31, 1999, August 1, 1999, for the period April 1,
38 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000
39 through March 31, 2001, April 1, 2001, for the period April 1, 2001
40 through March 31, 2002, April 1, 2002, for the period April 1, 2002
41 through March 31, 2003, and for the state fiscal year beginning April 1,
42 2005 through March 31, 2006, and for the state fiscal year beginning
43 April 1, 2006 through March 31, 2007, and for the state fiscal year
44 beginning April 1, 2007 through March 31, 2008, and for the state fiscal
45 year beginning April 1, 2008 through March 31, 2009, and for the state
46 fiscal year beginning April 1, 2009 through March 31, 2010, and for the
47 state fiscal year beginning April 1, 2010 through March 31, 2016, and
48 for the state fiscal year beginning April 1, 2016 through March 31,
49 2019, and for the state fiscal year beginning April 1, 2019 through
50 March 31, 2021, the department of health is authorized to pay public
51 general hospitals, as defined in subdivision 10 of section 2801 of the
52 public health law, operated by the state of New York or by the state
53 university of New York or by a county, which shall not include a city
54 with a population of over one million, of the state of New York, and
55 those public general hospitals located in the county of Westchester, the
56 county of Erie or the county of Nassau, additional payments for inpa-

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

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

46 PART F

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

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

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

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

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

39 (3)(a) The superintendent of financial services shall determine and
40 certify to each general hospital and to the commissioner of health the
41 cost of excess malpractice insurance for medical or dental malpractice
42 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988
43 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July
44 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,
45 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June
46 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995
47 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July
48 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,
49 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June
50 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002
51 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July
52 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,
53 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June
54 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009
55 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July
56 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and

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

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

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

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

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

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

1 the period July 1, 1993 to June 30, 1994, or covering the period July 1,
2 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,
3 1996, or covering the period July 1, 1996 to June 30, 1997, or covering
4 the period July 1, 1997 to June 30, 1998, or covering the period July 1,
5 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,
6 2000, or covering the period July 1, 2000 to June 30, 2001, or covering
7 the period July 1, 2001 to October 29, 2001, or covering the period
8 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to
9 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or
10 covering the period July 1, 2004 to June 30, 2005, or covering the peri-
11 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to
12 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or
13 covering the period July 1, 2008 to June 30, 2009, or covering the peri-
14 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to
15 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or
16 covering the period July 1, 2012 to June 30, 2013, or covering the peri-
17 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to
18 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or
19 covering the period July 1, 2016 to June 30, 2017, or covering the peri-
20 od July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to
21 June 30, 2019, or covering the period July 1, 2019 to June 30, 2020

22 shall notify a covered physician or dentist by mail, mailed to the
23 address shown on the last application for excess insurance coverage or
24 equivalent excess coverage, of the amount due to such provider from such
25 physician or dentist for such coverage period determined in accordance
26 with paragraph (a) of this subdivision. Such amount shall be due from
27 such physician or dentist to such provider of excess insurance coverage
28 or equivalent excess coverage in a time and manner determined by the
29 superintendent of financial services.

30 (c) If a physician or dentist liable for payment of a portion of the
31 costs of excess insurance coverage or equivalent excess coverage cover-
32 ing the period July 1, 1992 to June 30, 1993, or covering the period
33 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to
34 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or
35 covering the period July 1, 1996 to June 30, 1997, or covering the peri-
36 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to
37 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or
38 covering the period July 1, 2000 to June 30, 2001, or covering the peri-
39 od July 1, 2001 to October 29, 2001, or covering the period April 1,
40 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,
41 2003, or covering the period July 1, 2003 to June 30, 2004, or covering
42 the period July 1, 2004 to June 30, 2005, or covering the period July 1,
43 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,
44 2007, or covering the period July 1, 2007 to June 30, 2008, or covering
45 the period July 1, 2008 to June 30, 2009, or covering the period July 1,
46 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,
47 2011, or covering the period July 1, 2011 to June 30, 2012, or covering
48 the period July 1, 2012 to June 30, 2013, or covering the period July 1,
49 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,
50 2015, or covering the period July 1, 2015 to June 30, 2016, or covering
51 the period July 1, 2016 to June 30, 2017, or covering the period July 1,
52 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,
53 2019, or covering the period July 1, 2019 to June 30, 2020 determined in
54 accordance with paragraph (a) of this subdivision fails, refuses or
55 neglects to make payment to the provider of excess insurance coverage or
56 equivalent excess coverage in such time and manner as determined by the

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

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

38 (e) A provider of excess insurance coverage or equivalent excess
39 coverage shall refund to the hospital excess liability pool any amount
40 allocable to the period July 1, 1992 to June 30, 1993, and to the period
41 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June
42 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the
43 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to
44 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to
45 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000
46 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,
47 and to the period April 1, 2002 to June 30, 2002, and to the period July
48 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,
49 2004, and to the period July 1, 2004 to June 30, 2005, and to the period
50 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June
51 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the
52 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to
53 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to
54 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012
55 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and
56 to the period July 1, 2014 to June 30, 2015, and to the period July 1,

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

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

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

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

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

47 § 5. The superintendent of financial services and the commissioner of
48 health shall determine, no later than June 15, 2002, June 15, 2003, June
49 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,
50 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,
51 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June
52 15, 2018, [~~and~~] June 15, 2019, and June 15, 2020 the amount of funds
53 available in the hospital excess liability pool, created pursuant to
54 section 18 of chapter 266 of the laws of 1986, and whether such funds
55 are sufficient for purposes of purchasing excess insurance coverage for
56 eligible participating physicians and dentists during the period July 1,

1 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003
2 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to
3 June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June
4 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30,
5 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30,
6 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
7 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
8 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,
9 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
10 as applicable.

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

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

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

50 § 20. Notwithstanding any law, rule or regulation to the contrary,
51 only physicians or dentists who were eligible, and for whom the super-
52 intendent of financial services and the commissioner of health, or their
53 designee, purchased, with funds available in the hospital excess liabil-
54 ity pool, a full or partial policy for excess coverage or equivalent
55 excess coverage for the coverage period ending the thirtieth of June,
56 two thousand [~~eighteen~~] nineteen, shall be eligible to apply for such

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

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

22 PART G

23 Section 1. Intentionally omitted.

24 § 2. Intentionally omitted.

25 § 3. Intentionally omitted.

26 § 4. Intentionally omitted.

27 § 5. Intentionally omitted.

28 § 5-a. Subdivision 8 of section 4403-f of the public health law, as
29 amended by section 21 of part B of chapter 59 of the laws of 2016, is
30 amended to read as follows:

31 8. Payment rates for managed long term care plan enrollees eligible
32 for medical assistance. The commissioner shall establish payment rates
33 for services provided to enrollees eligible under title XIX of the
34 federal social security act. Such payment rates shall be subject to
35 approval by the director of the division of the budget and shall reflect
36 savings to both state and local governments when compared to costs which
37 would be incurred by such program if enrollees were to receive compara-
38 ble health and long term care services on a fee-for-service basis in the
39 geographic region in which such services are proposed to be provided.
40 Payment rates shall be risk-adjusted to take into account the character-
41 istics of enrollees, or proposed enrollees, including, but not limited
42 to: frailty, disability level, health and functional status, age,
43 gender, the nature of services provided to such enrollees, and other
44 factors as determined by the commissioner. The risk adjusted premiums
45 may also be combined with disincentives or requirements designed to
46 mitigate any incentives to obtain higher payment categories. In setting
47 such payment rates, the commissioner shall consider costs borne by the
48 managed care program to ensure actuarially sound and adequate rates of
49 payment to ensure quality of care shall comply with all applicable laws
50 and regulations, state and federal, including regulations as to actuari-
51 al soundness for medicaid managed care. Prior to each annual rate peri-
52 od and, to the extent practicable prior to the effective date of any
53 change in law, regulation or other state or federal mandate impacting
54 the cost of the managed care plans' operations or of the providers

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

19 § 5-b. The public health law is amended by adding a new section 3614-f
20 to read as follows:

21 § 3614-f. Payments for home and community based long term care
22 services. The payment of claims submitted under contracts or agreements
23 with insurers under the medical assistance program for home and communi-
24 ty based long term care services provided under this article or by
25 fiscal intermediaries operating pursuant to section three hundred
26 sixty-five-f of the social services law shall provide that any funds
27 appropriated to compensate for minimum wage pursuant to section six
28 hundred fifty-two of the labor law shall be provided by insurers in
29 amendments to existing contracts with home and community based long term
30 care services providers under this article and to fiscal intermediaries
31 operating pursuant to section three hundred sixty-five-f of the social
32 services law at least ninety days prior to the effective date of any
33 such law or regulation impacting wages. Insurers shall provide such
34 funds in an amount that supplements any current contracts or agreements
35 and shall not use such funds to supplant payments for existing services
36 under the Medicaid program. Such insurers shall include but not be
37 limited to Medicaid managed care plans and Medicaid managed long term
38 care plans.

39 § 5-c. Paragraph (b) of subdivision 10 of section 3614 of the public
40 health law, as amended by section 5 of part C of chapter 109 of the laws
41 of 2006, is amended and a new paragraph (e) is added to read as follows:

42 (b) Programs which have their rates adjusted pursuant to this subdivi-
43 sion shall use such funds solely for the purposes of recruitment, train-
44 ing and retention of non-supervisory home care services workers or other
45 personnel with direct patient care responsibility. Such purpose shall
46 include the recruitment, training and retention of non-supervisory home
47 care services workers or any worker with direct patient care responsi-
48 bility employed in licensed home care services agencies under contract
49 with such agencies. Such agencies are prohibited from using such fund
50 for any other purpose. For purposes of the long term home health care
51 program, such payment shall be treated as supplemental payments and not
52 effect any current cost cap requirement. For purposes of the managed
53 long term care program, plans shall distribute such funds in their
54 entirety using a reasonable methodology. Such payments shall be supple-
55 mental to reimbursement rates, and plans shall provide written notifica-
56 tion to each contracted agency indicating the amount of funds disbursed

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

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

22 § 5-d. Subdivision 12 of section 366-a of the social services law, as
23 added by section 36-c of part B of chapter 57 of the laws of 2015, is
24 amended to read as follows:

25 12. The commissioner shall develop expedited procedures for determin-
26 ing medical assistance eligibility for any medical assistance applicant
27 with an immediate need for personal care or consumer directed personal
28 assistance services pursuant to paragraph (e) of subdivision two of
29 section three hundred sixty-five-a of this title or section three
30 hundred sixty-five-f of this title, respectively, and hospice. Such
31 procedures shall require that a final eligibility determination be made
32 within seven days of the date of a complete medical assistance applica-
33 tion.

