

STATE OF NEW YORK

2007--B

IN ASSEMBLY

January 18, 2019

A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the social services law, in relation to reimbursement of transportation costs (Part A); to amend the public health law, in relation to updating copayments; to amend the public health law, in relation to extending and enhancing the Medicaid drug cap; to amend the social services law and the public health law, in relation to extending the preferred drug program to Medicaid managed care providers and offering the program to other health plans; and to repeal certain provisions of the social services law relating thereto (Part B); to amend the social services law, in relation to extension of the National Diabetes Prevention Program; and in relation to medical assistance coverage for medically tailored meals and medical nutrition therapy for the purpose of disease management (Part C); to amend chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to extending the medicaid global cap (Part D); to amend chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to extending the provisions thereof; to amend chapter 56 of the laws of 2013, amending the social services law relating to eligibility conditions, in relation to extending the provisions thereof; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to extending the provisions thereof; to amend chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to amend chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation

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

LBD12571-03-9

to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, in relation to the effectiveness thereof; to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medical expenditures, in relation to extending the provisions thereof; to amend the public health law, in relation to hospital assessments; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative costs; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to rates of payments; to amend the public health law, in relation to reimbursement rate promulgation for residential health care facilities; to amend the public health law, in relation to residential health care facility, and certified home health agency services payments; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to extending government rates for behavioral services and adding an alternative payment methodology requirement; to amend section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to transfer of funds and the effectiveness thereof; and to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof (Part E); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, relating to the effectiveness of certain provisions of such chapter, in relation to extending certain provisions concerning the hospital excess liability pool; and to amend part H of chapter 57 of the laws of 2017, amending the New York Health Care Reform Act of 1996 and other laws relating to extending certain provisions relating thereto, in relation to extending provisions relating to excess coverage (Part F); to amend



the social services law and the public health law, in relation to needs assessment and rate adequacy for medicaid; to establish a residential healthcare facilities case mix adjustment workgroup (Part G); to amend the public health law, in relation to waiver of certain regulations; to amend the public health law, in relation to certain rates and payment methodologies; and providing for the repeal of certain provisions upon expiration thereof (Part H); intentionally omitted (Part I); to amend the insurance law and the public health law, in relation to guaranteed availability, pre-existing conditions and employee welfare funds; and to repeal certain provisions of the insurance law relating thereto (Subpart A); and to amend the insurance law, in relation to actuarial value requirements and essential health benefits (Subpart B) (Part J); to amend chapter 517 of the laws of 2016 amending the public health law relating to payments from the New York state medical indemnity fund, in relation to the effectiveness thereof (Part K); intentionally omitted (Part L); intentionally omitted (Part M); intentionally omitted (Part N); intentionally omitted (Part O); intentionally omitted (Part P); to amend the public health law, in relation to the healthcare facility transformation program state III authorizing additional awards for statewide II applications and additional funding awarded to certain health care providers (Part Q); intentionally omitted (Part R); intentionally omitted (Part S); to amend the public health law, in relation to codifying the creation of NY State of Health, the official Health Plan Marketplace within the department of health (Part T); intentionally omitted (Part U); to amend the social services law, in relation to compliance of managed care organizations and providers participating in the Medicaid program (Part V); to amend part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part W); intentionally omitted (Part X); intentionally omitted (Part Y); to amend the public health law and the mental hygiene law, in relation to integrated services (Part Z); intentionally omitted (Part AA); intentionally omitted (Part BB); intentionally omitted (Part CC); intentionally omitted (Part DD); to amend the mental hygiene law, in relation to the establishment of the independent intellectual and developmental disability ombudsman program (Part EE); to amend the mental hygiene law, in relation to a suspension of service of a state-operated individualized residential alternative (Part FF); to amend the mental hygiene law, in relation to requiring the office of alcoholism and substance abuse services to maintain a directory on their website (Part GG); to amend chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness thereof (Part HH); to amend the public health law, in relation to funding early intervention services; and to repeal certain provisions of the public health law and the insurance law relating thereto (Part II); to amend the social services law, in relation to enhanced rates of payment (Part JJ); to amend the public health law, in relation to expanding child health plus services (Part KK); and to amend the financial services law, in relation to disputes involving fees paid to health care providers (Part LL)

