*** § 2807-t. Assessments on covered lives.** 1. Definitions. (a) "Individual" means a person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services in the period other than:

(i) any person who is eligible for payments as a beneficiary of title XVIII of the federal social security act (medicare);

(ii) any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services contingent upon such person's relationship to an "individual" as a spouse, child, stepchild, adopted child, family member, or dependent, as defined by the specified third-party payor, or as contingent upon any other similar relationship to an "individual" as such relationship is defined by the specified third-party payor;

(iii) any person for whom the specified third-party payor has agreed to provide coverage for hospital confinement on other than an expense incurred basis;

(iv) any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services pursuant to the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law;

(v) any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services pursuant to the comprehensive motor vehicle insurance reparations act;

(vi) any person (hereinafter referred to as the "primary insured") otherwise meeting the definition of an "individual" as set forth under this section if the specified third-party payor has agreed to provide reimbursement for such person as part of a "family unit"; and

(vii) effective on and after April first, two thousand five, any person covered under a student policy issued pursuant to article forty-three of the insurance law, or a blanket student accident, blanket student health, or blanket student accident and health insurance policy.

(b) "Family unit" means any person for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services in the period, together with one or more additional persons for whom the specified third-party payor has agreed to provide reimbursement for inpatient hospital services in the period contingent upon such person's relationship to said person as a spouse, child, stepchild,

adopted child, family member, or dependent, as defined by the specified third-party payor, or as contingent upon any other similar relationship, as such relationship is defined by the specified third-party payor. Excluded from the definition is any family unit where the specified third-party payor has agreed to provide: coverage for hospital confinement on other than an expense incurred basis; reimbursement for inpatient hospital services pursuant to the worker's compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law; and reimbursement for inpatient hospital services pursuant to the comprehensive motor vehicle insurance reparations act. If a family unit of two persons includes one person who is eligible for payments as a beneficiary of title XVIII of the social security act (medicare), that family unit shall be deemed an individual for purposes of this section. If a family unit of three or more persons includes one person who is not eligible for medicare and the remaining two or more persons are eligible for medicare, that family unit shall be deemed an individual for purposes of this section. A family unit of two or more persons, all of whom are eligible for medicare, shall not be considered a family unit or an individual for purposes of this section.

(c) "Specified third-party payor", for purposes of this section, shall have the same meaning as set forth in section twenty-eight hundred seven-s of this article.

(d) "Region", for purposes of this section, shall have the same meaning as set forth in section twenty-eight hundred seven-s of this article.

2. Determination of annual regional payment amount. The sum total to be generated each year for each region shall be referred to as the annual regional payment amount, as determined in accordance with subdivision six of section twenty-eight hundred seven-s of this article.

3. Election. Any specified third-party payor may make an election to make payments for the assessments required by this section, on behalf of the liable persons or entities pursuant to subdivision eight of this section, directly to the commissioner or the commissioner's designee. The election pursuant to this subdivision must be in writing, filed with the commissioner or the commissioner's designee on such forms and in

such manner as the commissioner shall require. An election by a specified third-party payor shall take effect for nineteen hundred ninety-seven on the next following January first, April first, July first, or October first not less than thirty days after the election is filed. Beginning December first, nineteen hundred ninety-seven, an election pursuant to this section must be made no later than December first of the year prior to the assessment year. However, any specified third-party payor licensed pursuant to the insurance law or certified pursuant to article forty-four of this chapter between December first of the year prior to the assessment year and December thirty-first of the assessment year may make an election subsequent to such licensure or certification and during said time period, to take effect on the next following January first, April first, July first or October first not less than thirty days after such election is filed. Specified third-party payors other than those licensed pursuant to the insurance law or certified pursuant to this chapter which have not provided coverage prior to December first of the year prior to the assessment year may make an election at any time from December first of the year prior to said assessment year to December thirty-first of said assessment year, to take effect on the next following January first, April first, July first or October first not less than thirty days after the election is filed. An election shall remain in effect unless revoked in writing by a specified third-party payor, which revocation shall be effective on the first day of the next calendar year quarter, provided that such payor has provided notice of its intention to so revoke at least thirty days prior to the beginning of such calendar quarter.

(a) A specified third-party payor filing an election pursuant to this subdivision must agree: to provide the data and information required by subdivision four of this section; to provide such certification of data and access to individual and family unit data for audit verification purposes as the commissioner shall require for purposes of this section; and to the jurisdiction of the state to maintain an action in the courts of the state of New York to enforce any provision of this section related to payment of the assessments.

