

STATE OF NEW YORK

8614--A

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 -- recommitted to the Committee on Health in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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:

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

11 PART A

12 Section 1. Section 369-gg of the social services law, as added by
13 section 51 of part C of chapter 60 of the laws of 2014, paragraph (c) of
14 subdivision 1 as separately amended by sections 4 of part BBB of chapter
15 56 and part P of chapter 57 of the laws of 2022, paragraph (e) of subdi-
16 vision 1, and subdivisions 5 and 7 as amended by section 2 of part H of
17 chapter 57 of the laws of 2021, subdivision 2 as amended and subdivision
18 9 as added by section 28-a, subdivision 6 as added by section 28 and

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

LBD14093-02-6

1 subdivision 8 as amended by section 46 of part B of chapter 57 of the
2 laws of 2015, paragraph (d) of subdivision 3 as amended by section 2 and
3 paragraph (b) of subdivision 5 as amended by section 7-a of part BBB of
4 chapter 56 of the laws of 2022 and paragraph (d) of subdivision 3 as
5 separately amended by chapter 669 of the laws of 2022, is amended to
6 read as follows:

7 § 369-gg. Basic health program. 1. Definitions. For purposes of this
8 section:

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

15 (b) "Approved organization" means an eligible organization approved by
16 the commissioner to underwrite a basic health insurance plan pursuant to
17 this title;

18 (c) "Health care services" means (i) the services and supplies as
19 defined by the commissioner in consultation with the superintendent of
20 financial services, and shall be consistent with and subject to the
21 essential health benefits as defined by the commissioner in accordance
22 with the provisions of the patient protection and affordable care act
23 (P.L. 111-148) and consistent with the benefits provided by the refer-
24 ence plan selected by the commissioner for the purposes of defining such
25 benefits, and shall include coverage of and access to the services of
26 any national cancer institute-designated cancer center licensed by the
27 department of health within the service area of the approved organiza-
28 tion that is willing to agree to provide cancer-related inpatient,
29 outpatient and medical services to all enrollees in approved organiza-
30 tions' plans in such cancer center's service area under the prevailing
31 terms and conditions that the approved organization requires of other
32 similar providers to be included in the approved organization's network,
33 provided that such terms shall include reimbursement of such center at
34 no less than the fee-for-service medicaid payment rate and methodology
35 applicable to the center's inpatient and outpatient services; (ii)
36 dental and vision services as defined by the commissioner, and (iii) as
37 defined by the commissioner and subject to federal approval, certain
38 services and supports provided to enrollees eligible pursuant to subpar-
39 agraph one of paragraph (g) of subdivision one of section three hundred
40 sixty-six of this article who have functional limitations and/or chronic
41 illnesses that have the primary purpose of supporting the ability of the
42 enrollee to live or work in the setting of their choice, which may
43 include the individual's home, a worksite, or a provider-owned or
44 controlled residential setting;

45 (d) "Qualified health plan" means a health plan that meets the crite-
46 ria for certification described in § 1311(c) of the Patient Protection
47 and Affordable Care Act (P.L. 111-148), and is offered to individuals
48 through the health insurance exchange marketplace; [~~and~~]

49 (e) "Basic health insurance plan" means a standard health plan provid-
50 ing health care services, separate and apart from qualified health
51 plans, that is issued by an approved organization and certified in
52 accordance with this section[+];

53 (f) "Eligible small group" means any employer, or trustee or trustees
54 of a fund established by an employer, members of a trade association,
55 labor union, fund established or participated in by two or more employ-
56 ers or by one or more labor unions, association, or a trustee or trus-

1 tees of a fund established, created or maintained for the benefit of
2 members of one or more associations, church, or any entity that may be
3 eligible to purchase group coverage under the insurance law, provided
4 that any of the foregoing groups identified employ, represent, or cover
5 one hundred or less individuals;

