STATE OF NEW YORK

8614

2025-2026 Regular Sessions

IN SENATE

December 12, 2025

Introduced by Sen. COONEY -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the social services law, in relation to the basic health program (Part A); and to amend the financial services law, in relation to consumer protection from health care costs; and to repeal certain provisions of such law relating thereto (Part B)

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

Section 1. This act enacts into law components of legislation relating to health equity, affordability, and reform. Each component is wholly contained within a Part identified as Parts A through B. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, paragraph (c) of subdivision 1 as separately amended by sections 4 of part BBB of chapter 56 and part P of chapter 57 of the laws of 2022, paragraph (e) of subdivision 1, and subdivisions 5 and 7 as amended by section 2 of part H of chapter 57 of the laws of 2021, subdivision 2 as amended and subdivision 9 as added by section 28-a, subdivision 6 as added by section 28 and subdivision 8 as amended by section 46 of part B of chapter 57 of the laws of 2015, paragraph (d) of subdivision 3 as amended by section 2 and paragraph (b) of subdivision 5 as amended by section 7-a of part BBB of

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

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chapter 56 of the laws of 2022 and paragraph (d) of subdivision 3 as separately amended by chapter 669 of the laws of 2022, is amended to read as follows:

§ 369-gg. Basic health program. 1. Definitions. For purposes of this section:

(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 to underwrite a basic health insurance plan pursuant to this title;

(c) "Health care services" means (i) the services and supplies as defined by the commissioner 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 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, and (iii) as defined by the commissioner and subject to federal approval, certain services and supports provided to enrollees eligible pursuant to subparagraph one of paragraph (g) of subdivision one of section three hundred sixty-six of this article 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 health insurance exchange marketplace; [~~and~~]

(e) "Basic health insurance plan" means a standard 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 this section[~~.~~]**;**

(f) "Eligible small group" means any employer, or trustee or trustees of a fund established by an employer, members of a trade association, labor union, fund established or participated in by two or more employers or by one or more labor unions, association, or a trustee or trustees of a fund established, created or maintained for the benefit of members of one or more associations, church, or any entity that may be eligible to purchase group coverage under the insurance law, provided

that any of the foregoing groups identified employ, represent, or cover one hundred or less individuals;

(g) "Qualified dependents" mean the spouse, and any dependent children of an individual seeking coverage through the basic health program buy-in; and

(h) "Family coverage" means the cost to buy-in to the basic health program for an individual and any qualified dependents based on the per member, per month cost applicable.

2. Authorization. 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 basic health program. The commissioner's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services to offer a basic health program in accordance with 42 U.S.C. 18051. The commissioner may take any and all actions necessary to obtain such approvals. Notwithstanding the foregoing, within ninety days of the effective date of [~~the~~] part B of chapter fifty-seven of the laws of two thousand fifteen [~~which amended this subdivision~~] the commissioner shall submit a report to the temporary president of the senate and the speaker of the assembly detailing a contingency plan in the event eligibility rules or regulations are modified or repealed; or in the event federal payment is reduced from ninety five percent of the premium tax credits and cost-sharing reductions pursuant to the patient protection and affordable care act (P.L. 111-148). The contingency plan shall be implemented within ninety days of the above stated events or the time period specified in federal law.

3. Eligibility. A person is eligible to receive coverage for health care services pursuant to this title if [~~he or she~~] such person:

(a) resides in New York state and is under sixty-five years of age;

(b) is not eligible for medical assistance under title eleven of this article or for the child health insurance plan described in title one-A of article twenty-five of the public health law;

(c) is 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 of such code; provided, however, that the commissioner of health may seek authority from the secretary of health and human services to permit individuals who are eligible for a small group employer-sponsored plan to purchase coverage through the basic health program buy-in; and

(d) (i) except as provided by subparagraph (ii) of this paragraph, has 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, unless the individual or an eligible small group purchases coverage through a basic health plan under the basic health program buy-in set forth under subdivision eleven or twelve of this section; 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; however, MAGI eligible noncitizens lawfully present in the United States 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 title if such noncitizen would be ineligible for medical assistance under title eleven of this article due to their immigration status;