(b) If a specified third-party payor is acting in an administrative services capacity on behalf of an organization, such as a self-insured fund, the consent of the organization to the election and the conditions

pursuant to paragraph (a) of this subdivision must be submitted with the election. Such consent may be set forth in writing in the agreement between the specified third-party payor and the organization.

(c) If a specified third-party payor, including a payor operating in accordance with the insurance law or article forty-four of this chapter, making an election pursuant to this subdivision is acting in an administrative services capacity on behalf of an organization or organizations, such specified third-party payor must specify (i) whether such election applies to payments on behalf of all such organizations, and (ii) identify any organizations for which such specified third-party payor is acting to which the election does not apply and establish, in accordance with guidelines established by the superintendent of financial services, a system through which general hospitals and the commissioner can identify the status of a patient as a patient for whom the election does not apply.

(d) The commissioner may deny a specified third-party payor the opportunity to make an election pursuant to this subdivision based on repeated late payments, failure to remit correct amounts, or failure to provide adequate verification of the accuracy of payments.

(e) The commissioner or the commissioner's designee shall make available to all general hospitals a list of the specified third-party payors which have elected pursuant to this subdivision to remit payments pursuant to this section.

4. Assessments shall be calculated as follows: (a) Every specified third-party payor that has made an election pursuant to this section shall report to the commissioner or the commissioner's designee the number of individuals for a period as determined by the commissioner during the calendar year prior to the assessment year residing within each region ("individual member months"). Every such specified third-party payor shall also report to the commissioner or the commissioner's designee the number of family units for a period as determined by the commissioner during the calendar year prior to the assessment year residing within each region ("family member months"). For purposes of this section, the family unit is considered to reside in the region in which the primary insured resides.

(b) The superintendent of financial services shall advise the

commissioner of the average number of persons covered under family insurance contracts providing health care coverage approved by the superintendent for the year two years prior to the assessment year.

(c) The commissioner shall calculate the total number of "individual member months" for each region for all specified third-party payors to determine "aggregate individual member months" for each region.

(d) The commissioner shall calculate the total number of "family member months" for each region for all specified third-party payors to determine "aggregate family member months" for each region. The commissioner shall multiply the average number of persons covered under family insurance contracts, as reported to the commissioner by the superintendent of financial services, by the "aggregate family member months" to determine "adjusted aggregate family member months" for each region. The commissioner shall add the number of "adjusted aggregate family member months" for each region to the total number of "aggregate individual member months" for each region. This amount shall be known as "total covered member months" for each region.

(e) The annual regional payment amount for nineteen hundred ninety-seven, nineteen hundred ninety-eight, nineteen hundred ninety-nine, two thousand and each year thereafter, respectively for each region determined pursuant to subdivision two of this section shall be divided by an estimate derived from population based data sources of the total covered member months determined consistent with the provisions of paragraphs (a), (b), (c) and (d) of this subdivision in that region to establish the individual annual assessment for nineteen hundred ninety-seven, nineteen hundred ninety-eight, nineteen hundred ninety-nine, two thousand and each year thereafter, respectively. The individual annual assessment shall be multiplied by the average family size reported to the commissioner by the superintendent of financial services to establish the family unit annual assessment in that region for nineteen hundred ninety-seven, nineteen hundred ninety-eight, nineteen hundred ninety-nine, two thousand and each year thereafter, respectively.

(f) Effective January first, two thousand nine, a specified third-party payor that has made an election pursuant to this section may report to the commissioner or the commissioner's designee the number of individuals and family units enrolled as of the last day of each month

in fulfillment of the monthly reporting requirement set forth in paragraph (a) of this subdivision. A specified third-party payor choosing to report monthly enrollment counts on this basis shall indicate its choice at the beginning of a calendar year in a form and manner specified by the commissioner and such reporting method shall remain in effect the entire calendar year.

5. Monthly payments. (a) Within thirty days after the end of each month, a specified third-party payor which made an election pursuant to this section shall remit to the commissioner or the commissioner's designee one-twelfth of the individual annual assessment for each of the individuals residing in this state which were included on the membership rolls of that specified third-party payor during all or any portion of the prior month. Within thirty days after the end of each month, a specified third-party payor which made an election pursuant to this section shall also remit to the commissioner or the commissioner's designee one-twelfth of the family unit annual assessment for each family unit for which the primary insured resided in this state which were included on the membership rolls of that specified third-party payor during all or any portion of the prior month. Provided, however, for assessment obligations arising out of individual and family assessments established pursuant to this section on or after January first, two thousand, the commissioner may permit certain specified third-party payors which have at least one full year of pool payment experience to submit such payments on an annual basis, based on an annual demonstration by a payor through its prior year's pool payment experience that total pool obligations under this section and sections twenty-eight hundred seven-j and twenty-eight hundred seven-s of this article are not expected to exceed ten thousand dollars in the current pool year. If a specified third-party payor fails to make such payments within sixty days of notification of a 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 payor demonstrates good cause for such failure to timely make such payments, and further provided that the amount of such penalty shall not exceed the amount of the delinquent liability.

