STATE OF NEW YORK

2237--A

2023-2024 Regular Sessions

IN SENATE

January 19, 2023

Introduced by Sens. RIVERA, BRESLIN, BRISPORT, BROUK, CHU, CLEARE, COMRIE, COONEY, FERNANDEZ, GIANARIS, GONZALEZ, GOUNARDES, HARCKHAM, HINCHEY, HOYLMAN-SIGAL, JACKSON, KAVANAGH, KENNEDY, LIU, MAY, MAYER, MYRIE, PARKER, PERSAUD, RAMOS, SALAZAR, SANDERS, SEPULVEDA, SERRANO, STAVISKY, THOMAS, WEBB -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- reported favorably from said committee and committed to the Committee on Finance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the social services law, in relation to coverage for certain individuals under the 1332 state innovation program

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

Section 1. Section 369-ii of the social services law, as added by section 3 of part H of chapter 57 of the laws of 2023, is amended to read as follows:

§ 369-ii. 1332 state innovation program. 1. Authorization. Notwithstanding section three hundred sixty-nine-gg of this title, subject to federal approval, if it is in the financial interest of the state to do so, the commissioner of health is authorized, with the approval of the director of the budget, to establish a 1332 state innovation program pursuant to section 1332 of the patient protection and affordable care act (P.L. 111-148) and subdivision twenty-five of section two hundred sixty-eight-c of the public health law. The commissioner of health's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services and the secretary of the treasury based on an application for a waiver for state innovation. The commissioner of health [~~may~~] **shall** take all actions necessary to obtain such approvals.

2. Definitions. For the purposes of this section:

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

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(a) "Eligible organization" means an insurer licensed pursuant to article thirty-two or forty-two of the insurance law, a corporation or an organization under article forty-three of the insurance law, or an organization certified under article forty-four of the public health law, including providers certified under section forty-four hundred three-e of the public health law.

(b) "Approved organization" means an eligible organization approved by the commissioner of health to underwrite a 1332 state innovation health insurance plan pursuant to this section.

(c) "Health care services" means:

(i) the services and supplies as defined by the commissioner of health in consultation with the superintendent of financial services, and shall be consistent with and subject to the essential health benefits as defined by the commissioner in accordance with the provisions of the patient protection and affordable care act (P.L. 111-148) and consistent with the benefits provided by the reference plan selected by the commissioner of health for the purposes of defining such benefits, and shall include coverage of and access to the services of any national cancer institute-designated cancer center licensed by the department of health within the service area of the approved organization that is willing to agree to provide cancer-related inpatient, outpatient and medical services to all enrollees in approved organizations' plans in such cancer center's service area under the prevailing terms and conditions that the approved organization requires of other similar providers to be included in the approved organization's network, provided that such terms shall include reimbursement of such center at no less than the fee-for-service medicaid payment rate and methodology applicable to the center's inpatient and outpatient services;

(ii) dental and vision services as defined by the commissioner of health, and

(iii) as defined by the commissioner of health and subject to federal approval, certain services and supports provided to enrollees who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the enrollee to live or work in the setting of their choice, which may include the individual's home, a worksite, or a provider-owned or controlled residential setting.

(d) "Qualified health plan" means a health plan that meets the criteria for certification described in § 1311(c) of the patient protection and affordable care act (P.L. 111-148), and is offered to individuals through the NY State of Health, the official health Marketplace, or Marketplace, as defined in subdivision two of section two hundred sixty-eight-a of the public health law.

(e) "Basic health insurance plan" means a health plan providing health care services, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with section three hundred sixty-nine-gg of this title.

(f) "1332 state innovation plan" means a standard health plan providing health care services, separate and apart from a qualified health plan and a basic health insurance plan, that is issued by an approved organization and certified in accordance with this section.

