§ 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; and (ii) dental and vision services as defined by the commissioner;

* NB Effective until January 1, 2031

* (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;

* NB Effective January 1, 2031

(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.

* NB Repealed if federal approval is withdrawn or 42 U.S.C. 18051 is repealed

* (e) "Basic health insurance plan" means a standard health plan, separate and apart from qualified health plans, that is issued by an approved organization and certified in accordance with this section.

* NB Effective if federal approval is withdrawn or 42 U.S.C. 18051 is

repealed

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 chapter 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:

(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; 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; 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 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 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) or (4) of paragraph (b) of subdivision 1 of section three hundred and sixty-six of the social services law 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.

* NB Repealed if federal approval is withdrawn or 42 U.S.C. 18051 is repealed

* (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; 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 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 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) or (4) of paragraph (b) of subdivision 1 of section three hundred and sixty-six of the social services law 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 shall lose eligibility to receive coverage for health care services in accordance with time frames and procedures determined by the commissioner.

* NB Effective if federal approval is withdrawn or 42 U.S.C. 18051 is repealed

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 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.

(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.

* NB Repealed if federal approval is withdrawn or 42 U.S.C. 18051 is repealed

* 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. Such premium payments shall be established in the following

manner:

(i) up to twenty dollars monthly for an individual with a household income above one hundred and fifty percent of the federal poverty line but 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; and

(ii) no payment is required for individuals with a household income at or below one hundred and 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.

(b) The commissioner shall establish cost sharing obligations for enrollees, subject to federal approval. There shall be no cost-sharing obligations for 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.

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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.

(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, 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.

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* 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, which, at a minimum, shall include essential health benefits as defined in 42 U.S.C. 18022(b); to reduce the premiums 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.

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repealed

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 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; and the demographics of basic health program enrollees including age and immigration status.