34 § 5-e. Subdivision 31 of section 364-j of the social services law, as
35 added by section 36-b of part B of chapter 57 of the laws of 2015, is
36 amended to read as follows:

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

48 § 5-f. Subparagraph (ii) of paragraph (k) of subdivision 3 of section
49 461-l of the social services law, as added by section 2 of part B of
50 chapter 57 of the laws of 2018, is amended to read as follows:

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

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

3 § 5-g. Paragraph (m) of subdivision 3 of section 461-1 of the social
4 services law, as added by section 2 of part B of chapter 57 of the laws
5 of 2018, is amended to read as follows:

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

11 § 5-h. Workgroup on case mix adjustments for residential health care
12 facilities. The commissioner of health shall convene and chair a work-
13 group on case mix adjustments to Medicaid rates of payment for residen-
14 tial health care facilities. The workgroup shall be comprised of resi-
15 dential health care facilities or representatives from such facilities,
16 representatives from the statewide associations and other such experts
17 on case mix as required by the commissioner. The workgroup shall review
18 recent case mix data and related analyses conducted by the department,
19 the department's Minimum Data Set (MDS) census collection process and
20 case mix adjustments authorized under subdivision 2-c of section twen-
21 ty-eight hundred eight of the public health law. Such review shall seek
22 to promote a higher degree of accuracy in the MDS data, reduce audit
23 findings and target abuses. The workgroup shall offer recommendations on
24 how to improve accuracy in the MDS census collection process, reduce
25 audit findings and reduce or eliminate abusive practices. In developing
26 its recommendations, the workgroup shall ensure that the census
27 collection process and case mix adjustment continues to recognize the
28 need to adjust rates for residential health care facilities that serve
29 high-need residents. The workgroup shall also consider any changes in
30 federal law and regulations relating to nursing home reimbursement,
31 including adoption of the patient driven payment model, and administra-
32 tive complexity in revising the census collection and rate promulgation
33 processes. The commissioner and department of health shall be prohibited
34 from reducing or recouping case mix adjustments for periods prior to the
35 implementation of the workgroup recommendations; provided, such limita-
36 tion shall not apply to audits by the Office of the Medicaid Inspector
37 General, audits conducted by the department of health, or in cases of
38 fraud or abuse. The workgroup shall report its recommendations no later
39 than July first, two thousand nineteen. Such recommendations shall be
40 adopted by the commissioner on a prospective basis and rely on assess-
41 ment data submitted no earlier than such adoption; however, any rate
42 adjustments based on the recommendations of the workgroup shall be
43 implemented only after such adjustments are approved by an independent
44 actuary, and in no event shall such adjustments result in a reduction in
45 rates of over \$122 million in state-share funds.

46 § 5-i. Subdivision 31 of section 364-j of the social services law is
47 amended by adding a new paragraph (b) to read as follows:

48 (b) Prior to any managed long-term care payment reduction related to
49 personal care services, the commissioner shall promulgate regulations
50 allowing utilization management of personal care services in accordance
51 with a recipient's plan of treatment that will realize corresponding
52 cost reductions in personal care services. The regulations shall not be
53 adopted, nor shall a related payment reduction occur, until it is deter-
54 mined by an independent actuary that the regulations will achieve cost
55 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 29PHARMACY BENEFIT MANAGERSSection 2901. Definitions.

2902. Acting without a registration.

2903. Registration requirements for pharmacy benefit managers.

2904. Reporting requirements for pharmacy benefit managers.

2905. Acting without a license.

2906. Licensing of a pharmacy benefit manager.

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

2908. Penalties for violations.

2909. Stay or suspension of superintendent's determination.

2910. Revoked 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:

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

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

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

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

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

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

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

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

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

52 § 2903. Registration requirements for pharmacy benefit managers. (a)
53 Every pharmacy benefit manager that performs pharmacy benefit management
54 services prior to January first, two thousand twenty-one shall register
55 with the superintendent in a manner acceptable to the superintendent,
56 and shall pay a fee of two thousand dollars for each year or fraction of

1 a year in which the registration shall be valid. The superintendent, in
2 consultation with the commissioner of health, may establish, by regu-
3 lation, minimum registration standards required for a pharmacy benefit
4 manager. The superintendent can reject a registration application filed
5 by a pharmacy benefit manager that fails to comply with the minimum
6 registration standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 (5) protection of consumers.

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

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

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

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

1 the superintendent a written application therefor in such form or forms
2 and supplements thereto as the superintendent prescribes, and pay a fee
3 of two thousand dollars for each year or fraction of a year in which a
4 license shall be valid.

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

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

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

28 (f) The superintendent may refuse to issue a pharmacy benefit manag-
29 er's license if, in the superintendent's judgment, the applicant or any
30 member, principal, officer or director of the applicant, is not trust-
31 worthy and competent to act as or in connection with a pharmacy benefit
32 manager, or that any of the foregoing has given cause for revocation or
33 suspension of such license, or has failed to comply with any prerequi-
34 site for the issuance of such license.

35 (g) Licensees and applicants for a license under this section shall be
36 subject to examination by the superintendent as often as the superinten-
37 dent may deem it expedient. The superintendent may promulgate regu-
38 lations establishing methods and procedures for facilitating and verify-
39 ing compliance with the requirements of this section and such other
40 regulations as necessary.

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

47 § 2907. Revocation or suspension of a registration or license of a
48 pharmacy benefit manager. (a) The superintendent may refuse to renew,
49 may revoke, or may suspend for a period the superintendent determines
50 the registration or license of any pharmacy benefit manager if, after
51 notice and hearing, the superintendent determines that the registrant or
52 licensee or any member, principal, officer, director, or controlling
53 person of the registrant or licensee, has:

54 (1) violated any insurance laws, section two hundred eighty-a of the
55 public health law, or violated any regulation, subpoena or order of the

1 superintendent or of another state's insurance commissioner, or has
2 violated any law in the course of his or her dealings in such capacity;

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

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

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

9 (B) demonstrated incompetence;

10 (C) demonstrated untrustworthiness; or

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

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

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

18 (7) been convicted of a felony;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49 § 2911. Change of address. A registrant or licensee under this article
50 shall inform the superintendent by a means acceptable to the superinten-
51 dent of a change of address within thirty days of the change.

52 § 2912. Applicability of other laws. Nothing in this article shall be
53 construed to exempt a pharmacy benefit manager from complying with the
54 provisions of articles twenty-one and forty-nine of this chapter and
55 article forty-nine of the public health law or any other provision of
56 this chapter or the financial services law.

1 § 2913. Assessments. Pharmacy benefit managers that file a registra-
2 tion with the department or are licensed by the department shall be
3 assessed by the superintendent for the operating expenses of the depart-
4 ment that are solely attributable to regulating such pharmacy benefit
5 managers in such proportions as the superintendent shall deem just and
6 reasonable.

7 § 2914. Duty, accountability and transparency. (a) The pharmacy bene-
8 fit manager shall have a fiduciary relationship with and obligation to
9 the health insurer and shall perform pharmacy benefit management
10 services with care, skill, prudence, diligence, and professionalism.

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

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

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

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

34 (f) Any information required to be disclosed by a pharmacy benefit
35 manager to a health insurer under this section that is reasonable desig-
36 nated by the pharmacy benefit manager as proprietary or trade secret
37 information shall be kept confidential by the health insurer, except as
38 required or permitted by law, including disclosure necessary to prose-
39 cute or defend any legitimate legal claim or cause of action.

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

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

47 5. A pharmacy benefit manager may not substitute or cause the substi-
48 tuting of one prescription drug for another in dispensing a prescription
49 or alter or cause the altering of the term of a prescription, except
50 with approval of the prescriber or as explicitly required or permitted
51 by law.

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

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

1 section one thousand two hundred fourteen, one thousand two hundred
2 seventeen, one thousand two hundred twenty, one thousand three hundred
3 thirteen, subparagraph (B) of paragraph two of subsection (i) of section
4 one thousand three hundred twenty-two, subparagraph (B) of paragraph two
5 of subsection (i) of section one thousand three hundred twenty-four, two
6 thousand one hundred two, two thousand one hundred seventeen, two thou-
7 sand one hundred twenty-two, two thousand one hundred twenty-three,
8 subsection (p) of section two thousand three hundred thirteen, section
9 two thousand three hundred twenty-four, two thousand five hundred two,
10 two thousand five hundred three, two thousand five hundred four, two
11 thousand six hundred one, two thousand six hundred two, two thousand six
12 hundred three, two thousand six hundred four, two thousand six hundred
13 six, two thousand seven hundred three, two thousand nine hundred two,
14 two thousand nine hundred five, three thousand one hundred nine, three
15 thousand two hundred twenty-four-a, three thousand four hundred twenty-
16 nine, three thousand four hundred thirty-three, paragraph seven of
17 subsection (e) of section three thousand four hundred twenty-six, four
18 thousand two hundred twenty-four, four thousand two hundred twenty-five,
19 four thousand two hundred twenty-six, seven thousand eight hundred nine,
20 seven thousand eight hundred ten, seven thousand eight hundred eleven,
21 seven thousand eight hundred thirteen, seven thousand eight hundred
22 fourteen and seven thousand eight hundred fifteen of this chapter; or
23 section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one
24 hundred five of the penal law.

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

27 PART J

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

41 SUBPART A

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

44 (t) (1) Any insurer that delivers or issues for delivery in this state
45 hospital, surgical or medical expense group policies in the small group
46 or large group market shall offer to any employer in this state all such
47 policies in the applicable market, and shall accept at all times
48 throughout the year any employer that applies for any of those policies.
49 (2) The requirements of paragraph one of this subsection shall apply
50 with respect to an employer that applies for coverage either directly
51 from the insurer or through an association or trust to which the insurer
52 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]~~

1 ~~percent of such eligible employees or, if less, fifty or more~~ shall not
2 require a minimum number or minimum percentage of such employees be
3 insured when ~~such~~ the policy is providing coverage for group hospital,
4 medical, major medical or similar comprehensive types of expense reim-
5 bursed insurance and, for all other types of group accident and health
6 insurance, ~~must~~ the policy shall insure a minimum of fifty percent or
7 five of such eligible employees, whichever is fewer.

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

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

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

20 § 7. Paragraph 1 of subsection (d) of section 4317 of the insurance
21 law, as amended by section 72 of part D of chapter 56 of the laws of
22 2013, is amended to read as follows:

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

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

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

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

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

55 § 10. Section 4413 of the insurance law is amended by adding a new
56 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

1 article five of the social services law, title eleven-D of article five
2 of the social services law, title one-A of article twenty-five of [~~the~~
3 ~~public health law~~] this chapter or title eighteen of the federal Social
4 Security Act, and, further provided, that such health maintenance organ-
5 ization shall not discontinue a contract for an individual receiving
6 comprehensive-type coverage in effect prior to January first, two thou-
7 sand four who is ineligible to purchase policies offered after such date
8 pursuant to this section or section four thousand three hundred [~~twen-~~
9 ~~ty-two of this article~~] twenty-eight of the insurance law due to the
10 provision of 42 U.S.C. 1395ss in effect prior to January first, two
11 thousand four. [~~Subject to the creditable coverage requirements of~~
12 ~~subsection (a) of section four thousand three hundred eighteen of the~~
13 ~~insurance law, the organization may, as an alternative to the use of a~~
14 ~~pre-existing condition provision, elect to offer contracts without a~~
15 ~~pre-existing condition provision to such groups but may require that~~
16 ~~coverage shall not become effective until after a specified affiliation~~
17 ~~period of not more than sixty days after the application for coverage is~~
18 ~~submitted. The organization is not required to provide health care~~
19 ~~services or benefits during such period and no premium shall be charged~~
20 ~~for any coverage during the period. After January first, nineteen~~
21 ~~hundred ninety six, all individual direct payment contracts shall be~~
22 ~~issued only pursuant to sections four thousand three hundred twenty one~~
23 ~~and four thousand three hundred twenty two of the insurance law. Such~~
24 ~~contracts may not, with respect to an eligible individual (as defined in~~
25 ~~section 2741(b) of the federal Public Health Service Act, 42 U.S.C. §~~
26 ~~300gg-41(b), impose any pre-existing condition exclusion.]~~

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

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

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

36 SUBPART B

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

40 (A) Any family policy providing hospital or surgical expense insurance
41 (but not including such insurance against accidental injury only) shall
42 provide that, in the event such insurance on any person, other than the
43 policyholder, is terminated because the person is no longer within the
44 definition of the family as set forth in the policy but before such
45 person has attained the limiting age, if any, for coverage of adults
46 specified in the policy, such person shall be entitled to have issued to
47 that person by the insurer, without evidence of insurability, upon
48 application therefor and payment of the first premium, within sixty days
49 after such insurance shall have terminated, an individual conversion
50 policy that contains the essential health benefits package described in
51 paragraph [~~one~~] three of subsection [~~(b)~~] (f) of section [~~four thousand~~
52 ~~three hundred twenty eight of this chapter. The insurer shall offer one~~
53 ~~policy at each level of coverage as defined in section 1302(d) of the~~
54 ~~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]~~.