3. State innovation plan eligible individual. (a) A person is eligible to receive coverage for health care under this section if they:

(i) reside in New York state and are under sixty-five years of age**, including individuals that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status provided they are determined eligible pursuant to subdivision nine of**

this section and are determined eligible through the waiver process to receive coverage under this section regardless of direct federal financial support for such individuals;

(ii) are not eligible for medical assistance under title eleven of this article, excluding eligibility for limited medical assistance for the treatment of an emergency medical condition authorized pursuant to 42 U.S.C. 1396, or for the child health insurance plan described in title one-A of article twenty-five of the public health law;

(iii) are not eligible for minimum essential coverage, as defined in section 5000A(f) of the Internal Revenue Service Code of 1986, or is eligible for an employer-sponsored plan that is not affordable, in accordance with section 5000A(f) of such code; and

(iv) have household income at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and has household income that exceeds one hundred thirty-three percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; provided, however, that MAGI eligible noncitizens lawfully present in the United States, and individuals that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status with household incomes at or below one hundred thirty-three percent of the federal poverty line shall be eligible to receive coverage for health care services pursuant to the provisions of this section [~~if such noncitizen would be ineligible for medical assistance under title eleven of this article due to their immigration status~~].

(b) Subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this section who but for their eligibility under this section would be eligible for coverage pursuant to subparagraphs two or four of paragraph (b) of subdivision one of section three hundred sixty-six of this article, shall be administratively enrolled, as defined by the commissioner of health, in medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year.

(c) Subject to federal approval, an individual who is eligible for and receiving coverage for health care services pursuant to this section is eligible to continue to receive health care services pursuant to this section during the individual's pregnancy and for a period of one year following the end of the pregnancy without regard to any change in the income of the household that includes the pregnant individual, even if such change would render the pregnant individual ineligible to receive health care services pursuant to this section.

(d) For the purposes of this section, 1332 state innovation program eligible individuals are prohibited from being treated as qualified individuals under section 1312 of the Affordable Care Act and as eligible individuals under section 1331 of the ACA and enrolling in qualified health plan through the Marketplace or standard health plan through the Basic Health Program.

4. Enrollment. (a) Subject to federal approval, the commissioner of health is authorized to establish an application and enrollment procedure for prospective enrollees. Such procedure will include a verification system for applicants, which must be consistent with 42 USC § 1320b-7.

(b) Such procedure shall allow for continuous enrollment for enrollees to the 1332 state innovation program where an individual may apply and enroll for coverage at any point.

(c) Upon an applicant's enrollment in a 1332 state innovation plan, coverage for health care services pursuant to the provisions of this section shall be retroactive to the first day of the month in which the individual was determined eligible, except in the case of program transitions within the Marketplace.

(d) A person who has enrolled for coverage pursuant to this section, and who loses eligibility to enroll in the 1332 state innovation program for a reason other than [~~citizenship status,~~] lack of state residence, [~~failure to provide a valid social security number,~~] providing inaccurate information that would affect eligibility when requesting or renewing health coverage pursuant to this section, or failure to make an applicable premium payment, before the end of a twelve month period beginning on the effective date of the person's initial eligibility for coverage, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility, shall have their eligibility for coverage continued until the end of such twelve month period, provided that the state receives federal approval for using funds under an approved 1332 waiver.

5. Premiums. Subject to federal approval, the commissioner of health shall establish premium payments enrollees in a 1332 state innovation plan shall pay to approved organizations for coverage of health care services pursuant to this section. Such premium payments shall be established in the following manner:

(a) up to fifteen dollars monthly for an individual with a household income above two hundred percent of the federal poverty line but at or below two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size; and

(b) no payment is required for individuals with a household income at or below two hundred percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size.

6. Cost-sharing. The commissioner of health shall establish cost-sharing obligations for enrollees, subject to federal approval, including childbirth and newborn care consistent with the medical assistance program under title eleven of this article. There shall be no cost-sharing obligations for enrollees for:

(a) dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision two of this section; and

(b) services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision two of this section.

7. Rates of payment. (a) The commissioner of health shall select the contract with an independent actuary to study and recommend appropriate reimbursement methodologies for the cost of health care service coverage pursuant to this section. Such independent actuary shall review and make recommendations concerning appropriate actuarial assumptions relevant to the establishment of reimbursement methodologies, including but not limited to; the adequacy of rates of payment in relation to the population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the utilization of such services and the network of providers required to meet state standards.

(b) Upon consultation with the independent actuary and entities representing approved organizations, the commissioner of health shall

develop reimbursement methodologies and fee schedules for determining rates of payment, which rates shall be approved by the director of the division of the budget, to be made by the department to approved organizations for the cost of health care services coverage pursuant to this section. Such reimbursement methodologies and fee schedules may include provisions for capitation arrangements.