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

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

12 2. Authorization. If it is in the financial interest of the state to
13 do so, the commissioner of health is authorized, with the approval of
14 the director of the budget, to establish a basic health program. The
15 commissioner's authority pursuant to this section is contingent upon
16 obtaining and maintaining all necessary approvals from the secretary of
17 health and human services to offer a basic health program in accordance
18 with 42 U.S.C. 18051. The commissioner may take any and all actions
19 necessary to obtain such approvals. Notwithstanding the foregoing, with-
20 in ninety days of the effective date of [~~the~~] part B of chapter fifty-
21 seven of the laws of two thousand fifteen [~~which amended this subdivi-~~
22 ~~sion~~] the commissioner shall submit a report to the temporary president
23 of the senate and the speaker of the assembly detailing a contingency
24 plan in the event eligibility rules or regulations are modified or
25 repealed; or in the event federal payment is reduced from ninety five
26 percent of the premium tax credits and cost-sharing reductions pursuant
27 to the patient protection and affordable care act (P.L. 111-148). The
28 contingency plan shall be implemented within ninety days of the above
29 stated events or the time period specified in federal law.

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

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

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

36 (c) is not eligible for minimum essential coverage, as defined in
37 section 5000A(f) of the Internal Revenue Service Code of 1986, or is
38 eligible for an employer-sponsored plan that is not affordable, in
39 accordance with section 5000A of such code; provided, however, that the
40 commissioner of health may seek authority from the secretary of health
41 and human services to permit individuals or eligible small groups to
42 purchase coverage through the basic health program buy-in; and

43 (d) (i) except as provided by subparagraph (ii) of this paragraph, has
44 household income at or below two hundred percent of the federal poverty
45 line defined and annually revised by the United States department of
46 health and human services for a household of the same size, unless the
47 individual or an eligible small group purchases coverage through a basic
48 health plan under the basic health program buy-in set forth under subdivi-
49 vision eleven or twelve of this section; and has household income that
50 exceeds one hundred thirty-three percent of the federal poverty line
51 defined and annually revised by the United States department of health
52 and human services for a household of the same size; however, MAGI
53 eligible noncitizens lawfully present in the United States with house-
54 hold incomes at or below one hundred thirty-three percent of the federal
55 poverty line shall be eligible to receive coverage for health care
56 services pursuant to the provisions of this title if such noncitizen

1 would be ineligible for medical assistance under title eleven of this
2 article due to their immigration status;

3 (ii) subject to federal approval and the use of state funds, unless
4 the commissioner may use funds under subdivision seven of this section,
5 has household income at or below two hundred fifty percent of the feder-
6 al poverty line defined and annually revised by the United States
7 department of health and human services for a household of the same
8 size; and has household income that exceeds one hundred thirty-three
9 percent of the federal poverty line defined and annually revised by the
10 United States department of health and human services for a household of
11 the same size; however, MAGI eligible [~~aliens~~] noncitizens lawfully
12 present in the United States with household incomes at or below one
13 hundred thirty-three percent of the federal poverty line shall be eligi-
14 ble to receive coverage for health care services pursuant to the
15 provisions of this title if such [~~alien~~] noncitizen would be ineligible
16 for medical assistance under title eleven of this article due to their
17 immigration status;

18 (iii) subject to federal approval if required and the use of state
19 funds, unless the commissioner may use funds under subdivision seven of
20 this section, a pregnant individual who is eligible for and receiving
21 coverage for health care services pursuant to this title is eligible to
22 continue to receive health care services pursuant to this title during
23 the pregnancy and for a period of one year following the end of the
24 pregnancy without regard to any change in the income of the household
25 that includes the pregnant individual, even if such change would render
26 the pregnant individual ineligible to receive health care services
27 pursuant to this title;

28 (iv) subject to federal approval, a child born to an individual eligi-
29 ble for and receiving coverage for health care services pursuant to this
30 title who would be eligible for coverage pursuant to subparagraphs [~~(2)~~]
31 two or [~~(4)~~] four of paragraph (b) of subdivision [~~1~~] one of section
32 three hundred [~~and~~] sixty-six of [~~the social services law~~] this article
33 shall be deemed to have applied for medical assistance and to have been
34 found eligible for such assistance on the date of such birth and to
35 remain eligible for such assistance for a period of one year.