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

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

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

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

25 (l) [~~On and after October first, two thousand thirteen, an~~] An insurer
26 shall not offer individual hospital, medical or surgical expense insur-
27 ance policies unless the policies meet the requirements of subsection
28 (b) of section four thousand three hundred twenty-eight of this chapter.
29 Such policies that are offered within the health benefit exchange estab-
30 lished [~~pursuant to section 1311 of the affordable care act, 42 U.S.C. §~~
31 ~~18031, or any regulations promulgated thereunder,~~] by this state also
32 shall meet any requirements established by the health benefit exchange.

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

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

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

49 § 3217-i. Essential health benefits package and limit on cost-sharing.
50 (a) For purposes of this article, "essential health benefits" shall mean
51 the following categories of benefits:

- 52 (1) ambulatory patient services;
53 (2) emergency services;
54 (3) hospitalization;
55 (4) maternity and newborn care;

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

3 (6) prescription drugs;

4 (7) rehabilitative and habilitative services and devices;

5 (8) laboratory services;

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

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

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

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

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

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

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

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

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

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

48 (d) Every individual or group accident and health insurance policy
49 that provides hospital, surgical, or medical expense coverage and is not
50 a grandfathered health plan, and every student accident and health
51 insurance policy shall limit the insured's cost-sharing for in-network
52 services in a policy year to not more than the maximum out-of-pocket
53 amount determined by the superintendent for all policies subject to this
54 section. Such amount shall not exceed any annual out-of-pocket limit on
55 cost-sharing set by the United States secretary of health and human
56 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 electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein [~~or which~~], contain modified protein, or are amino acid based [~~which~~] that are medically necessary[~~, and such coverage for such modified solid food~~]

~~products for any calendar year or for any continuous period of twelve months for any insured individual shall not exceed two thousand five hundred dollars~~].

§ 15. 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-~~

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

3 § 23. Intentionally omitted.

4 § 24. Intentionally omitted.

5 § 25. Intentionally omitted.

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

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

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

25 (y) Every contract ~~[which]~~ that provides coverage for prescription
26 drugs shall include coverage for the cost of enteral formulas for home
27 use, whether administered orally or via tube feeding, for which a physi-
28 cian or other licensed health care provider legally authorized to
29 prescribe under title eight of the education law has issued a written
30 order. Such written order shall state that the enteral formula is clear-
31 ly medically necessary and has been proven effective as a disease-spe-
32 cific treatment regimen. Specific diseases and disorders for which
33 enteral formulas have been proven effective shall include, but are not
34 limited to, inherited diseases of amino-acid or organic acid metabolism;
35 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
36 motility such as chronic intestinal pseudo-obstruction; and multiple,
37 severe food allergies including, but not limited to immunoglobulin E and
38 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
39 food protein induced enterocolitis syndrome; eosinophilic disorders; and
40 impaired absorption of nutrients caused by disorders affecting the
41 absorptive surface, function, length, and motility of the gastrointesti-
42 nal tract. Enteral formulas ~~[which]~~ that are medically necessary and
43 taken under written order from a physician for the treatment of specific
44 diseases shall be distinguished from nutritional supplements taken elec-
45 tively. Coverage for certain inherited diseases of amino acid and organ-
46 ic acid metabolism as well as severe protein allergic conditions shall
47 include modified solid food products that are low protein, ~~[or which]~~
48 contain modified protein, or are amino acid based ~~[which]~~ that are
49 medically necessary~~[, and such coverage for such modified solid food~~
50 ~~products for any calendar year or for any continuous period of twelve~~
51 ~~months for any insured individual shall not exceed two thousand five~~
52 ~~hundred dollars].~~

53 § 28. Intentionally omitted.

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

(11) 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

1 ~~[one]~~ three of subsection ~~[(b)]~~ (f) of section four thousand three
2 hundred ~~[twenty-eight]~~ six-h of this ~~[chapter]~~ article by another corpo-
3 ration, insurer or health maintenance organization within the corpo-
4 ration's same holding company system, as defined in article fifteen of
5 this chapter.

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

9 (1) (A) If any such contract is terminated in accordance with the
10 provisions of paragraph one of subsection (c) of this section, or any
11 such contract is terminated because of a default by the remitting agent
12 in the payment of premiums not cured within the grace period and the
13 remitting agent has not replaced the contract with similar and contin-
14 uous coverage for the same group whether insured or self-insured, or any
15 such contract is terminated in accordance with the provisions of subpar-
16 agraph (E) of paragraph two of subsection (c) of this section, or if an
17 individual other than the contract holder is no longer covered under a
18 "family contract" because the individual is no longer within the defi-
19 nition set forth in the contract, or a spouse is no longer covered under
20 the contract because of divorce from the contract holder or annulment of
21 the marriage, or any such contract is terminated because of the death of
22 the contract holder, then such individual, former spouse, or in the case
23 of the death of the contract holder the surviving spouse or other depen-
24 dents of the deceased contract holder covered under the contract, as the
25 case may be, shall be entitled to convert, without evidence of insura-
26 bility, upon application therefor and the making of the first payment
27 thereunder within sixty days after the date of termination of such
28 contract, to a contract that contains the essential health benefits
29 package described in paragraph ~~[one]~~ three of subsection ~~[(b)]~~ (f) of
30 section four thousand three hundred ~~[twenty-eight]~~ six-h of this ~~[chap-~~
31 ~~ter]~~ article.

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

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

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

49 (1) ~~[On and after October first, two thousand thirteen, a]~~ A corpo-
50 ration shall not offer individual hospital, medical, or surgical expense
51 insurance contracts unless the contracts meet the requirements of
52 subsection (b) of section four thousand three hundred twenty-eight of
53 this article. Such contracts that are offered within the health benefit
54 exchange established ~~[pursuant to section 1311 of the affordable care~~
55 ~~act, 42 U.S.C. § 18031, or any regulations promulgated thereunder,]~~ by
56 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

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

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

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

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

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

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

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

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

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

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

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

49 (f) For purposes of this section:

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

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

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

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

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

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

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

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

(c) In addition to or in lieu of the individual enrollee direct payment contracts required under this section, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article may offer individual enrollee direct payment contracts within the health benefit exchange established ~~[pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031, or any regulations promulgated thereunder]~~ by this state, subject to any requirements established by the health benefit exchange. If a health maintenance organization satisfies the requirements of subsection (a) of this section by offering individual enrollee direct payment contracts, only within the health benefit exchange, the health maintenance organization, not including a holder of a special purpose certificate of authority issued pursuant to section four thousand four hundred three-a of the public health law, shall also offer at least one individual enrollee direct payment contract at each level of coverage as defined in subsection (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 (1) 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49 § 4329. Prescription drug coverage. (a) Every corporation subject to
50 the provisions of this article that issues a contract that provides
51 coverage for prescription drugs shall, with respect to the prescription
52 drug coverage, publish an up-to-date, accurate, and complete list of all
53 covered prescription drugs on its formulary drug list, including any
54 tiering structure that it has adopted and any restrictions on the manner
55 in which a prescription drug may be obtained, in a manner that is easily
56 accessible to insureds and prospective insureds. The formulary drug list

1 shall clearly identify the preventive prescription drugs that are avail-
2 able without annual deductibles or coinsurance, including co-payments.

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

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

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

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

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

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

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

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

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

53 (5) (A) If a corporation denies a request for an exception under para-
54 graph two or three of this subsection, the insured, the insured's desig-
55 nee, or the insured's prescribing health care provider shall have the
56 right to request that such denial be reviewed by an external appeal

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

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

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

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

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

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

47 SUBPART E

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

50 § 2607. Discrimination because of sex or marital status. (a) No indi-
51 vidual or entity shall refuse to issue any policy of insurance, or
52 cancel or decline to renew ~~such~~ the policy because of the sex or mari-
53 tal status of the applicant or policyholder or engage in sexual stere-
54 otyping.

(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

1 are consistent with those established for other benefits within a given
2 policy.

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

10 (v) [(iii)] Coverage shall not be required to include the diagnosis and
11 treatment of infertility in connection with: (I) ~~[in vitro fertiliza-~~
12 ~~tion, gamete intrafallopian tube transfers or zygote intrafallopian tube~~
13 ~~transfers; (II)]~~ the reversal of elective sterilizations; ~~[(III)] (II)~~
14 sex change procedures; ~~[(IV)] (III)~~ cloning; or ~~[(V)] (IV)~~ medical or
15 surgical services or procedures that are deemed to be experimental in
16 accordance with clinical guidelines referenced in clause ~~[(vi)] (iv)~~ of
17 this subparagraph.

18 ~~[(vi)] (iv)~~ The superintendent, in consultation with the commissioner
19 of health, shall promulgate regulations which shall stipulate the guide-
20 lines and standards which shall be used in carrying out the provisions
21 of this subparagraph, which shall include:

22 (I) ~~[The determination of "infertility" in accordance with the stand-~~
23 ~~ards and guidelines established and adopted by the American College of~~
24 ~~Obstetricians and Gynecologists and the American Society for Reproduc-~~
25 ~~tive Medicine;~~

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

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

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

41 § 5. Paragraph 3 of subsection (s) of section 4303 of the insurance
42 law, as amended by section 2 of part K of chapter 82 of the laws of
43 2002, is amended to read as follows:

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

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

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

55 ~~[(C)] (B)~~ Coverage may be subject to co-payments, coinsurance and
56 deductibles as may be deemed appropriate by the superintendent and as

1 are consistent with those established for other benefits within a given
2 policy.

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

10 ~~(E)]~~ (C) Coverage shall not be required to include the diagnosis and
11 treatment of infertility in connection with: (i) ~~[in vitro fertiliza-~~
12 ~~tion, gamete intrafallopian tube transfers or zygote intrafallopian tube~~
13 ~~transfers; (ii)]~~ the reversal of elective sterilizations; ~~[(iii)]~~ (ii)
14 sex change procedures; ~~[(iv)]~~ (iii) cloning; or ~~[(v)]~~ (iv) medical or
15 surgical services or procedures that are deemed to be experimental in
16 accordance with clinical guidelines referenced in subparagraph ~~[(F)]~~ (D)
17 of this paragraph.

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

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

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

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

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

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

45 PART M

46 Intentionally Omitted

47 PART N

48 Intentionally Omitted

49 PART O

50 Intentionally Omitted

1 PART P

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

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

9 § 1-a. (a) Within 90 days after the date on which this act takes
10 effect, the department of health shall adopt all necessary regulations
11 to define "elevated lead levels" to mean a blood lead level greater than
12 or equal to 5 micrograms per deciliter of whole blood, or such lower
13 blood lead level as the department may establish, to be utilized in its
14 lead poisoning prevention program. The department shall be authorized
15 to promulgate regulations on an emergency basis to implement the
16 provisions of this act.

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

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

26 § 1370-f. Lead safe residential rental properties. 1. Definitions.
27 For the purposes of this section:

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

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

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

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

40 2. The commissioner shall promulgate rules and regulations establish-
41 ing minimum standards for the maintenance of lead safe residential
42 rental properties. Such rules and regulations shall include:

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

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

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

51 4. All paint on any residential rental property on which the original
52 construction was completed prior to January first, nineteen hundred
53 seventy-eight, shall be presumed to be lead-based paint. This presump-
54 tion may be overcome by a certification issued by a federally certified
55 lead-based paint inspector or risk assessor that the property has been

1 determined not to contain lead-based paint, or by such other means as
2 may be prescribed by the rules and regulations adopted by the commis-
3 sioner pursuant to this section.