(ii) subject to federal approval and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, has 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; however, MAGI eligible [~~aliens~~] noncitizens lawfully present in the United States 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 title if such [~~alien~~] noncitizen would be ineligible for medical assistance under title eleven of this article due to their immigration status;

(iii) subject to federal approval if required and the use of state funds, unless the commissioner may use funds under subdivision seven of this section, a pregnant individual who is eligible for and receiving coverage for health care services pursuant to this title is eligible to continue to receive health care services pursuant to this title during the 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 title;

(iv) subject to federal approval, a child born to an individual eligible for and receiving coverage for health care services pursuant to this title who would be eligible for coverage pursuant to subparagraphs [~~(2)~~] two or [~~(4)~~] four of paragraph (b) of subdivision [~~1~~] one of section three hundred [~~and~~] sixty-six of [~~the social services law~~] this article shall be deemed to have applied for 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.

An applicant who fails to make an applicable premium payment, if any, shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

3-a. Basic health program buy-in. A person or an eligible small group shall be permitted to purchase coverage from the state to enroll an individual or any qualified dependents in a basic health plan through the basic health program buy-in described under subdivision ten of this section, as long as the individual, and any qualified dependents otherwise meet the eligibility requirements in paragraphs (a), (b), and (c) of subdivision three of this section. An applicant who fails to make an applicable premium payment shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

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

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

(c) Upon an applicant's enrollment in a basic health insurance plan, coverage for health care services pursuant to the provisions of this

title shall be prospective. Coverage shall begin in a manner consistent with the requirements for qualified health plans offered through the health insurance exchange marketplace, as delineated in federal regulation at 42 CFR 155.420(b)(1) or any successor regulation thereof.

(d) A person who has enrolled for coverage pursuant to this title, and who loses eligibility to enroll in the basic health 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 title, 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 [~~his or her~~] their eligibility for coverage continued until the end of such twelve month period, provided that the state receives federal approval for using funds from the basic health program trust fund, established under section 97-oooo of the state finance law, for the costs associated with such assistance.

5. Premiums and cost sharing. (a) Subject to federal approval, the commissioner shall establish premium payments enrollees shall pay to approved organizations for coverage of health care services pursuant to this title. 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.

(a-1) For an individual with a household income above 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, an individual who purchases individual, or family coverage through the basic health program buy-in under subdivision ten of this section, or an eligible small group who purchases or contributes to the cost of such coverage under subdivision eleven of this section for such individual and any qualified dependents, shall make monthly payments equaling the per member-per month payment received by a basic health plan for providing basic health program services in the region where the individual resides, provided that the commissioner shall pursue any federal waivers and be permitted to take any other actions necessary to use federal premium tax credits cost sharing reductions, and any other federal subsidies that may be available for such individuals, and in the absence of federal subsidies, state funds, to finance the program and keep the applicable premium payments and cost sharing owed for basic health program buy-in members as affordable as possible and consistent with the coverage and benefit design applicable to basic health program beneficiaries. The commissioner shall be authorized to create variable premium amounts and plan designs based on income, consistent with current practice, such that individuals at lower household income levels could pay lower premiums and have lower or less cost sharing compared to individuals at higher income levels.

(a-2) Eligible small groups that purchase coverage for an individual and any qualified dependents under subdivision eleven of this section may be required to pay to the state or basic health plan, a premium supplement payment as described in subparagraph (ii) of paragraph (a-3) of this subdivision. Such fund shall be used to help ensure program viability, and for other purposes that may be allowed by the secretary of health and human services, including but not limited to, rate adequa-

cy for approved organizations and network providers, as may be determined by the commissioner.

(a-3) (i) The commissioner shall contract with an independent actuary to study and make recommendations around premiums and cost sharing for the basic health program buy-in. The analysis for developing premiums for approved organizations shall include an analysis of rates of payment in relation to the expected population to be served adjusted for case mix, the scope of health care services approved organizations must provide, the projected utilization of such services, the network of providers required to meet state standards, and subject to approval from the secretary of health and human services and the division of the budget, existing rates of payment in effect under the basic health program, and subject to approval by the secretary of health and human services and subject to the discretion of the commissioner and the division of the budget once enrollment in the basic health program buy-in has reached more than two hundred thousand enrollees, rates of payment in effect under Medicare Part A, B, and C.