(b) The specified third party-payor shall be entitled to rely on the

residence location information provided to the payor by an employer, group or other party providing enrollment information to the specified third-party payor, provided the specified third-party payor has no reason to doubt the accuracy of the information.

(c) Specified third-party payors shall not be responsible for remitting the monthly assessment for any individual or for any family unit for any month in which it is subsequently determined that the specified third-party payor had no liability to provide coverage for inpatient hospital services for such individual or family unit.

6. Prospective adjustments. (a) The commissioner shall annually reconcile the sum of the actual payments made to the commissioner or the commissioner's designee for each region pursuant to section twenty-eight hundred seven-s of this article and pursuant to this section for the prior year with the regional allocation of the gross annual statewide amount specified in subdivision six of section twenty-eight hundred seven-s of this article for such prior year. The difference between the actual amount raised for a region and the regional allocation of the specified gross annual amount for such prior year shall be applied as a prospective adjustment to the regional allocation of the specified gross annual payment amount for such region for the year next following the calculation of the reconciliation. The authorized dollar value of the adjustments shall be the same as if calculated retrospectively.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, for covered lives assessment rate periods on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-one, for amounts collected in the aggregate in excess of one billion forty-five million dollars on an annual basis, and for the period January first, two thousand twenty-two to December thirty-first, two thousand twenty-nine for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis, prospective adjustments shall be suspended if the annual reconciliation calculation from the prior year would otherwise result in a decrease to the regional allocation of the specified gross annual payment amount for that region, provided, however, that such suspension shall be lifted upon a determination by the commissioner, in consultation with the director of the budget, that sixty-five million dollars in aggregate

collections on an annual basis over and above one billion forty-five million dollars on an annual basis for the period on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-one and for the period January first, two thousand twenty-two to December thirty-first, two thousand twenty-nine for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis have been reserved and set aside for deposit in the HCRA resources fund. Any amounts collected in the aggregate at or below one billion forty-five million dollars on an annual basis for the period on and after January first, two thousand fifteen through December thirty-first, two thousand twenty-two, and for the period January first, two thousand twenty-three to December thirty-first, two thousand twenty-nine for amounts collected in the aggregate in excess of one billion eighty-five million dollars on an annual basis, shall be subject to regional adjustments reconciling any decreases or increases to the regional allocation in accordance with paragraph (a) of this subdivision.

7. (a) In the case two or more specified third-party payors covering a single contract holder where both specified third-party payors cover separate components of the inpatient care benefits otherwise subject to the assessment, the assessment shall be apportioned between the insurers.

(b) With regard to assessment obligations arising out of individual and family assessments established pursuant to this section, where a single contract holder has separate components of the inpatient care benefits otherwise subject to the assessment covered by two or more entities, the assessment may be apportioned between the entities, provided that:

(i) Apportionment agreements or arrangements may only be entered into between or among specified third-party payers which have elected to make direct payments to the commissioner or the commissioner's designee pursuant to this subdivision; and

(ii) The aggregate of apportioned covered lives assessment payments must result in the payment of one hundred percent of the applicable covered lives assessment; and

(iii) Apportionment agreements between or among apportioning payers

and any modifications, amendments or termination of such agreements must be in writing and signed by all such payers, provided, however, that where one apportioning payor agrees to pay one hundred percent of the applicable covered lives assessment, no written agreement shall be required, provided there is other written evidence of the arrangement and any modifications, amendments and/or terminations thereof, emanating from the apportioning payor paying one hundred percent of the applicable covered lives assessment to the other apportioning payor or payors or to the particular group to which the arrangement relates, and further provided that such written evidence contains the name of the particular group to which the arrangement relates; and

(iv) Copies of apportionment agreements, and any modifications, amendments and/or terminations thereof, and written evidence of arrangements by which one apportioning payor agrees to pay one hundred percent of the applicable covered lives assessment, and any modifications, amendments and/or terminations thereof, must be maintained in the files of each apportioning payor while the apportionment is in effect and for a period of not less than six years after termination thereof and shall be made available to the department upon request for audit verification purposes.