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

40 3-a. Basic health program buy-in. A person or an eligible small group
41 shall be permitted to purchase coverage from the state to enroll an
42 individual or any qualified dependents in a basic health plan through
43 the basic health program buy-in described under subdivisions eleven and
44 twelve of this section, as long as the individual, and any qualified
45 dependents otherwise meet the eligibility requirements in paragraphs
46 (a), (b), and (c) of subdivision three of this section. An applicant who
47 fails to make an applicable premium payment shall lose eligibility to
48 receive coverage for health care services in accordance with time frames
49 and procedures determined by the commissioner.

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

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

1 (c) Upon an applicant's enrollment in a basic health insurance plan,
2 coverage for health care services pursuant to the provisions of this
3 title shall be prospective. Coverage shall begin in a manner consistent
4 with the requirements for qualified health plans offered through the
5 health insurance exchange marketplace, as delineated in federal regu-
6 lation at 42 CFR 155.420(b)(1) or any successor regulation thereof.

7 (d) A person who has enrolled for coverage pursuant to this title, and
8 who loses eligibility to enroll in the basic health program for a reason
9 other than citizenship status, lack of state residence, failure to
10 provide a valid social security number, providing inaccurate information
11 that would affect eligibility when requesting or renewing health cover-
12 age pursuant to this title, or failure to make an applicable premium
13 payment, before the end of a twelve month period beginning on the effec-
14 tive date of the person's initial eligibility for coverage, or before
15 the end of a twelve month period beginning on the date of any subsequent
16 determination of eligibility, shall have [~~his or her~~] **their** eligibility
17 for coverage continued until the end of such twelve month period,
18 provided that the state receives federal approval for using funds from
19 the basic health program trust fund, established under section 97-0000
20 of the state finance law, for the costs associated with such assistance.

21 5. Premiums and cost sharing. (a) Subject to federal approval, the
22 commissioner shall establish premium payments enrollees shall pay to
23 approved organizations for coverage of health care services pursuant to
24 this title. No payment is required for individuals with a household
25 income at or below two hundred percent of the federal poverty line
26 defined and annually revised by the United States department of health
27 and human services for a household of the same size.

28 (a-1) For an individual with a household income above two hundred
29 percent of the federal poverty line defined and annually revised by the
30 United States department of health and human services for a household of
31 the same size, an individual who purchases individual, or family cover-
32 age through the basic health program buy-in under subdivision eleven of
33 this section, or an eligible small group who purchases or contributes to
34 the cost of such coverage under subdivision twelve of this section for
35 such individual and any qualified dependents, shall make monthly
36 payments equaling the per member-per month payment received by a basic
37 health plan for providing basic health program services in the region
38 where the individual resides, provided that the commissioner shall
39 pursue any federal waivers and be permitted to take any other actions
40 necessary to use federal premium tax credits cost sharing reductions,
41 and any other federal subsidies that may be available for such individ-
42 uals, and in the absence of federal subsidies, state funds, to finance
43 the program and keep the applicable premium payments and cost sharing
44 owed for basic health program buy-in members as affordable as possible
45 and consistent with the coverage and benefit design applicable to basic
46 health program beneficiaries. The commissioner shall be authorized to
47 create variable premium amounts and plan designs based on income,
48 consistent with current practice, such that individuals at lower house-
49 hold income levels could pay lower premiums and have lower or less cost
50 sharing compared to individuals at higher income levels.