(ii) Premium supplement payments. The analysis conducted by the independent actuary shall include recommended premium supplement payment amounts that the commissioner, in consultation with the division of the budget, may require to be paid by certain individuals or eligible small groups to increase available funds and maintain the affordability of the basic health program for individuals at lower income levels who obtain coverage under the buy-in described in subdivisions ten and eleven of this section. The analysis may consider anticipated savings for eligible small groups and individuals who would otherwise have to purchase coverage from the health insurance exchanges or the small group market, as applicable, to provide varying options of premium supplements across household income levels and small group size.

(a-4) For coverage purchased through subdivision ten or eleven of this section, for individuals and qualified dependents with household incomes above five hundred percent of the federal poverty line, as defined and annually revised by the United States department of health and human services for a household of the same size, or any eligible small group purchasing or contributing to such coverage on their behalf, in the discretion of the commissioner and the division of the budget, a premium supplement payment may be required by either individuals or eligible small groups to increase state share funds for the program. The premium supplement amount may vary based on income levels and shall be determined by the commissioner to ensure the program remains affordable and does not present undue barriers to purchasing coverage.

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval. There shall be no cost-sharing obligations for enrollees for dental and vision services as defined in subparagraph (ii) of paragraph (c) of subdivision one of this section; services and supports as defined in subparagraph (iii) of paragraph (c) of subdivision one of this section; and health care services authorized under subparagraphs (iii) and (iv) of paragraph (d) of subdivision three of this section. Such cost sharing shall: (i) not include deductibles for individuals at any household income level; (ii) subject to available funds, not require any cost sharing for household incomes not exceeding five 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, but if this is not possible, then such cost sharing shall be set as low as possible for the lowest household incomes; and (iii) not be established as a percentage

of the cost of the service and comprise a fixed cost intended to be as affordable as possible and not act as a barrier to care, that in no event shall be more than two hundred dollars for any covered health care service. Cost sharing owed for services above five hundred percent of the federal poverty line shall vary based on income to promote equity and fairness.

6. Rates of payment. (a) The commissioner 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 title. 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, existing rates of payment in effect under the basic health program, and subject to approval by the secretary of health and human services and the division of the budget, and once enrollment in the basic health program buy-in has reached more than one hundred thousand enrollees, rates of payment in effect under Medicare Part A, B, and C.

(b) Upon consultation with the independent actuary and entities representing approved organizations, the commissioner shall develop reimbursement methodologies and fee schedules for determining rates of payment, which rate 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 title. Such reimbursement methodologies and fee schedules may include provisions for capitation arrangements.

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

(d) The department 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 basic health plan authorized under this section. Such report shall be provided annually to the temporary president of the senate and the speaker of the assembly.

7. Any funds transferred by the secretary of health and human services to the state pursuant to 42 U.S.C. 18051(d) shall be deposited in trust. Funds from the trust shall be used for providing health benefits through [~~an approved organization~~] a basic health plan, which, at a minimum, shall include essential health benefits as defined in 42 U.S.C. 18022(b); to reduce the premiums, if any, and cost sharing of participants in the basic health program; or for such other purposes as may be allowed by the secretary of health and human services. Health benefits available through the basic health program shall be provided by one or more approved organizations pursuant to an agreement with the department of health and shall meet the requirements of applicable federal and state laws and regulations.

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 [~~his or her~~] 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. Reporting. The commissioner 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 basic health program and its impact on the financial interest of the state; its impact on the health benefit exchange including enrollment and premiums; its impact on the number of uninsured individuals in the state; its impact on the Medicaid global cap; **its impact on health care affordability for middle class New Yorkers; its impact on small business and economic activity; its impact on population trends in the state; the impact of basic health program payment rates on hospital finances and financial sustainability, and recommendations to address any potential concerns based on migration from the commercial insurance market to the basic health program;** and the demographics of basic health program enrollees including age and immigration status.

10. Network participation. Any provider licensed or certified under article thirty-one or thirty-two of the mental hygiene law, and any hospital licensed under article twenty-eight of the public health law, including any clinic, physician or specialist group, outpatient facility or practice, ambulatory care setting or other office-based setting, or other health care setting owned in whole or in part by a hospital licensed under article twenty-eight of the public health law, as well as any single or multi-specialty free-standing ambulatory surgery centers licensed under article twenty-eight of the public health law, shall make covered health care services available to any individual in the basic health program. Approved organizations operating basic health plans and providers shall use good faith efforts to negotiate network participation arrangements to provide covered services for individuals enrolled in the basic health program.