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

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

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

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

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

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

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

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

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

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

48 § 1110. School and day care potable water testing and standards. 1.
49 For the purposes of this section, "day care facilities" shall mean a
50 child day care center, group family day care home, or a family day care
51 home licensed or registered with the office of children and family
52 services. The provisions of this section do not apply to child day care
53 centers, group family day care homes, family day care homes, school-age
54 child care programs and small day care centers that hold a permit issued
55 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

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

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

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

15 § 1110-a. Park potable water testing and standards. 1. The person,
16 officer, board or commission having the management and control of the
17 potable water supply of any park shall conduct periodic first-drawn tap
18 testing of potable water systems to monitor for lead contamination in
19 each park under his or her jurisdiction as required by regulations
20 promulgated pursuant to this section. The testing shall be conducted and
21 the results analyzed by an entity or entities approved by the commis-
22 sioner. Such periodic first-drawn tap testing shall occur at least once
23 every three years.

24 2. Where a finding of lead contamination is made, the person, officer,
25 board or commission having the management and control of the potable
26 water supply of such park shall: (a) continue first-drawn tap water
27 testing pursuant to regulations promulgated pursuant to this section;
28 (b) provide park visitors with an adequate supply of safe, potable water
29 for drinking as required by rules and regulations of the department
30 until future tests indicate lead levels pursuant to regulations promul-
31 gated pursuant to this section; (c) conspicuously post warnings to park
32 visitors the form and content of such warnings to be promulgated by the
33 commissioner, as well as posting such warnings and test results on the
34 park's website; (d) notwithstanding any provision of law to the contra-
35 ry, abate such contamination within ninety days; and (e) immediately
36 transmit a copy of the results of all such testing and any lead remedi-
37 ation plans to the commissioner of parks, recreation and historic pres-
38 ervation in a format to be determined by such commissioner.

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

42 4. The commissioner of parks, recreation and historic preservation
43 shall make a copy of the results of all such testing and any lead reme-
44 diation plans available to the public on the office of parks, recreation
45 and historic preservation's website and any additional means as chosen
46 by such commissioner. A copy of the results of all testing shall also be
47 immediately transmitted to the department in a format to be determined
48 by the commissioner. The commissioner of parks, recreation and historic
49 preservation, in conjunction with the commissioner, shall publish a
50 report biennially based on the findings from the tap water testing
51 conducted according to the provisions of this section. Such report shall
52 be sent to the commissioner, the governor, the temporary president of
53 the senate, and the speaker of the assembly and shall be made available
54 on the department's and office of parks, recreation and historic preser-
55 vation'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-1 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

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

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

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

18 § 2509. Maternal mortality review board. 1. (a) There is hereby estab-
19 lished in the department the maternal mortality review board for the
20 purpose of reviewing maternal deaths and maternal morbidity and develop-
21 ing and disseminating findings, recommendations, and best practices to
22 contribute to the prevention of maternal mortality and morbidity. The
23 board shall assess the cause of death, factors leading to death and
24 preventability for each maternal death reviewed and, in the discretion
25 of the board, cases of severe maternal morbidity, and shall develop and
26 disseminate strategies for reducing the risk of maternal mortality and
27 morbidity, including risk resulting from racial, economic, or other
28 disparities. The commissioner may delegate the authority to conduct
29 maternal mortality reviews.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 5. Each board:

7 (a) shall make and report findings and recommendations to the commis-
8 sioner or city commissioner, as the case may be, regarding the cause of
9 death, factors leading to death, and preventability of each maternal
10 death case, and each case of severe maternal morbidity reviewed by the
11 board, by reviewing relevant information for each case in the state or
12 the city of New York, as the case may be, and consulting with experts as
13 needed to evaluate the information for each death; and shall provide
14 such findings and recommendations, including best practices and strate-
15 gies for reducing the risk of maternal mortality and morbidity, to the
16 advisory council; provided that material provided to the advisory coun-
17 cil shall not include any information that would be confidential under
18 this section;

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

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

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

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

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

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

1 8. (a) There is hereby established in the department an advisory coun-
2 cil on maternal mortality and morbidity.

3 (b) The advisory council:

4 (i) may review the findings of the boards;

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

7 (iii) may hold public hearings on those matters;

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

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

12 (c) The advisory council shall consist of at least twenty members, to
13 be determined by the commissioner. The commissioner and the city commis-
14 sioner shall each appoint half of the members of the council. The
15 commissioner shall appoint the chair of the council.

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

22 (e) The terms of the council members shall be three years. The
23 appointing official may choose to reappoint council members to addi-
24 tional three-year terms. Vacancies on the council shall be filled by
25 appointment by the appointing official. A majority of the appointed
26 membership of the council shall constitute a quorum. When any member of
27 the council fails to attend three consecutive regular meetings, unless
28 such absence is for good cause, that membership may be deemed vacant for
29 purposes of the appointment of a successor.

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

31 (g) Members of the council shall be indemnified under section seven-
32 teen of the public officers law. Members of the council shall not be
33 compensated for their participation on the council but shall receive
34 reimbursement for their ordinary and necessary expenses of partic-
35 ipation. Membership on the council shall not disqualify any person from
36 holding any public office or employment.

37 § 3. This act shall take effect immediately.

38 PART S

39 Intentionally Omitted

40 PART T

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

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

45 TITLE VII

46 NY STATE OF HEALTH

47 Section 268. Statement of policy and purposes.

48 268-a. Definitions.

49 268-b. Establishment of NY State of Health, The Official Health
50 Plan Marketplace.

51 268-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 regu-
lations, under which benefits for medical care are secondary or inci-
dental 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 indem-
nity, 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 cover-
age 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 indi-
viduals through the Marketplace;
(b) resides in this state;
(c) at the time of enrollment, is not incarcerated, other than incar-
ceration 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

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

3 16. In accordance with applicable federal and state law, inform indi-
4 viduals of eligibility requirements for the Medicaid program under title
5 XIX of the social security act and the social services law, the chil-
6 dren's health insurance program (CHIP) under title XXI of the social
7 security act and this chapter, the basic health program under section
8 three hundred sixty-nine-gg of the social services law, or any applica-
9 ble state or local public health insurance program and if, through
10 screening of the application by the Marketplace, the Marketplace deter-
11 mines that such individuals are eligible for any such program, enroll
12 such individuals in such program.

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

17 (a) there is no affordable health plan available covering the individ-
18 ual, as defined by applicable law; or

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

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

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

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

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

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

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

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

49 § 268-d. Special functions of the Marketplace related to health plan
50 certification and qualified health plan oversight. 1. Health plans
51 certified by the Marketplace shall meet the following requirements:

52 (a) The insurer offering the health plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (A) claims payment policies and practices;

18 (B) periodic financial disclosures;

19 (C) data on enrollment and disenrollment;

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

21 (E) data on rating practices;

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

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

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

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

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

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

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

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

1 coverage, and shall include, at a minimum, the essential pediatric
2 dental benefits prescribed by the secretary pursuant to section
3 1302(b)(1)(J) of the federal act, and such other dental benefits as the
4 Marketplace or secretary may specify in regulations.

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

12 § 268-e. Appeals and appeal hearings; judicial review. 1. Any appli-
13 cant or enrollee, or any individual authorized to act on behalf of any
14 such applicant or enrollee, may appeal to the department from determi-
15 nations of department officials or failures to make determinations upon
16 grounds specified in subdivision four of this section. The department
17 must review the appeal de novo and give such person an opportunity for
18 an appeal hearing. The department may also, on its own motion, review
19 any decision made or any case in which a decision has not been made by
20 the Marketplace or a social services official within the time specified
21 by law or regulations of the department. The department may make such
22 additional investigation as it may deem necessary, and the commissioner
23 must make such determination as is justified and in accordance with
24 applicable law.

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

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

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

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

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

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

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

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

46 (B) eligibility for Medicaid;

47 (C) eligibility for Child Health Plus;

48 (D) eligibility for the Basic Health Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 § 268-f. Marketplace advisory committee. 1. There is hereby created
40 the marketplace advisory committee, which shall consider and advise the
41 department and commissioner on matters concerning the provision of
42 health care coverage through the NY State of Health or Marketplace.

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

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

48 (i) health plan consumer advocates;

49 (ii) small business consumer representatives;

50 (iii) health care provider representatives;

51 (iv) representatives of the health insurance industry;

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

54 (i) licensed insurance producers; and

55 (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,

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

24 § 2. This act shall take effect immediately.

25 PART V

26 Intentionally Omitted

27 PART W

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

33 Section 1. The office of mental health is authorized to recover fund-
34 ing from community residences and family-based treatment providers
35 licensed by the office of mental health, consistent with contractual
36 obligations of such providers, and notwithstanding any other inconsis-
37 tent provision of law to the contrary, in an amount equal to 50 percent
38 of the income received by such providers which exceeds the fixed amount
39 of annual Medicaid revenue limitations, as established by the commis-
40 sioner of mental health. Recovery of such excess income shall be for the
41 following fiscal periods: for programs in counties located outside of
42 the city of New York, the applicable fiscal periods shall be January 1,
43 2003 through December 31, 2009 and January 1, 2011 through December 31,
44 [2019] 2022; and for programs located within the city of New York, the
45 applicable fiscal periods shall be July 1, 2003 through June 30, 2010
46 and July 1, 2011 through June 30, [2019] 2022.

47 § 2. This act shall take effect immediately.

48 PART X

1 Section 1. Subdivision 9 of section 730.10 of the criminal procedure
2 law, as added by section 1 of part Q of chapter 56 of the laws of 2012,
3 is amended to read as follows:

4 9. "Appropriate institution" means: (a) a hospital operated by the
5 office of mental health or a developmental center operated by the office
6 for people with developmental disabilities; ~~or~~ (b) a hospital licensed
7 by the department of health which operates a psychiatric unit licensed
8 by the office of mental health, as determined by the commissioner
9 provided, however, that any such hospital that is not operated by the
10 state shall qualify as an "appropriate institution" only pursuant to the
11 terms of an agreement between the commissioner and the hospital; or (c)
12 a mental health unit operating within a local correctional facility
13 except those located within a city with a population of one million or
14 more; provided however, that any such mental health unit operating with-
15 in a local correctional facility shall qualify as an "appropriate insti-
16 tution" only pursuant to the terms of an agreement between the commis-
17 sioner of mental health, director of community services and the sheriff
18 for the respective locality. Nothing in this article shall be construed
19 as requiring a hospital or local correctional facility to consent to
20 providing care and treatment to an incapacitated person at such hospital
21 or local correctional facility. The commissioner of mental health shall
22 promulgate regulations for demonstration programs at no more than two
23 counties to implement restoration to competency within a local correc-
24 tional facility. Subject to annual appropriation, the commissioner of
25 mental health may, at such commissioner's discretion, make funds avail-
26 able for state aid grants to any county that develops and operates a
27 mental health unit within a local correctional facility pursuant to this
28 section. Nothing in this article shall be construed as requiring a
29 hospital or local correctional facility to consent to providing care and
30 treatment to an incapacitated person at such hospital or local correc-
31 tional facility.

32 § 2. This act shall take effect immediately and shall be deemed to
33 have been in full force and effect on and after April 1, 2019; provided,
34 however, that this act shall expire and be deemed repealed March 31,
35 2024; effective immediately, the addition, amendment and/or repeal of
36 any rule or regulation necessary for the implementation of this act on
37 its effective date are authorized to be made and completed on or before
38 such effective date.

39 PART Y

40 Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter
41 57 of the laws of 2006, relating to establishing a cost of living
42 adjustment for designated human services programs, as amended by section
43 1 of part AA of chapter 57 of the laws of 2018, are amended to read as
44 follows:

45 3-b. Notwithstanding any inconsistent provision of law, beginning
46 April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and
47 ending ~~March 31, 2019~~ December 31, 2019, the commissioners shall not
48 include a COLA for the purpose of establishing rates of payments,
49 contracts or any other form of reimbursement~~[, provided that the commis-~~
50 ~~sioners of the office for people with developmental disabilities, the~~
51 ~~office of mental health, and the office of alcoholism and substance~~
52 ~~abuse services shall not include a COLA beginning April 1, 2017 and~~
53 ~~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-1 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

1 certified pursuant to article sixteen or article thirty-two of the
2 mental hygiene law to obtain an operating certificate from the depart-
3 ment if such provider has been authorized to provide integrated services
4 in accordance with regulations issued by the commissioner in consulta-
5 tion with the commissioner of the office of mental health [and], the
6 commissioner of the office of alcoholism and substance abuse services
7 and the commissioner of the office for people with developmental disa-
8 bilities, including regulations issued pursuant to subdivision seven of
9 section three hundred sixty-five-1 of the social services law or part L
10 of chapter fifty-six of the laws of two thousand twelve.