(c) The commissioner of health shall have the authority to promulgate regulations, including emergency regulations, necessary to effectuate the provisions of this subdivision.

(d) The department of health shall require the independent actuary selected pursuant to paragraph (a) of this subdivision to provide a complete actuarial report, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates for the 1332 state innovation plan authorized under this section. Such report shall be provided annually to the temporary president of the senate and the speaker of the assembly.

8. An individual who is lawfully admitted for permanent residence, permanently residing in the United States under color of law, or who is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15), and who would be ineligible for medical assistance under title eleven of this article due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall be considered to be ineligible for medical assistance for purposes of paragraphs (b) and (c) of subdivision three of this section.

9. **(a) In determining eligibility for residents of the state that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status, the commissioner of health may place limitations on enrollment to ensure that the costs associated with rendering services to this population do not exceed the revenues anticipated to be transferred to the 1332 state innovation program fund, pursuant to section ninety-eight-d of the state finance law. In establishing any limitations pursuant to this subdivision the commissioner of health shall enroll at least two hundred forty thousand individuals and may enroll additional individuals as reasonably practicable while ensuring continual coverage for such additional individuals based on current and anticipated 1332 state innovation program fund reserves.**

(b) In determining any limitations on enrollment, the commissioner of health shall determine income bands for such individuals from zero to two hundred fifty percent of the federal poverty line defined and annually revised by the United States department of health and human services for a household of the same size. The commissioner of health shall prioritize the enrollment of individuals from the lowest income band first and then the remaining income bands in ascending order.

(c) Notwithstanding the provisions of paragraph (b) of this subdivision, the commissioner of health may also include subsets of the population whose continued health and well-being would be significantly at risk without routine access to health care. Population subsets to be prioritized for enrollment shall be determined by the commissioner of health and shall include but not be limited to: (i) individuals with life threatening conditions, (ii) individuals in need of an organ transplant; and (iii) individuals with significant behavioral health issues including but not limited to serious mental illness or substance use disorder.

10. The commissioner of health shall take all actions necessary to obtain all necessary approvals from the secretary of health and human services and the secretary of the treasury to utilize moneys transferred

to the basic health program trust fund, pursuant to section ninety-seven-oooo of the state finance law, as added by section fifty-three of part C of chapter sixty of the laws of two thousand fourteen, for costs associated with the provision of health care services to all persons eligible for coverage under the waiver. If approval is not granted for all persons eligible for coverage under the waiver, the commissioner of health shall take all actions necessary to obtain approval for the use of moneys of the basic health program trust fund for costs associated with the provision of health care services to individuals under the waiver that would otherwise be eligible for participation in the basic health program, established pursuant to section three hundred sixty-nine-gg of this title.

11. Reporting. The commissioner of health shall submit a report to the temporary president of the senate and the speaker of the assembly annually by December thirty-first. The report shall include, at a minimum, an analysis of the 1332 state innovation program and its impact on the financial interest of the state; its impact on the Marketplace including enrollment and premiums; its impact on the number of uninsured individuals in the state; its impact on the Medicaid global cap; any enrollment limitations established pursuant to subdivision nine of this section including the rationale and supporting fiscal calculations used to justify such limitation, including any historical data, if available, for the previous three years related to any previous limitations of enrollment, funds transferred to the 1332 state innovation program fund pursuant to section ninety-eight-d of the state finance law, and totals on any savings to the state due to coverage of residents of the state that are ineligible for the basic health program under 42 U.S.C. section 18051 on the basis of immigration status; any moneys utilized from the basic health plan trust fund to support the delivery of health care services to persons eligible for coverage under the waiver; and the demographics of the 1332 state innovation program enrollees including age and immigration status.

[~~10.~~] 12. Severability. If the secretary of health and human services or the secretary of the treasury do not approve any provision of the application for a state innovation waiver, such decision shall in no way affect or impair any other provisions that the secretaries may approve under this section.

§ 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 on the same date and in the same manner as section 3 of part H of chapter 57 of the laws of 2023 amending the social services law relating to enacting the 1332 state innovation program, takes effect.