11. Basic health program buy-in for individuals. Any individual who meets the eligibility requirements of paragraphs (a) and (b) of subdivision three of this section shall be permitted to purchase basic health program coverage for themselves and any qualified dependents who otherwise meet the eligibility requirements of paragraphs (a) and (b) of subdivision three of this section, through the basic health program buy-in. Subject to approval from the United States secretary of health and human services, the basic health program buy-in shall allow eligible individuals to pay the regional per member, per month premium that is paid to a basic health plan for eligible individuals in the region, or any subsidized premium based on the availability of federal or state subsidies as basic health program funds permit, for themselves and any qualified dependents, and gain coverage through the basic health program.

12. Basic health program buy-in for eligible small groups. Any eligible small group may pay to a basic health plan the full or partial amount of the premium costs for an individual and their qualified dependents to buy-in to the basic health program as a benefit to members of the eligible small group. The commissioner shall establish procedures through which eligible small groups can pay voluntary premium contributions, and if contributions are made, any applicable required subsidy equivalency payments and premium supplements for covered individuals and their qualified dependents, directly to a basic health plan on an aggregate, monthly basis.

13. The commissioner shall seek any federal waivers, approvals, and take any and all actions necessary to implement this section, including but not limited to federal waivers and approvals, and pursue any state statutory or regulatory changes necessary to implement this act, including establishing penalties, fines, and oversight authority, in conjunction with the department of taxation and finance, to capture accurate information from individuals and eligible small groups, and ensure eligible small groups are complying with the requirements of this section.

§ 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; provided, further, that the amendments to paragraphs (c) and (e) of subdivision 1, paragraph (d) of subdivision 3, and subdivisions 5 and 7 of section 369-gg of the social services law made by section one of this act shall not affect the expiration of such paragraphs and subdivisions and shall be deemed to expire therewith.

PART B

Section 1. Legislative intent. The legislature finds and declares all of the following:

The medical care a person requires should never result in financial hardship or bankruptcy, yet for too many New Yorkers, an unexpected medical emergency or diagnosis carries both life-altering health and financial consequences. An individual should not need to substantially modify theirs and their family's future by liquidating college or retirement savings or need to create a "Go-Fund Me" to afford the bills from a medical emergency.

As a result of the Affordable Care Act, health insurance plans today are required to establish out-of-pocket payment maximums that are intended to limit one's out-of-pocket cost liability for health care expenses. However, the out-of-pocket maximum excludes out-of-network care as well as premium contributions paid by an individual. This means that the sum of premium payments a person makes for their health care does not count towards the out-of-pocket cap. It also means what is often the most expensive health care services that may be rendered for an individual, out-of-network health care services are not subject to the maximum cap, and even if a plan offers an out-of-network cap, this may be so high that it offers no relief for the consumer.

While there are many contributing factors as to why individuals undergoing treatment receive unaffordable medical bills, out-of-network charges continue to top that list. New York has tried to protect consumers from out-of-network bills through the Independent Dispute Resolution process. Unfortunately, it has not been able to protect consumers from experiencing crushing financial burdens associated with costly medical care, and has created an incentive for costs to increase. Specifically, studies have shown New York's Independent Dispute Resolution process and its ultimate reliance on providers' own charges, instead of what providers are actually reimbursed from commercial health insurers for the services provided, has deeply harmed consumers, contributing more than anything else to the severe financial burden New Yorkers' experience and associate when they are undergoing treatment or experience a medical crisis. The Independent Dispute Resolution process

creates a financial incentive for providers to remain out-of-network and consistently increase their "charges", as charges are part of the criteria used to determine payment of a disputed out-of-network charge. Higher charges also result in higher Independent Dispute Resolution awards and more costs being built into premiums in subsequent years, creating an annual spiral of increasing costs that burden us all. It is essential to address health care costs in a way that is fair to our providers but ultimately puts consumers first.