51 (a-2) Eligible small groups that purchase coverage for an individual
52 and any qualified dependents under subdivision twelve of this section
53 may be required to pay to the state or basic health plan, a premium
54 supplement payment as described in subparagraph (ii) of paragraph (a-3)
55 of this subdivision. Such fund shall be used to help ensure program
56 viability, and for other purposes that may be allowed by the secretary

1 of health and human services, including but not limited to, rate adequacy
2 for approved organizations and network providers, as may be deter-
3 mined by the commissioner.

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

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

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

44 (b) The commissioner shall establish cost sharing obligations for
45 enrollees, subject to federal approval. There shall be no cost-sharing
46 obligations for enrollees for dental and vision services as defined in
47 subparagraph (ii) of paragraph (c) of subdivision one of this section;
48 services and supports as defined in subparagraph (iii) of paragraph (c)
49 of subdivision one of this section; and health care services authorized
50 under subparagraphs (iii) and (iv) of paragraph (d) of subdivision three
51 of this section. Such cost sharing shall: (i) not include deductibles
52 for individuals at any household income level; (ii) subject to avail-
53 able funds, not require any cost sharing for household incomes not
54 exceeding five hundred percent of the federal poverty line defined and
55 annually revised by the United States department of health and human
56 services for a household of the same size, but if this is not possible,

1 then such cost sharing shall be set as low as possible for the lowest
2 household incomes; and (iii) not be established as a percentage
3 of the cost of the service and comprise a fixed cost intended to be as
4 affordable as possible and not act as a barrier to care, that
5 in no event shall be more than two hundred dollars for any covered
6 health care service. Cost sharing owed for services above five
7 hundred percent of the federal poverty line shall vary based on income
8 to promote equity and fairness.

9 6. Rates of payment. (a) The commissioner shall select the contract
10 with an independent actuary to study and recommend appropriate
11 reimbursement methodologies for the cost of health care service coverage
12 pursuant to this title. Such independent actuary shall review and make
13 recommendations concerning appropriate actuarial assumptions relevant to
14 the establishment of reimbursement methodologies, including but not
15 limited to; the adequacy of rates of payment in relation to the popu-
16 lation to be served adjusted for case mix, the scope of health care
17 services approved organizations must provide, the utilization of such
18 services and the network of providers required to meet state standards,
19 existing rates of payment in effect under the basic health program, and
20 subject to approval by the secretary of health and human services and
21 the division of the budget, and once enrollment in the basic health
22 program buy-in has reached more than one hundred thousand enrollees,
23 rates of payment in effect under Medicare Part A, B, and C.

24 (b) Upon consultation with the independent actuary and entities
25 representing approved organizations, the commissioner shall develop
26 reimbursement methodologies and fee schedules for determining rates of
27 payment, which rate shall be approved by the director of the division of
28 the budget, to be made by the department to approved organizations for
29 the cost of health care services coverage pursuant to this title. Such
30 reimbursement methodologies and fee schedules may include provisions for
31 capitation arrangements.

32 (c) The commissioner shall have the authority to promulgate regu-
33 lations, including emergency regulations, necessary to effectuate the
34 provisions of this subdivision.

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

42 7. Any funds transferred by the secretary of health and human services
43 to the state pursuant to 42 U.S.C. 18051(d) shall be deposited in trust.
44 Funds from the trust shall be used for providing health benefits through
45 ~~[an approved organization]~~ a basic health plan, which, at a minimum,
46 shall include essential health benefits as defined in 42 U.S.C.
47 18022(b); to reduce the premiums, if any, and cost sharing of partic-
48 ipants in the basic health program; or for such other purposes as may be
49 allowed by the secretary of health and human services. Health benefits
50 available through the basic health program shall be provided by one or
51 more approved organizations pursuant to an agreement with the department
52 of health and shall meet the requirements of applicable federal and
53 state laws and regulations.

54 8. An individual who is lawfully admitted for permanent residence,
55 permanently residing in the United States under color of law, or who is
56 a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C.

