§ 2807-ff. New York managed care organization provider tax. 1. The commissioner, subject to the approval of the director of the budget, shall: apply for a waiver or waivers of the broad-based and uniformity requirements related to the establishment of a New York managed care organization provider tax (the "MCO provider tax") in order to secure federal financial participation for the costs of the medical assistance program; and, subject to approval by the centers for Medicare and Medicaid services, impose the MCO provider tax as an assessment upon insurers, health maintenance organizations, and managed care organizations (collectively referred to as "health plan") offering the following plans or products:

(a) Medical assistance program coverage provided by managed care providers pursuant to section three hundred sixty-four-j of the social services law;

(b) A health insurance plan serving individuals enrolled pursuant to title one-A of article twenty-five of this chapter;

(c) Essential plan coverage certified pursuant to title eleven-D of article five of the social services law;

(d) Coverage purchased on the New York insurance exchange established pursuant to section two hundred sixty-eight-b of this chapter; or

(e) Any other comprehensive coverage subject to articles thirty-two, forty-two and forty-three of the insurance law, or article forty-four of this chapter.

1-a. On or after April first, two thousand twenty-six, the commissioner, subject to the approval of the director of the budget, shall apply for an amendment of the MCO provider tax, subject to approval by the centers for Medicare and Medicaid services, to impose an amended MCO provider tax as an assessment upon health plans no sooner than January first, two thousand twenty-seven, as established in paragraph (b) of subdivision four of this section.

2. The MCO provider tax shall comply with all relevant provisions of federal laws, rules and regulations.

3. The department shall post on its website the MCO provider tax approval letter by the centers for Medicare and Medicaid services (the

"approval letter").

4. (a) Prior to January first, two thousand twenty-seven, a health plan, as defined in subdivision one of this section, shall pay the MCO provider tax for each calendar year as follows:

(i) For Medicaid member months below two hundred fifty thousand member months, a health plan shall pay one hundred twenty-six dollars per member month;

(ii) For Medicaid member months greater than or equal to two hundred fifty thousand member months but less than five hundred thousand member months, a health plan shall pay eighty-eight dollars per member month;

(iii) For Medicaid member months greater than or equal to five hundred thousand member months, a health plan shall pay twenty-five dollars per member month;

(iv) For essential plan member months less than two hundred fifty thousand member months, a health plan shall pay thirteen dollars per member month;

(v) For essential plan member months greater than or equal to two hundred fifty thousand member months, a health plan shall pay seven dollars per member month;

(vi) For non-essential plan non-Medicaid member months, consisting of the populations covered by the products described in paragraphs (b), (d), and (e) of subdivision one of this section, less than two hundred fifty thousand member months, a health plan shall pay two dollars per member month; and

(vii) For non-essential plan non-Medicaid member months greater than or equal to two hundred fifty thousand member months, a health plan shall pay one dollar and fifty cents per member month.

(b) Effective January first, two thousand twenty-seven, subject to any required approvals by the centers for Medicare and Medicaid services, a health plan, as defined in subdivision one of this section, shall pay the MCO provider tax for each calendar year at a rate of 0.35% of the health plan's total premium revenue.

5. A health plan shall remit the MCO provider tax due pursuant to this section to the commissioner or their designee quarterly or at a frequency defined by the commissioner.

6. Funds accumulated from the MCO provider tax, including interest and penalties, shall be deposited and credited by the commissioner, or the commissioner's designee, to the healthcare stability fund established in section ninety-nine-ss of the state finance law.

7. (a) Every health plan subject to the approved MCO provider tax shall submit reports in a form prescribed by the commissioner to accurately disclose information required to implement this section.

(b) If a health plan fails to file reports required pursuant to this subdivision within sixty days of the date such reports are due and after notification of such reporting delinquency, the commissioner may assess a civil penalty of up to ten thousand dollars for each failure; provided, however, that such civil penalty shall not be imposed if the health plan demonstrates good cause for the failure to timely file such reports.

8. (a) If a payment made pursuant to this section is not timely, interest shall be payable in the same rate and manner as defined in subdivision eight of section twenty-eight hundred seven-j of this article.

(b) The commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan has demonstrated that imposition of the full amount of the MCO provider tax pursuant to the timelines applicable under the approval letter has a high likelihood of creating an undue financial hardship for the health plan or creates a significant financial difficulty in providing needed services to Medicaid beneficiaries. In addition, the commissioner may waive a portion or all of either the interest or penalties, or both, assessed under this section if the commissioner determines, in their sole discretion, that the health plan did not have the information necessary from the department to pay the tax required in this section. Waiver of some or all of the interest or penalties pursuant to this subdivision shall be conditioned on the health plan's agreement to make MCO provider tax payments on an alternative schedule developed by the department that takes into account the financial situation of the health

plan and the potential impact on the delivery of services to Medicaid beneficiaries.

(c) Overpayment by or on behalf of a health plan of a payment shall be applied to any other payment due from the health plan pursuant to this section, or, if no payment is due, at the election of the health plan, shall be applied to future payments or refunded to the health plan. Interest shall be paid on overpayments from the date of overpayment to the date of crediting or refunding at the rate determined in accordance with this subdivision only if the overpayment was made at the direction of the commissioner. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

9. Payments and reports submitted or required to be submitted to the commissioner pursuant to this section by a health plan shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments and reports are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by a health plan; provided, however, that nothing in this section shall be construed as precluding the commissioner from pursuing collection of any such payments which are identified as delinquent within such six-year period, or which are identified as delinquent as a result of an audit commenced within such six-year period, or from conducting an audit of any adjustment or reconciliation made by a health plan, or from conducting an audit of payments made prior to such six-year period which are found to be commingled with payments which are otherwise subject to timely audit pursuant to this section.

10. In the event of a merger, acquisition, establishment, or any other similar transaction that results in the transfer of health plan responsibility for all enrollees under this section from a health plan to another health plan or similar entity, and that occurs at any time during which this section is effective, the resultant health plan or similar entity shall be responsible for paying the full tax amount as provided in this section that would have been the responsibility of the health plan to which that full tax amount was assessed upon the

effective date of any such transaction. If a merger, acquisition, establishment, or any other similar transaction results in the transfer of health plan responsibility for only some of a health plan's enrollees under this section but not all enrollees, the full tax amount as provided in this section shall remain the responsibility of that health plan to which that full tax amount was assessed.