§ 2. Article 6 of the financial services law is REPEALED and a new article 6 is added to read as follows:

ARTICLE 6

CONSUMER PROTECTION FROM HEALTH CARE COSTS

Section 601. Applicability.
602. Definitions.
603. Rates of payment for non-participating services.
604. Annual limit on consumer health care expenditures.

§ 601. Applicability. This article shall not apply to health care services, including emergency services, where physician fees are subject to schedules or other monetary limitations under any other law, including the workers' compensation law and article fifty-one of the insurance law, and shall not preempt any such law, any program for individuals covered by article five of the social services law, article twenty-five of the public health law, titles XVIII, XIX, and XXI of the federal social security act, or chapter 89 of title 5 of the United States code.

§ 602. Definitions. For purposes of this article:

(a) "Emergency health care services" means health care services rendered to an insured experiencing an "emergency condition".

(b) "Emergency condition" means medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including 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: (1) 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; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; (4) serious disfigurement of such person; or (5) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the social security act 42 U.S.C. 1395dd.

(c) "Health care plan" means an insurer licensed to write accident and health insurance pursuant to article thirty-two of the insurance law; a corporation organized pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of the public health law; or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law.

(d) "Insured" means a patient covered under a health care plan's policy or contract.

(e) "Nonemergency health care services" means health care services rendered to an insured experiencing a medical condition other than an emergency condition.

(f) "In-network contracted rate" means the rate contracted between an insured's health care plan and a participating health care provider for the reimbursement of health care services delivered by that health care provider to the insured.

(g) "Median, in-network contracted rate" means the median allowed amount paid to in-network providers for a specific service by a specific health plan.

(h) "Non-participating commercial rate for emergency services" means the amount set pursuant to this section, and used to determine the rate of payment to a health care provider for the provision of emergency health care services to an insured when the health care provider is not in the insurer's network.

(i) "Noncontracted commercial rate for nonemergency services" means the amount set pursuant to this section, and used to determine the rate of payment to a health care provider for the provision of nonemergency health care services to an insured when the health care provider is not in the insurer's network.

§ 603. Rates of payment for non-participating services. All health care plans shall pay non-participating providers of emergency and non-emergency health care services provided to an insured at the insurers median, in-network rate for the service provided. Providers shall be prohibited from balance billing an insured for any amount above the median, in-network rate paid for the health care service. The superintendent may promulgate regulations necessary to implement this section, including establishing a default out-of-network reimbursement rate for both emergency and non-emergency services, which shall account for the actual average in-network reimbursed amount for the claim, and may be set as a percentage of the Medicare fee schedule rate for the service.

§ 604. Annual limit on consumer health care expenditures. (a) Notwithstanding any out-of-pocket maximums that may exist today, the superintendent shall establish annual limits on the overall financial amount an insured shall be responsible for in the state regulated commercial health insurance market, for payment of health care costs under a contract with a New York state regulated health plan, which shall be inclusive of all premium contributions made directly by the individual for individual or family coverage, as well as any amounts paid towards copays, coinsurance, and deductibles, for health care services, irrespective of whether the service is provided by an in-network or out-of-network provider, such that when the total amount of health care costs paid by an individual reaches the applicable limit, the consumer is no longer financially responsible to the insurer for payment of out-of-pocket costs. For purposes of this section, any financial contributions toward the premium made by an employer for health insurance coverage shall not count towards the annual out-of-pocket maximum.

(b) In implementing subsection (a) of this section, the superintendent may use the IRS Employer Health Plan Affordability Threshold as a baseline, but shall establish cap amounts at various household income levels, such that individuals with less household income shall be subject to a lower annual payment cap, and individuals with higher household income shall be subject to a higher annual cap, but in no event shall the annual out-of-pocket maximum cap more than double the IRS Employer Health Plan Affordability Threshold for individuals at any income level. The superintendent shall be permitted to apply for any federal waivers and pursue any reinsurance options for insurers or the state and take other actions consistent with this section to implement its intent.

(c) The commissioner of health shall work with the commissioner of taxation and finance to establish appropriate penalties and safeguards to ensure proper implementation of this article.

§ 3. This act shall take effect immediately, provided however, that it shall apply to all health care plan policies beginning on January 1, 2027. 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.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by a 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 provision had not been included herein.

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