11 § 2. Subdivision (f) of section 31.02 of the mental hygiene law, as
12 added by section 2 of subpart B of part S of chapter 57 of the laws of
13 2018, is amended to read as follows:

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

27 § 3. Subdivision (b) of section 32.05 of the mental hygiene law, as
28 amended by section 3 of subpart B of part S of chapter 57 of the laws of
29 2018, is amended to read as follow:

30 (b) (i) Methadone, or such other controlled substance designated by
31 the commissioner of health as appropriate for such use, may be adminis-
32 tered to an addict, as defined in section thirty-three hundred two of
33 the public health law, by individual physicians, groups of physicians
34 and public or private medical facilities certified pursuant to article
35 twenty-eight or thirty-three of the public health law as part of a chem-
36 ical dependence program which has been issued an operating certificate
37 by the commissioner pursuant to subdivision (b) of section 32.09 of this
38 article, provided, however, that such administration must be done in
39 accordance with all applicable federal and state laws and regulations.
40 Individual physicians or groups of physicians who have obtained authori-
41 zation from the federal government to administer buprenorphine to
42 addicts may do so without obtaining an operating certificate from the
43 commissioner. (ii) No provision of this article or any other provision
44 of law shall be construed to require a provider licensed pursuant to
45 article twenty-eight of the public health law or article thirty-one of
46 this chapter to obtain an operating certificate from the office of alco-
47 holism and substance abuse services if such provider has been authorized
48 to provide integrated services in accordance with regulations issued by
49 the commissioner of alcoholism and substance abuse services in consulta-
50 tion with the commissioner of the department of health [and], the
51 commissioner of the office of mental health and the commissioner of the
52 office for people with developmental disabilities, including regulations
53 issued pursuant to subdivision seven of section three hundred sixty-
54 five-1 of the social services law or part L of chapter fifty-six of the
55 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-1 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[7] case management[7] 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-

1 able by the insurer to any insured, prospective insured, or in-network
2 provider upon request.

3 (J) For purposes of this paragraph:

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

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

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

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

25 § 5. Paragraph 30 of subsection (i) of section 3216 of the insurance
26 law, as amended by section 1 of part B of chapter 71 of the laws of
27 2016, is amended to read as follows:

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

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

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

54 (D) This subparagraph shall apply to facilities in this state that are
55 licensed, certified or otherwise authorized by the office of alcoholism
56 and substance abuse services that are participating in the insurer's

1 provider network. Coverage provided under this paragraph shall not be
2 subject to preauthorization. Coverage provided under this paragraph
3 shall also not be subject to concurrent utilization review during the
4 first ~~[fourteen]~~ twenty-eight days of the inpatient admission provided
5 that the facility notifies the insurer of both the admission and the
6 initial treatment plan within ~~[forty-eight hours]~~ two business days of
7 the admission. The facility shall perform daily clinical review of the
8 patient, including ~~[the]~~ periodic consultation with the insurer at or
9 just prior to the fourteenth day of the inpatient admission to ensure
10 that the facility is using the evidence-based and peer reviewed clinical
11 review tool utilized by the insurer which is designated by the office of
12 alcoholism and substance abuse services and appropriate to the age of
13 the patient, to ensure that the inpatient treatment is medically neces-
14 sary for the patient. Prior to discharge, the facility shall provide
15 the patient and the insurer with a written discharge plan which shall
16 describe arrangements for additional services needed following discharge
17 from the inpatient facility as determined using the evidence-based and
18 peer-reviewed clinical review tool utilized by the insurer which is
19 designated by the office of alcoholism and substance abuse services.
20 Prior to discharge, the facility shall indicate to the insurer whether
21 services included in the discharge plan are secured or determined to be
22 reasonably available. Any utilization review of treatment provided under
23 this subparagraph may include a review of all services provided during
24 such inpatient treatment, including all services provided during the
25 first ~~[fourteen]~~ twenty-eight days of such inpatient treatment.
26 Provided, however, the insurer shall only deny coverage for any portion
27 of the initial ~~[fourteen]~~ twenty-eight day inpatient treatment on the
28 basis that such treatment was not medically necessary if such inpatient
29 treatment was contrary to the evidence-based and peer reviewed clinical
30 review tool utilized by the insurer which is designated by the office of
31 alcoholism and substance abuse services. An insured shall not have any
32 financial obligation to the facility for any treatment under this
33 subparagraph other than any copayment, coinsurance, or deductible other-
34 wise required under the policy.

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

39 (F) For purposes of this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (G) For purposes of this paragraph:

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

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

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

51 (iv) "substance use disorder" shall have the meaning set forth in the
52 most recent edition of the diagnostic and statistical manual of mental
53 disorders or the most recent edition of another generally recognized
54 independent standard of current medical practice such as the interna-
55 tional 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

1 care provided in a facility issued an operating certificate by the
2 commissioner of mental health pursuant to the provisions of article
3 thirty-one of the mental hygiene law, or in a facility operated by the
4 office of mental health, or, for care provided in other states, to simi-
5 larly licensed or certified hospitals or facilities; and

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

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

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

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

27 (E) For purposes of this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52 (21) the most recent comparative analysis performed by the insurer to
53 assess the provision of its covered services in accordance with the Paul
54 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
55 Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal
56 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

1 department, providing services for diagnosis or treatment of mental[
2 ~~nervous or emotional disorders or ailments~~] health conditions; (ii)
3 three or more additional years experience in psychotherapy under the
4 supervision, satisfactory to the state board for social work, of a
5 psychiatrist, a licensed and registered psychologist or a licensed clin-
6 ical social worker qualified for reimbursement pursuant to subsection
7 (e) of this section, or (iii) a combination of the experience specified
8 in items (i) and (ii) of this subparagraph totaling three years, satis-
9 factory to the state board for social work.

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

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

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

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

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

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

~~(B) (i) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services, shall provide comparable coverage for adults and children with biologically based mental illness. Such group policies issued or delivered in this state shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the policy, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a policy provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the policy is written under one license or two licenses.~~

~~(ii) For purposes of this paragraph, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.]~~ Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the policy.

§ 14. Subparagraphs (C), (D) and (E) of paragraph 5 of subsection (1) of section 3221 of the insurance law are REPEALED and five new subparagraphs (C), (D), (E), (F) and (G) are added to read as follows:

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

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

(E) For purposes of this paragraph:

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

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

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

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

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

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

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

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

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

51 (B) Coverage provided under this paragraph may be limited to facili-
52 ties in New York state ~~[which are certified]~~ that are licensed, certi-
53 fied or otherwise authorized by the office of alcoholism and substance
54 abuse services and, in other states, to those which are accredited by
55 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-

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

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

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

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

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

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

39 (C-1) A large group policy that provides coverage under this paragraph
40 may not impose copayments or coinsurance for outpatient substance use
41 disorder services that exceeds the copayment or coinsurance imposed for
42 a primary care office visit. Provided that only one such copayment may
43 be imposed for all services provided in a single day by a facility
44 licensed, certified or otherwise authorized by the office of alcoholism
45 and substance abuse services to provide outpatient substance use disor-
46 der services.

47 § 17. Subparagraph (E) of paragraph 7 of subsection (1) of section
48 3221 of the insurance law, as added by section 4 of part MM of chapter
49 57 of the laws of 2018, is amended and three new subparagraphs (F), (G)
50 and (H) are added to read as follows:

51 (E) This subparagraph shall apply to facilities in this state that are
52 licensed, certified or otherwise authorized by the office of alcoholism
53 and substance abuse services for the provision of outpatient, intensive
54 outpatient, outpatient rehabilitation and opioid treatment that are
55 participating in the insurer's provider network. Coverage provided under
56 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 (1) 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 (1) of section 3221 of the insurance law, as amended by section 39 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

19 § 20. Items (i) and (iii) of subparagraph (C) of paragraph 17 of
20 subsection (1) of section 3221 of the insurance law, as amended by chap-
21 ter 596 of the laws of 2011, are amended to read as follows:

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

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

39 § 21. Paragraph 17 of subsection (1) of section 3221 of the insurance
40 law is amended by adding four new subparagraphs (H), (I), (J) and (K) to
41 read as follows:

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

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

51 (J) For purposes of this paragraph:

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

54 (ii) "predominant" means that a financial requirement or treatment
55 limitation is the most common or frequent of such type of limit or
56 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:

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

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

10 (6) For purposes of this subsection:

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

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

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

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

34 (7) A corporation shall provide coverage under this paragraph, at a
35 minimum, consistent with the federal Paul Wellstone and Pete Domenici
36 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
37 1185a).

38 (8) This subparagraph shall apply to hospitals in this state that are
39 licensed by the office of mental health that are participating in the
40 corporation's provider network. Where the contract provides coverage for
41 inpatient hospital care, benefits for inpatient hospital care in a
42 hospital as defined by subdivision ten of section 1.03 of the mental
43 hygiene law provided to individuals who have not attained the age of
44 eighteen shall not be subject to preauthorization. Coverage provided
45 under this paragraph shall also not be subject to concurrent utiliza-
46 tion review during the first fourteen days of the inpatient admission,
47 provided the facility notifies the corporation of both the admission and
48 the initial treatment plan within two business days of the admission,
49 performs daily clinical review of the patient, and participates in peri-
50 odic consultation with the corporation to ensure that the facility is
51 using the evidence-based and peer reviewed clinical review criteria
52 utilized by the corporation which is approved by the office of mental
53 health and appropriate to the age of the patient, to ensure that the
54 inpatient care is medically necessary for the patient. All treatment
55 provided under this subparagraph may be reviewed retrospectively. Where
56 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

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

3 (4) This paragraph shall apply to facilities in this state [~~certified~~]
4 that are licensed, certified or otherwise authorized by the office of
5 alcoholism and substance abuse services that are participating in the
6 corporation's provider network. Coverage provided under this subsection
7 shall not be subject to preauthorization. Coverage provided under this
8 subsection shall also not be subject to concurrent utilization review
9 during the first [~~fourteen~~] twenty-eight days of the inpatient admission
10 provided that the facility notifies the corporation of both the admis-
11 sion and the initial treatment plan within [~~forty-eight hours~~] two busi-
12 ness days of the admission. The facility shall perform daily clinical
13 review of the patient, including [~~the~~] periodic consultation with the
14 corporation at or just prior to the fourteenth day of the inpatient
15 admission to ensure that the facility is using the evidence-based and
16 peer reviewed clinical review tool utilized by the corporation which is
17 designated by the office of alcoholism and substance abuse services and
18 appropriate to the age of the patient, to ensure that the inpatient
19 treatment is medically necessary for the patient. Prior to discharge,
20 the facility shall provide the patient and the corporation with a writ-
21 ten discharge plan which shall describe arrangements for additional
22 services needed following discharge from the inpatient facility as
23 determined using the evidence-based and peer-reviewed clinical review
24 tool utilized by the corporation which is designated by the office of
25 alcoholism and substance abuse services. Prior to discharge, the facili-
26 ty shall indicate to the corporation whether services included in the
27 discharge plan are secured or determined to be reasonably available. Any
28 utilization review of treatment provided under this paragraph may
29 include a review of all services provided during such inpatient treat-
30 ment, including all services provided during the first [~~fourteen~~] twen-
31 ty-eight days of such inpatient treatment. Provided, however, the
32 corporation shall only deny coverage for any portion of the initial
33 [~~fourteen~~] twenty-eight day inpatient treatment on the basis that such
34 treatment was not medically necessary if such inpatient treatment was
35 contrary to the evidence-based and peer reviewed clinical review tool
36 utilized by the corporation which is designated by the office of alco-
37 holism and substance abuse services. An insured shall not have any
38 financial obligation to the facility for any treatment under this para-
39 graph other than any copayment, coinsurance, or deductible otherwise
40 required under the contract.