1 1101(a)(15), and who would be ineligible for medical assistance under
2 title eleven of this article due to [~~his or her~~] their immigration
3 status if the provisions of section one hundred twenty-two of this chap-
4 ter were applied, shall be considered to be ineligible for medical
5 assistance for purposes of paragraphs (b) and (c) of subdivision three
6 of this section.

7 9. Reporting. The commissioner shall submit a report to the temporary
8 president of the senate and the speaker of the assembly annually by
9 December thirty-first. The report shall include, at a minimum, an analy-
10 sis of the basic health program and its impact on the financial interest
11 of the state; its impact on the health benefit exchange including
12 enrollment and premiums; its impact on the number of uninsured individ-
13 uals in the state; its impact on the Medicaid global cap; its impact on
14 health care affordability for middle class New Yorkers; its impact on
15 small business and economic activity; its impact on population trends in
16 the state; the impact of basic health program payment rates on hospital
17 finances and financial sustainability, and recommendations to address
18 any potential concerns based on migration from the commercial insurance
19 market to the basic health program; and the demographics of basic health
20 program enrollees including age and immigration status.

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

35 11. Basic health program buy-in for individuals. Any individual who
36 meets the eligibility requirements of paragraphs (a) and (b) of subdivi-
37 sion three of this section shall be permitted to purchase basic health
38 program coverage for themselves and any qualified dependents who other-
39 wise meet the eligibility requirements of paragraphs (a) and (b) of
40 subdivision three of this section, through the basic health program
41 buy-in. Subject to approval from the United States secretary of health
42 and human services, the basic health program buy-in shall allow eligible
43 individuals to pay the regional per member, per month premium that is
44 paid to a basic health plan for eligible individuals in the region, or
45 any subsidized premium based on the availability of federal or state
46 subsidies as basic health program funds permit, for themselves and any
47 qualified dependents, and gain coverage through the basic health
48 program.

49 12. Basic health program buy-in for eligible small groups. Any eligi-
50 ble small group may pay to a basic health plan or the state the full or
51 partial amount of the premium costs for an individual and their quali-
52 fied dependents to buy-in to the basic health program as a benefit to
53 members of the eligible small group. The commissioner shall establish
54 procedures through which eligible small groups can pay voluntary premium
55 contributions, and if required, any applicable premium supplements for

1 covered individuals and their qualified dependents, directly to a basic
2 health plan or the state.

3 13. The commissioner shall seek any federal waivers, approvals, and
4 take any and all actions necessary to implement this section, including
5 but not limited to federal waivers and approvals, and pursue any state
6 statutory or regulatory changes necessary to implement this act, includ-
7 ing establishing penalties, fines, and oversight authority, in conjunc-
8 tion with the department of taxation and finance, to capture accurate
9 information from individuals and eligible small groups, and ensure
10 eligible small groups are complying with the requirements of this
11 section.

12 § 2. This act shall take effect on the one hundred eightieth day after
13 it shall have become a law. Effective immediately, the addition, amend-
14 ment and/or repeal of any rule or regulation necessary for the implemen-
15 tation of this act on its effective date are authorized to be made and
16 completed on or before such effective date; provided, further, that the
17 amendments to paragraphs (c) and (e) of subdivision 1, paragraph (d) of
18 subdivision 3, and subdivisions 5 and 7 of section 369-gg of the social
19 services law made by section one of this act shall not affect the expi-
20 ration of such paragraphs and subdivisions and shall be deemed to expire
21 therewith.