8. Liability for assessments. (a) The assessments determined in accordance with this section shall, for individuals who have paid premiums directly to an insurer or to a health maintenance organization certified pursuant to article forty-four of this chapter or article forty-three of the insurance law for health care coverage which includes coverage of inpatient hospital services, be the liability of said individuals. The assessments determined in accordance with this section shall, for groups and entities who have paid premiums to an insurer or to a health maintenance organization certified pursuant to article forty-four of this chapter or article forty-three of the insurance law for health care coverage which includes coverage of inpatient hospital services, be the liability of said groups and entities. The assessments determined in accordance with this section shall, for individuals, groups and entities who have contributed to a self-insured fund for health care coverage which includes coverage of inpatient hospital services, be the liability of said individuals, groups or entities.

(b) Specified third-party payors shall make payments to the commissioner or the commissioner's designee of the full amount of the assessments determined in accordance with this section. Specified third-party payors may recover amounts due or paid to the commissioner or the commissioner's designee from the parties liable in accordance with paragraph (a) of this subdivision.

9. A specified third-party payor must either:

(a) jointly elect to pay the assessment pursuant to this section and the allowance pursuant to paragraph (c) of subdivision two and subdivision five of section twenty-eight hundred seven-j of this article; or

(b) pay the surcharge for an allowance determined in accordance with paragraph (b) of subdivision two of section twenty-eight hundred seven-j of this article, including the allowance determined in accordance with section twenty-eight hundred seven-s of this article.

10. (a) Payments and reports submitted or required to be submitted to the commissioner or to the commissioner's designee pursuant to this section by specified third-party payors 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 such specified third-party payors with regard to subsequent payments, provided, however, that nothing herein 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 adjustments and reconciliation made by a specified third party payor within such six year period, 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.

(b) Specified third-party payors which, in the course of an audit pursuant to this section fail to produce data or documentation requested

in furtherance of such an audit, within thirty days of such request, may be assessed a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if such specified third-party payor demonstrates good cause for such failure. The imposition of civil penalties pursuant to this section shall be subject to the provisions of section twelve-a of this chapter.

(c) Records required to be retained for audit verification purposes by specified third-party payors in accordance with this section shall include, but not be limited to, on a monthly basis, the source records generated by supporting information systems, financial accounting records, relevant correspondence and the addresses and dates of coverage for all individuals and family units, as defined by paragraphs (a) and (b) of subdivision one of this section, and such other records as may be required to prove compliance with, and to support reports submitted in accordance with, this section.

(d) If a specified third-party payor fails to produce data or documentation requested in furtherance of an audit pursuant to this section for a month to which an assessment applies, the commissioner may estimate, based on available financial and statistical data as determined by the commissioner, the amount due for such month. If the impact of the enrollment exemptions permitted pursuant to this section cannot be determined from such available financial and statistical data, the estimated amount due may be calculated on the basis of aggregate data derived from such available data for the year subject to audit. The commissioner shall take all necessary steps to collect amounts due as determined pursuant to this paragraph, including directing the state comptroller to offset such amounts due from any payments made by the state to the third party payor pursuant to this article. Interest and penalties shall be applied to such amounts due in accordance with the provisions of subdivision eight of section twenty-eight hundred seven-j of this article.

(e) The commissioner may, as part of a final resolution of an audit conducted pursuant to this subdivision, waive payment of interest and penalties otherwise applicable pursuant to subdivision eight of section twenty-eight hundred seven-j of this article, when amounts due as a result of such audit, other than such waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within

sixty days of the issuance of a final audit report that is mutually agreed to by the commissioner and auditee, provided, however, that if such final audit report is not so mutually agreed upon, then neither the commissioner nor the auditee shall have any obligations pursuant to this paragraph.

(f) The commissioner may enter into agreements with specified third-party payors in regard to which audit findings or prior settlements have been made pursuant to this section, extending and applying such audit findings or prior settlements, or a portion thereof, in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods. The commissioner may reduce or waive payment of interest and penalties otherwise applicable to such subsequent unaudited periods when such amounts due as a result of such agreement, other than reduced or waived interest and penalties, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement. Any payments made pursuant to agreements entered into in accordance with this paragraph shall be deemed to be in full satisfaction of any liability arising under this section, as referenced in such agreements and for the time periods covered by such agreements, provided, however, that the commissioner may audit future retroactive adjustments to payments made for such periods based on reports filed by payors subsequent to such agreements.

* NB Expires December 31, 2029