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

45 (6) For purposes of this subsection:

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

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

51 (C) "treatment limitation" means limits on the frequency of treatment,
52 number of visits, days of coverage, or other similar limits on the
53 scope or duration of treatment and includes nonquantitative treatment
54 limitations such as: medical management standards limiting or excluding
55 benefits based on medical necessity, or based on whether the treatment
56 is experimental or investigational; formulary design for prescription

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

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

13 (7) A corporation shall provide coverage under this paragraph, at a
14 minimum, consistent with the federal Paul Wellstone and Pete Domenici
15 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §
16 1185a).

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

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

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

40 (3-a) A contract that provides large group coverage that provides
41 coverage for outpatient substance use disorder services under this
42 subsection may not impose copayments or coinsurance for outpatient
43 substance use disorder services that exceed the copayment or coinsurance
44 imposed for a primary care office visit. Provided that only one such
45 copayment may be imposed for all services provided in a single day by a
46 facility licensed, certified or otherwise authorized by the office of
47 alcoholism and substance abuse services to provide outpatient substance
48 use disorder services.

49 § 28. Paragraph 5 of subsection (1) of section 4303 of the insurance
50 law, as added by section 5 of part MM of chapter 57 of the laws of 2018,
51 is amended and three new paragraphs 6, 7 and 8 are added to read as
52 follows:

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

1 that are participating in the corporation's provider network. Coverage
2 provided under this subsection shall not be subject to preauthorization.
3 Coverage provided under this subsection shall not be subject to concur-
4 rent review for the first [~~two~~] four weeks of continuous treatment, not
5 to exceed [~~fourteen~~] twenty-eight visits, provided the facility notifies
6 the corporation of both the start of treatment and the initial treatment
7 plan within [~~forty-eight hours~~] two business days. The facility shall
8 perform clinical assessment of the patient at each visit, including
9 [~~the~~] periodic consultation with the corporation at or just prior to the
10 fourteenth day of treatment to ensure that the facility is using the
11 evidence-based and peer reviewed clinical review tool utilized by the
12 corporation which is designated by the office of alcoholism and
13 substance abuse services and appropriate to the age of the patient, to
14 ensure that the outpatient treatment is medically necessary for the
15 patient. Any utilization review of the treatment provided under this
16 paragraph may include a review of all services provided during such
17 outpatient treatment, including all services provided during the first
18 [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twen-
19 ty-eight visits, of such outpatient treatment. Provided, however, the
20 corporation shall only deny coverage for any portion of the initial
21 [~~two~~] four weeks of continuous treatment, not to exceed [~~fourteen~~] twen-
22 ty-eight visits, for outpatient treatment on the basis that such treat-
23 ment was not medically necessary if such outpatient treatment was
24 contrary to the evidence-based and peer reviewed clinical review tool
25 utilized by the corporation which is designated by the office of alco-
26 holism and substance abuse services. A subscriber shall not have any
27 financial obligation to the facility for any treatment under this para-
28 graph other than any copayment, coinsurance, or deductible otherwise
29 required under the contract.

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

34 (7) For purposes of this subsection:

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

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

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

53 (D) "substance use disorder" shall have the meaning set forth in the
54 most recent edition of the diagnostic and statistical manual of mental
55 disorders or the most recent edition of another generally recognized

independent standard of current medical practice such as the international classification of diseases.

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

§ 29. Subsection (1-2) of section 4303 of the insurance law, as added by section 3 of part B of chapter 69 of the laws of 2016, is amended to read as follows:

(1-2) ~~(1)~~ Every contract that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall include immediate access, without prior authorization, to ~~[a five day emergency supply]~~ the formulary forms of prescribed medications covered under the contract for the treatment of substance use disorder ~~[where an emergency condition exists]~~, including a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, except where otherwise prohibited by law. Further, coverage ~~[of an emergency supply]~~ without prior authorization shall include formulary forms of medication for opioid overdose reversal otherwise covered under the contract prescribed or dispensed to an individual covered by the contract.

~~[(2) For purposes of this paragraph, an "emergency condition" means a substance use disorder condition that manifests itself by acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:~~

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

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

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

~~(iv) serious disfigurement of such person, or~~

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

~~(3) Coverage provided under this subsection may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the contract; provided, however, no contract shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This paragraph shall not preclude the imposition of a copayment or coinsurance on the initial limited supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]~~

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

(n) In addition to the requirements of subsection (i) of this section, every health service or medical expense indemnity corporation issuing a group contract pursuant to this section or a group remittance contract for delivery in this state which contract provides reimbursement to

1 subscribers or physicians, psychiatrists or psychologists for psychiat-
2 ric or psychological services or for the diagnosis and treatment of
3 ~~[mental, nervous or emotional disorders and ailments,]~~ mental health
4 conditions, however defined in such contract, must provide the same
5 coverage to persons covered under the group contract for such services
6 when performed by a licensed clinical social worker, within the lawful
7 scope of his or her practice, who is licensed pursuant to subdivision
8 two of section seven thousand seven hundred four of the education law
9 and in addition shall have either (i) three or more additional years
10 experience in psychotherapy, which for the purposes of this subsection
11 shall mean the use of verbal methods in interpersonal relationships with
12 the intent of assisting a person or persons to modify attitudes and
13 behavior which are intellectually, socially or emotionally maladaptive,
14 under supervision, satisfactory to the state board for social work, in a
15 facility, licensed or incorporated by an appropriate governmental
16 department, providing services for diagnosis or treatment of ~~[mental,~~
17 ~~nervous or emotional disorders or ailments,]~~ mental health conditions,
18 or (ii) three or more additional years experience in psychotherapy under
19 the supervision, satisfactory to the state board for social work, of a
20 psychiatrist, a licensed and registered psychologist or a licensed clin-
21 ical social worker qualified for reimbursement pursuant to subsection
22 (i) of this section, or (iii) a combination of the experience specified
23 in paragraphs (i) and (ii) totaling three years, satisfactory to the
24 state board for social work. The state board for social work shall
25 maintain a list of all licensed clinical social workers qualified for
26 reimbursement under this subsection.

27 § 31. Paragraph 2 of subsection (ee) of section 4303 of the insurance
28 law, as amended by section 40 of part D of chapter 56 of the laws of
29 2013, is amended to read as follows:

30 (2) Every contract that provides physician services, medical, major
31 medical or similar comprehensive-type coverage shall provide coverage
32 for the screening, diagnosis and treatment of autism spectrum disorder
33 in accordance with this paragraph and shall not exclude coverage for
34 screening, diagnosis or treatment of medical conditions otherwise
35 covered by the contract because the individual is diagnosed with autism
36 spectrum disorder. Such coverage may be subject to annual deductibles,
37 copayments and coinsurance as may be deemed appropriate by the super-
38 intendent and shall be consistent with those imposed on other benefits
39 under the contract. ~~[Coverage for applied behavior analysis shall be~~
40 ~~subject to a maximum benefit of six hundred eighty hours of treatment~~
41 ~~per contract or calendar year per covered individual.]~~ This paragraph
42 shall not be construed as limiting the benefits that are otherwise
43 available to an individual under the contract, provided however that
44 such contract shall not contain any limitations on visits that are sole-
45 ly applied to the treatment of autism spectrum disorder. No insurer
46 shall terminate coverage or refuse to deliver, execute, issue, amend,
47 adjust, or renew coverage to an individual solely because the individual
48 is diagnosed with autism spectrum disorder or has received treatment for
49 autism spectrum disorder. Coverage shall be subject to utilization
50 review and external appeals of health care services pursuant to article
51 forty-nine of this chapter as well as ~~[7]~~ case management~~[7]~~ and other
52 managed care provisions.

53 § 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of
54 section 4303 of the insurance law, as amended by chapter 596 of the laws
55 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:

1 (i) a physician who possesses a current and valid non-restricted
2 license to practice medicine and who specializes in behavioral health
3 and has experience in the delivery of substance use disorder courses of
4 treatment; or

5 (ii) a health care professional other than a licensed physician who
6 specializes in behavioral health and has experience in the delivery of
7 substance use disorder courses of treatment and, where applicable,
8 possesses a current and valid non-restricted license, certificate or
9 registration or, where no provision for a license, certificate or regis-
10 tration exists, is credentialed by the national accrediting body appro-
11 priate to the profession; ~~[and]~~ or

12 (D) for purposes of a determination involving treatment for a mental
13 health condition:

14 (i) a physician who possesses a current and valid non-restricted
15 license to practice medicine and who specializes in behavioral health
16 and has experience in the delivery of mental health courses or treat-
17 ment; or

18 (ii) a health care professional other than a licensed physician who
19 specializes in behavioral health and has experience in the delivery of
20 mental health courses of treatment and, where applicable, possesses a
21 current and valid non-restricted license, certificate, or registration
22 or, where no provision for a license, certificate or registration
23 exists, is credentialed by the national accrediting body appropriate to
24 the profession; and

25 § 37. Paragraph 9 of subsection (a) of section 4902 of the insurance
26 law, as amended by section 1 of part A of chapter 69 of the laws of
27 2016, is amended to read as follows:

28 (9) When conducting utilization review for purposes of determining
29 health care coverage for substance use disorder treatment, a utilization
30 review agent shall utilize an evidence-based and peer reviewed clinical
31 review ~~[tools designated by the office of alcoholism and substance abuse~~
32 ~~services that are appropriate to the age of the patient and consistent~~
33 ~~with the treatment service levels within the office of alcoholism and~~
34 ~~substance abuse services system]~~ tool that is appropriate to the age of
35 the patient. When conducting such utilization review for treatment
36 provided in this state, a utilization review agent shall utilize an
37 evidence-based and peer reviewed clinical tool designated by the office
38 of alcoholism and substance abuse services that is consistent with the
39 treatment service levels within the office of alcoholism and substance
40 abuse services system. All approved tools shall have inter rater reli-
41 ability testing completed by December thirty-first, two thousand
42 sixteen.

43 § 38. Subsection (a) of section 4902 of the insurance law is amended
44 by adding a new paragraph 12 to read as follows:

45 (12) When conducting utilization review for purposes of determining
46 health care coverage for a mental health condition, a utilization review
47 agent shall utilize evidence-based and peer reviewed clinical review
48 criteria that is appropriate to the age of the patient. The utilization
49 review agent shall use clinical review criteria deemed appropriate and
50 approved for such use by the commissioner of the office of mental
51 health, in consultation with the commissioner of health and the super-
52 intendent. Approved clinical review criteria shall have inter rater
53 reliability testing completed by December thirty-first, two thousand
54 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 (l-2) of section forty-three hundred three of the insurance law.

§ 41. Paragraphs (r), (t) and (u) of subdivision 1 of section 4408 of the public health law, paragraph (r) as amended and paragraphs (t) and (u) as added by section 18 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph (v) is added to read as follows:

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

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

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

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

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

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

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

§ 42. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 4900 of the public health law, as added by chapter 41 of the laws of 2014, is amended and a new subparagraph (iv) is added to read as follows:

(iii) for purposes of a determination involving substance use disorder treatment:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; ~~and~~ or

(iv) for purposes of a determination involving treatment for a mental health condition:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of a mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

§ 43. Paragraph (i) of subdivision 1 of section 4902 of the public health law, as amended by section 2 of part A of chapter 69 of the laws of 2016, is amended and a new paragraph (j) is added to read as follows:

(i) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization

review agent shall utilize an evidence-based and peer reviewed clinical review [tools designated by the office of alcoholism and substance abuse services that are appropriate to the age of the patient and consistent with the treatment service levels within the office of alcoholism and substance abuse services system] tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

(j) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner and the superintendent of financial services. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

§ 44. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date; provided, however, notwithstanding any provision of 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-yl)-N-phenylbutyramide. Other name: Butyryl Fentanyl.