22 PART B

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

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

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

43 While there are many contributing factors as to why individuals under-
44 going treatment receive unaffordable medical bills, out-of-network
45 charges continue to top that list. New York has tried to protect
46 consumers from out-of-network bills through the Independent Dispute
47 Resolution process. Unfortunately, it has not been able to protect
48 consumers from experiencing crushing financial burdens associated with
49 costly medical care, and has created an incentive for costs to increase.
50 Specifically, studies have shown New York's Independent Dispute Resol-
51 ution process and its ultimate reliance on providers' own charges,
52 instead of what providers are actually reimbursed from commercial health
53 insurers for the services provided, has deeply harmed consumers,
54 contributing more than anything else to the severe financial burden New

1 Yorkers' experience and associate when they are undergoing treatment or
2 experience a medical crisis. The Independent Dispute Resolution process
3 creates a financial incentive for providers to remain out-of-network and
4 consistently increase their "charges", as charges are part of the crite-
5 ria used to determine payment of a disputed out-of-network charge. High-
6 er charges also result in higher Independent Dispute Resolution awards
7 and more costs being built into premiums in subsequent years, creating
8 an annual spiral of increasing costs that burden us all. It is essen-
9 tial to address health care costs in a way that is fair to our providers
10 but ultimately puts consumers first.

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

13 ARTICLE 6

14 CONSUMER PROTECTION FROM HEALTH CARE COSTS

15 Section 601. Applicability.

16 602. Definitions.

17 603. Rates of payment for non-participating services.

18 604. Annual limit on consumer health care expenditures.

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

27 § 602. Definitions. For purposes of this article:

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

30 (b) "Emergency condition" means medical or behavioral condition that
31 manifests itself by acute symptoms of sufficient severity, including
32 severe pain, such that a prudent layperson, possessing an average know-
33 ledge of medicine and health, could reasonably expect the absence of
34 immediate medical attention to result in: (1) placing the health of the
35 person afflicted with such condition in serious jeopardy, or in the case
36 of a behavioral condition placing the health of such person or others in
37 serious jeopardy; (2) serious impairment to such person's bodily func-
38 tions; (3) serious dysfunction of any bodily organ or part of such
39 person; (4) serious disfigurement of such person; or (5) a condition
40 described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the
41 social security act 42 U.S.C. 1395dd.

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

50 (d) "Insured" means a patient covered under a health care plan's poli-
51 cy or contract.

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

55 (f) "In-network contracted rate" means the rate contracted between an
56 insured's health care plan and a participating health care provider for

1 the reimbursement of health care services delivered by that health care
2 provider to the insured.

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

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

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

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

28 § 604. Annual limit on consumer health care expenditures. (a) Notwith-
29 standing any out-of-pocket maximums that may exist today, the super-
30 intendent shall establish annual limits on the overall financial amount
31 an insured shall be responsible for in the state regulated commercial
32 health insurance market, for payment of health care costs under a
33 contract with a New York state regulated health plan, which shall be
34 inclusive of all premium contributions made directly by the individual
35 for individual or family coverage, as well as any amounts paid towards
36 copays, coinsurance, and deductibles, for health care services, irre-
37 spective of whether the service is provided by an in-network or out-of-
38 network provider, such that when the total amount of health care costs
39 paid by an individual reaches the applicable limit, the consumer is no
40 longer financially responsible to the insurer for payment of out-of-
41 pocket costs. For purposes of this section, any financial contributions
42 toward the premium made by an employer for health insurance coverage
43 shall not count towards the annual out-of-pocket maximum.

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

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

4 § 3. This act shall take effect immediately; provided however, that
5 it shall apply to all health care plan policies beginning on January 1,
6 2027. Effective immediately, the addition, amendment and/or repeal of
7 any rule or regulation necessary for the implementation of this act on
8 its effective date are authorized to be made and completed on or before
9 such effective date.

10 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-
11 sion, section or part of this act shall be adjudged by a court of compe-
12 tent jurisdiction to be invalid, such judgment shall not affect, impair,
13 or invalidate the remainder thereof, but shall be confined in its opera-
14 tion to the clause, sentence, paragraph, subdivision, section or part
15 thereof directly involved in the controversy in which such judgment
16 shall have been rendered. It is hereby declared to be the intent of the
17 legislature that this act would have been enacted even if such invalid
18 provision had not been included herein.

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