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

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

(61) 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide.

Other name: U-47700.

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

(63) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide.

Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl.

(64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide.

Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

(65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide.

Other name: tetrahydrofuranyl fentanyl.

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

(67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide.

Other name: cyclopropyl fentanyl.

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

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

(70) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide.

Other name: para-methoxybutyryl fentanyl.

(71) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide.

Other name: para-chloroisobutyryl fentanyl.

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

(73) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide.

Other name: cyclopentyl fentanyl.

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

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

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

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

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

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

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

1 services and providers. In implementing such program, the department
2 shall consider the advice of experts in asthma management, home care and
3 other relevant sectors in the continuum of care.

4 2. Eligibility. The department shall provide notice to all eligible
5 individuals of the availability of the home care asthma management
6 program, and shall have the opportunity to apply for participation in
7 the program. For the purposes of this section, an "eligible individual"
8 is a person who has been diagnosed with asthma and is eligible for
9 medical assistance.

10 3. Participating providers. All home care agencies certified or
11 licensed under article thirty-six of the public health law who elect to
12 provide services as described in subdivision four of this section to
13 eligible individuals may participate in the program.

14 4. Department guidelines. The department shall promulgate guidelines
15 for referral of individuals diagnosed with asthma to home care agencies
16 certified or licensed under article thirty-six of the public health law
17 and participating in the home care asthma management program for
18 follow-up services, including but not limited to:

19 (i) a home-based health assessment of the individual and home environ-
20 ment for asthma trigger reduction;

21 (ii) use of available telehealth and clinical technology to assist in
22 asthma management;

23 (iii) patient and family education and training in asthma self-manage-
24 ment; such asthma self-management education would include but not be
25 limited to basic facts about asthma, proper medication use, identifica-
26 tion and avoidance of environmental exposures that worsen asthma, self-
27 monitoring of asthma symptoms, asthma control, and using written asthma
28 action plans;

29 (iv) periodic follow-up services, in particular after emergency room
30 or hospital visits occur, providing patients with root cause analysis
31 and steps for prevention of future episodes; and

32 (v) coordination of home and community-based services, including
33 collaboration with the patient's primary care, managed care, health home
34 and specialty providers, as applicable.

35 5. Adjustment of rates. The commissioner shall adjust the rates of
36 payment to home care agencies certified under article thirty-six of the
37 public health law that participate in the home care asthma management
38 program.

39 6. Effectiveness. The provisions of this section shall not take effect
40 until all necessary approvals under federal law and regulation have been
41 obtained to receive federal financial participation in the costs of the
42 home care asthma management program provided pursuant to this section.

43 § 3. This act shall take effect immediately; provided that the depart-
44 ment of social services shall notify the legislative bill drafting
45 commission upon the occurrence of the enactment of the legislation
46 provided for in sections one and two of this act in order that the
47 commission may maintain an accurate and timely effective data base of
48 the official text of the laws of the state of New York in furtherance of
49 effectuating the provisions of section 44 of the legislative law and
50 section 70-b of the public officers law.

51 PART GG

52 Section 1. The department of health shall submit a Medicaid state plan
53 amendment to the centers for Medicare and Medicaid services of the
54 United States department of health and human services to request author-

1 ization to establish and administer a methodology to provide supple-
2 mental reimbursement to eligible ground emergency medical transportation
3 providers that provide ground emergency medical transportation services
4 to Medicaid beneficiaries. For the purposes of this section, "eligible
5 ground emergency medical transportation provider" means a provider who
6 provides ground emergency medical transportation services to Medicaid
7 beneficiaries and is enrolled as a Medicaid provider during the period
8 being claimed.

9 § 2. This act shall take effect immediately.

10 PART HH

11 Section 1. Primary and preventive reproductive health care program.
12 Notwithstanding any other provision of law to the contrary, the commis-
13 sioner of health shall ensure the availability of the full range of
14 reproductive services through a primary and preventive care reproductive
15 health program. The program shall provide sixteen million dollars in
16 grants to not-for-profit organizations with demonstrated experience
17 providing primary and preventive reproductive health care, including
18 organizations that have at least thirty-five years of family planning
19 experience and demonstrated expertise in contracting and grants manage-
20 ment. Notwithstanding section 112 or 163 of the state finance law or
21 contrary provisions of law, such distributions shall be made without a
22 competitive bid or request for proposal process. Notwithstanding any
23 inconsistent provision of law, the department of health may provide such
24 grants by interchange, suballocation or transfer from any appropriation,
25 fund or account with the approval of the director of the budget.

26 § 2. This act shall take effect upon a determination by the commis-
27 sioner of health that there is a need to establish a primary and preven-
28 tive reproductive health care program; provided that the commissioner of
29 health shall notify the legislative bill drafting commission upon the
30 occurrence of the enactment of the legislation provided for in section
31 one of this act in order that the commission may maintain an accurate
32 and timely effective data base of the official text of the laws of New
33 York in further of effectuating the provisions of section 44 of the
34 legislative law and section 70-b of the public officers law.

35 PART II

36 Section 1. The public health law is amended by adding a new section
37 2807-o to read as follows:

38 § 2807-o. Early intervention services pool. 1. Definitions. The
39 following words or phrases as used in this section shall have the
40 following meanings:

41 (a) "Early intervention services" shall mean services delivered to an
42 eligible child, pursuant to an individualized family service plan under
43 the early intervention program.

44 (b) "Early intervention program" shall mean the early intervention
45 program for toddlers with disabilities and their families as created by
46 title two-A of article twenty-five of this chapter.

47 (c) "Municipality" shall mean any county outside of the city of New
48 York or the city of New York.

49 2. Payments for early intervention services. (a) The commissioner
50 shall, from funds allocated for such purpose under paragraph (g) of
51 subdivision six of section twenty-eight hundred seven-s of this article,

1 make payments to municipalities and the state for the delivery of early
2 intervention services.

3 (b) Payments under this subdivision shall be made to municipalities
4 and the state by the commissioner. Each municipality and the state of
5 New York shall receive a share of such payments equal to its propor-
6 tionate share of the total approved statewide dollars not reimbursable
7 by the medical assistance program paid to providers of early inter-
8 vention services by the state and municipalities on account of early
9 intervention services in the last complete state fiscal year for which
10 such data is available.

11 § 2. Subdivision 6 of section 2807-s of the public health law is
12 amended by adding two new paragraphs (g) and (h) to read as follows:

13 (g) A further gross statewide amount for the state fiscal year two
14 thousand twenty and each state fiscal year thereafter shall be fifteen
15 million dollars.

16 (h) The amount specified in paragraph (g) of this subdivision shall be
17 allocated under section twenty-eight hundred seven-o of this article
18 among the municipalities and the state of New York based on each munici-
19 pality's share and the state's share of early intervention program
20 expenditures not reimbursable by the medical assistance program for the
21 latest twelve month period for which such data is available.

22 § 3. Subdivision 7 of section 2807-s of the public health law is
23 amended by adding a new paragraph (d) to read as follows:

24 (d) funds shall be added to the funds collected by the commissioner
25 for distribution in accordance with section twenty-eight hundred seven-o
26 of this article, in the following amount: fifteen million dollars for
27 the period beginning April first, two thousand twenty, and continuing
28 each state fiscal year thereafter.

29 § 4. Subdivision 1 of section 2557 of the public health law, as
30 amended by section 4 of part C of chapter 1 of the laws of 2002, is
31 amended to read as follows:

32 1. The approved costs for an eligible child who receives an evaluation
33 and early intervention services pursuant to this title shall be a charge
34 upon the municipality wherein the eligible child resides or, where the
35 services are covered by the medical assistance program, upon the social
36 services district of fiscal responsibility with respect to those eligi-
37 ble children who are also eligible for medical assistance. All approved
38 costs shall be paid in the first instance and at least quarterly by the
39 appropriate governing body or officer of the municipality upon vouchers
40 presented and audited in the same manner as the case of other claims
41 against the municipality. Notwithstanding the insurance law or regu-
42 lations thereunder relating to the permissible exclusion of payments for
43 services under governmental programs, no such exclusion shall apply with
44 respect to payments made pursuant to this title. Notwithstanding the
45 insurance law or any other law or agreement to the contrary, benefits
46 under this title shall be considered secondary to ~~[any plan of insurance~~
47 ~~or state government benefit]~~ the medical assistance program under which
48 an eligible child may have coverage. ~~[Nothing in this section shall~~
49 ~~increase or enhance coverages provided for within an insurance contract~~
50 ~~subject to the provisions of this title.]~~

51 § 5. Subdivision 2 of section 2557 of the public health law, as
52 amended by section 9-a of part A of chapter 56 of the laws of 2012, is
53 amended to read as follows:

54 2. The department shall reimburse the approved costs paid by a munici-
55 pality for the purposes of this title, other than those reimbursable by
56 the medical assistance program ~~[or by third party payors]~~, in an amount

1 of fifty percent of the amount expended in accordance with the rules and
2 regulations of the commissioner; provided, however, that in the
3 discretion of the department and with the approval of the director of
4 the division of the budget, the department may reimburse municipalities
5 in an amount greater than fifty percent of the amount expended. Such
6 state reimbursement to the municipality shall not be paid prior to April
7 first of the year in which the approved costs are paid by the munici-
8 pality, provided, however that, subject to the approval of the director
9 of the budget, the department may pay such state aid reimbursement to
10 the municipality prior to such date.

11 § 6. The section heading of section 2559 of the public health law, as
12 added by chapter 428 of the laws of 1992, is amended to read as follows:

13 ~~[Third party insurance and medical]~~ Medical assistance program
14 payments.

15 § 7. Subdivision 3 of section 2559 of the public health law, as added
16 by chapter 428 of the laws of 1992, paragraphs (a), (c) and (d) as
17 amended by section 11 of part A of chapter 56 of the laws of 2012 and
18 paragraph (b) as further amended by section 104 of part A of chapter 62
19 of the laws of 2011, is amended to read as follows:

20 3. (a) ~~[Providers of evaluations and early intervention services,~~
21 ~~hereinafter collectively referred to in this subdivision as "provider"~~
22 ~~or "providers", shall in the first instance and where applicable, seek~~
23 ~~payment from all third party payors including governmental agencies~~
24 ~~prior to claiming payment from a given municipality for evaluations~~
25 ~~conducted under the program and for services rendered to eligible chil-~~
26 ~~dren, provided that, the obligation to seek payment shall not apply to a~~
27 ~~payment from a third party payer who is not prohibited from applying~~
28 ~~such payment, and will apply such payment, to an annual or lifetime~~
29 ~~limit specified in the insured's policy.~~

30 ~~(i) Parents shall provide the municipality and service coordinator~~
31 ~~information on any insurance policy, plan or contract under which an~~
32 ~~eligible child has coverage.~~

33 ~~(ii)]~~ Parents shall provide the municipality and the service coordina-
34 tor with a written referral from a primary care provider as documenta-
35 tion, for eligible children, of the medical necessity of early inter-
36 vention services.

37 ~~[(iii) providers]~~ (b) Providers shall utilize the department's fiscal
38 agent and data system for claiming payment for evaluations and services
39 rendered under the early intervention program.

40 ~~[(b) The commissioner, in consultation with the director of budget and~~
41 ~~the superintendent of financial services, shall promulgate regulations~~
42 ~~providing public reimbursement for deductibles and copayments which are~~
43 ~~imposed under an insurance policy or health benefit plan to the extent~~
44 ~~that such deductibles and copayments are applicable to early inter-~~
45 ~~vention services.~~

46 ~~(c) Payments made for early intervention services under an insurance~~
47 ~~policy or health benefit plan, including payments made by the medical~~
48 ~~assistance program or other governmental third party payor, which are~~
49 ~~provided as part of an IFSP pursuant to section twenty-five hundred~~
50 ~~forty-five of this title shall not be applied by the insurer or plan~~
51 ~~administrator against any maximum lifetime or annual limits specified in~~
52 ~~the policy or health benefits plan, pursuant to section eleven of the~~
53 ~~chapter of the laws of nineteen hundred ninety-two which added this~~
54 ~~title.~~

55 ~~(d)]~~ (c) A municipality, or its designee, and a provider shall be
56 subrogated, to the extent of the expenditures by such municipality or

1 for early intervention services furnished to persons eligible for bene-
2 fits under this title, to any rights such person may have or be entitled
3 to from ~~[third-party reimbursement]~~ the medical assistance program. The
4 provider shall submit notice to the insurer or plan administrator of his
5 or her exercise of such right of subrogation upon the provider's assign-
6 ment as the early intervention service provider for the child. The right
7 of subrogation does not attach to benefits paid or provided ~~[under any~~
8 ~~health insurance policy or health benefits plan]~~ prior to receipt of
9 written notice of the exercise of subrogation rights ~~[by the insurer or~~
10 ~~plan administrator providing such benefits]~~. Notwithstanding any incon-
11 sistent provision of this title, except as provided for herein, no third
12 party payor other than the medical assistance program shall be required
13 to reimburse for early intervention services provided under this title.

14 § 8. Subdivision 3 of section 2543 of the public health law is
15 REPEALED.

16 § 9. Section 3235-a of the insurance law is REPEALED.

17 § 10. Subparagraph (F) of paragraph 25 of subsection (i) of section
18 3216 of the insurance law is REPEALED.

19 § 11. Subparagraph (F) of paragraph 17 of subsection (1) of section
20 3221 of the insurance law is REPEALED.

21 § 12. Paragraph 6 of subsection (ee) of section 4303 of the insurance
22 law is REPEALED.

23 § 13. This act shall take effect January 1, 2020; provided, however,
24 that the amendments to section 2807-s of the public health law made by
25 sections two and three of this act shall not affect the expiration of
26 such section and shall be deemed to expire therewith. Effective imme-
27 diately, the addition, amendment and/or repeal of any rule or regulation
28 necessary for the implementation of this act on its effective date are
29 authorized to be made and completed by the commissioner of health, on or
30 before such effective date.

31 PART JJ

32 Section 1. Subdivision 26 of section 206 of the public health law, as
33 amended by section 127-t of subpart B of part C of chapter 62 of the
34 laws of 2011, is amended and a new subdivision 26-a is added to read as
35 follows:

36 26. ~~(a)~~ The commissioner ~~[is hereby authorized and directed to]~~, in
37 consultation with the commissioner of alcoholism and substance use
38 services in relation to subparagraph (viii) of this paragraph, shall
39 review any policy or practice instituted in facilities operated by the
40 department of corrections and community supervision, and in all local
41 correctional facilities, as defined in subdivision sixteen of section
42 two of the correction law, regarding:

43 (i) human immunodeficiency virus (HIV)[7] and acquired immunodeficien-
44 cy syndrome (AIDS), [and] including the prevention and transmission of
45 HIV and the treatment of AIDS;

46 (ii) hepatitis C (HCV) including the prevention of the transmission of
47 ~~[HIV and HCV and the treatment of AIDS, HIV and]~~ HCV ~~[among inmates];~~

48 (iii) women's health;

49 (iv) transgender health;

50 (v) chronic health conditions including but not limited to asthma,
51 diabetes, and heart disease;

52 (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.

1 Section 1. Subdivision 5 of section 209 of the elder law, as amended
2 by section 1 of part S of chapter 59 of the laws of 2016, is amended to
3 read as follows:

4 5. Within amounts specifically appropriated therefor and consistent
5 with the criteria developed and required pursuant to this section the
6 director shall approve grants to eligible applicants. Individual grants
7 awarded for classic NORC programs shall be in amounts not to exceed
8 [~~two~~] three hundred thousand (~~[\$200,000]~~ \$300,000) dollars and for
9 neighborhood NORCs not less than sixty thousand (\$60,000) dollars in any
10 twelve month period.

11 § 2. This act shall take effect immediately.

12 PART LL

13 Section 1. The mental hygiene law is amended by adding a new section
14 13.44 to read as follows:

15 § 13.44 Direct support professional credential pilot program.

16 (a) Subject to appropriations, the office shall implement a profes-
17 sional credentialing pilot program to assist and enhance the field of
18 direct care support.

19 (b) The pilot program participants shall be selected by the commis-
20 sioner, in consultation with the regional offices under his or her
21 jurisdiction and the regional centers for workforce transformation. Such
22 pilot program participants shall include individuals employed by state-
23 operated facilities under the auspices of the office and not-for-profit
24 providers licensed and/or certified by the office. Pilot program partic-
25 ipants shall be geographically disbursed throughout the state, and as
26 determined by the commissioner, in regions of the state with the great-
27 est need.

28 (c) (1) When implementing the pilot program, the office shall focus on
29 assisting individuals in the field of direct support by advancing initi-
30 atives that: (i) promote direct support work as a career, with a focus
31 on creating opportunities for career advancement within the profession,
32 (ii) further professionalize the field by developing advanced skills and
33 competencies, (iii) promote the health, safety and well-being of the
34 people being served, and (iv) enhance workforce recruitment and
35 retention efforts, with a focus on direct support professional posi-
36 tions.

37 (2) Such initiatives shall include but not be limited to:

38 (i) a credentialing and education program for direct support profes-
39 sionals which shall utilize best practices including but not limited to
40 New York state direct support professional competencies, certification
41 programs offered by institutions of higher learning, and direct support
42 professional credentialing and education initiatives in other states;
43 and

44 (ii) a comprehensive training program which may include on-line train-
45 ing, mentorships, and support group components. To develop the training
46 program, the pilot may utilize national direct support professional
47 competency programs or credentialing standards and trainings.

48 (d) (1) There is hereby established within the office an advisory
49 council for direct support professional credentialing, which shall
50 advise, oversee and assist with the implementation of the pilot program
51 established pursuant to this section.

52 (2) (i) The council shall consist of the commissioner or his or her
53 designee, who shall chair the council and twenty-one additional members.
54 Seven members shall be appointed upon the recommendation of the commis-

1 sioner, seven members shall be appointed upon the recommendation of the
2 temporary president of the senate and seven members shall be appointed
3 upon the recommendation of the speaker of the assembly. (ii) The compo-
4 sition of the council shall be as follows:

5 (A) five individuals from the direct support professional credential
6 technical report advisory group, at least two of whom shall be not-for-
7 profit providers of services;

8 (B) five individuals from the direct support professional credential
9 technical report advisory group project staff identified by the commis-
10 sioner, at least one of whom is from an institute of higher learning;

11 (C) six individuals from the office's regional center for workforce
12 transformation; each individual shall represent one of the six regions
13 covered by the regional center for workforce transformation;

14 (D) four direct support professionals, of whom two shall be creden-
15 tialed direct support professionals; and

16 (E) a self-advocate or a representative of a self-advocacy association
17 for individuals with intellectual or developmental disabilities.

18 (3) Members of the taskforce shall serve without compensation, but may
19 be reimbursed for actual costs incurred for participation on such task-
20 force.

21 (4) The council shall meet at least four times in each full calendar
22 year or at the request of the chair or commissioner.

23 (5) The council may establish committees as it deems necessary to
24 particular subjects of importance related to the implementation of the
25 pilot program.

26 (6) The council may consider any matter relating to initiatives
27 advanced as part of the pilot program and shall advise and provide
28 recommendations to the office on any such matter, including, but not
29 limited to:

30 (i) ensuring the program is person-centered, accessible, applicable
31 and relevant for people and families who reside in the state of New
32 York; and

33 (ii) providing recommendations and assistance to the office to: (A)
34 seek approval from the federal centers for Medicare and Medicaid
35 services for the statewide credentialing program to be included in the
36 state's 1115 demonstration waiver, as approved by the commissioner; (B)
37 collaborate with managed care organizations to ensure the statewide
38 credentialing program is incorporated into managed care contracts for
39 long term services and supports; and (C) develop the report required
40 pursuant to subdivision (e) of this section.

41 (e) The office in consultation with the participants of the pilot
42 program and the advisory council established pursuant to this section,
43 shall issue a report no later than November fifteenth, two thousand
44 twenty-two to the governor, the temporary president of the senate, the
45 speaker of the assembly, the assembly chair of the committee on mental
46 health, and the senate chair of the committee on mental health and
47 developmental disabilities, detailing the progress of the pilot program,
48 all relevant data and information taking into consideration any privacy
49 concerns or confidential restrictions to share such information, and
50 recommendations which shall include but not be limited to:

51 (1) rate of recruitment and retention for direct support professionals
52 of providers participating in the pilot program compared to the rate for
53 non-participating providers;

54 (2) number of direct support professionals credentialed;

55 (3) enhancement of quality supports and services to individuals with
56 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

1 and potential regulatory changes to help effectuate the duties and
2 responsibilities required in this article, and any other changes that
3 may significantly affect the lives of persons with disabilities in the
4 state.

5 (c) The office of the advocate for people with disabilities shall, to
6 the extent practicable, review and report to the governor upon proposed
7 legislation and regulations. The office of the advocate for people with
8 disabilities shall submit comments, where appropriate, to the state
9 agency which referred such proposed legislation and regulations evaluat-
10 ing: (i) the impact of the proposed legislation or regulation upon
11 persons with disabilities; (ii) the relationship and impact of such
12 proposed legislation or regulation on existing programs affecting
13 persons with disabilities; and (iii) any modifications that would help
14 persons with disabilities or aid in the implementation of the new
15 proposal. All state agencies shall cooperate with the office of the
16 advocate for people with disabilities to ensure that the office is able
17 to fulfill the requirements under this article.

18 § 463. Director; general responsibilities. The head of the office of
19 the advocate for people with disabilities shall be the director, who
20 shall be appointed by the governor and receive a salary to be fixed by
21 the governor within the amounts appropriated therefor. The director,
22 subject to rules prescribed by the governor, may appoint and fix the
23 compensation of employees of the office within the amounts appropriated
24 therefor.

25 § 2. Subdivisions 1 and 2 of section 702 of the executive law, as
26 added by chapter 551 of the laws of 2002, are amended to read as
27 follows:

28 1. The most integrated setting coordinating council is hereby created
29 within the executive department to have and exercise the functions,
30 powers and duties provided by the provisions of this article and any
31 other provision of law. The council shall be comprised of the commis-
32 sioners of: the department of health, the office of mental retardation
33 and developmental disabilities, the office of mental health, the depart-
34 ment of transportation, the office of children and family services, the
35 office of alcohol and substance abuse services, the department of educa-
36 tion, and the division of housing and community renewal. In addition,
37 the council shall consist of the director of the office for the aging,
38 ~~[a representative from]~~ the director of the office of the advocate for
39 ~~[persons]~~ people with disabilities, ~~[a representative from the commis-~~
40 ~~sion on quality of care for the mentally disabled,~~ three consumers of
41 services for individuals with disabilities, one to be appointed by the
42 governor, one to be appointed by the temporary president of the senate,
43 and one to be appointed by the speaker of the assembly, three individ-
44 uals with expertise in the field of community services for people of all
45 ages with disabilities, one to be appointed by the governor, one to be
46 appointed by the temporary president of the senate, and one to be
47 appointed by the speaker of the assembly, and three individuals with
48 expertise in or recipients of services available to senior citizens with
49 disabilities, one to be appointed by the governor, one to be appointed
50 by the temporary president of the senate, and one to be appointed by the
51 speaker of the assembly.

52 2. The ~~[commissioners of the department of health, the office of~~
53 ~~mental health, the office of mental retardation and developmental disa-~~
54 ~~bilities, and the director of the office for the aging]~~ director of the
55 office of the advocate for people with disabilities shall ~~[rotate]~~ serve
56 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.