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 major components of legislation
2 which are necessary to implement the state fiscal plan for the 2019-2020
3 state fiscal year. Each component is wholly contained within a Part
4 identified as Parts A through LL. The effective date for each particular
5 provision contained within such Part is set forth in the last section of
6 such Part. Any provision in any section contained within a Part, includ-
7 ing the effective date of the Part, which makes a reference to a section
8 "of this act", when used in connection with that particular component,
9 shall be deemed to mean and refer to the corresponding section of the
10 Part in which it is found. Section three of this act sets forth the
11 general effective date of this act.

12

PART A

13 Section 1. Subdivision 4 of section 365-h of the social services law,
14 as separately amended by section 50 of part B and section 24 of part D
15 of chapter 57 of the laws of 2015, is amended to read as follows:

16 4. The commissioner of health is authorized to assume responsibility
17 from a local social services official for the provision and reimburse-
18 ment of transportation costs under this section. If the commissioner
19 elects to assume such responsibility, the commissioner shall notify the
20 local social services official in writing as to the election, the date
21 upon which the election shall be effective and such information as to
22 transition of responsibilities as the commissioner deems prudent. The
23 commissioner is authorized to contract with a transportation manager or
24 managers to manage transportation services in any local social services
25 district, other than transportation services provided or arranged for:
26 enrollees of managed long term care plans issued certificates of author-
27 ity under section forty-four hundred three-f of the public health law
28 and adult day health care programs located at a licensed residential
29 health care facility as defined by section twenty-eight hundred one of
30 the public health law or an approved extension site thereof. Any trans-
31 portation manager or managers selected by the commissioner to manage
32 transportation services shall have proven experience in coordinating
33 transportation services in a geographic and demographic area similar to
34 the area in New York state within which the contractor would manage the
35 provision of services under this section. Such a contract or contracts
36 may include responsibility for: review, approval and processing of
37 transportation orders; management of the appropriate level of transpor-
38 tation based on documented patient medical need; and development of new
39 technologies leading to efficient transportation services. If the
40 commissioner elects to assume such responsibility from a local social
41 services district, the commissioner shall examine and, if appropriate,
42 adopt quality assurance measures that may include, but are not limited
43 to, global positioning tracking system reporting requirements and
44 service verification mechanisms. Any and all reimbursement rates devel-
45 oped by transportation managers under this subdivision shall be subject
46 to the review and approval of the commissioner.

47 § 2. Intentionally omitted.

48 § 3. Intentionally omitted.

49 § 4. This act shall take effect immediately and shall be deemed to
50 have been in full force and effect on and after April 1, 2019; provided,
51 however, that the amendments to subdivision 4 of section 365-h of the



1 social services law made by section one of this act shall not affect the
2 repeal of such section and shall expire and be deemed repealed there-
3 with.

4

PART B

5 Section 1. Intentionally omitted.

6 § 2. Intentionally omitted.

7 § 3. Intentionally omitted.

8 § 4. Intentionally omitted.

9 § 5. Paragraphs (b) and (c) of subdivision 2 of section 280 of the
10 public health law, paragraph (b) as amended and paragraph (c) as added
11 by section 8 of part D of chapter 57 of the laws of 2018, are amended
12 and a new paragraph (d) is added to read as follows:

13 (b) for state fiscal year two thousand eighteen--two thousand nine-
14 teen, be limited to the ten-year rolling average of the medical compo-
15 nent of the consumer price index plus four percent and minus a pharmacy
16 savings target of eighty-five million dollars; [and]

17 (c) for state fiscal year two thousand nineteen--two thousand twenty,
18 be limited to the ten-year rolling average of the medical component of
19 the consumer price index plus four percent and minus a pharmacy savings
20 target of eighty-five million dollars[.]; and

21 (d) for state fiscal year two thousand twenty--two thousand twenty-
22 one, be limited to the ten-year rolling average of the medical component
23 of the consumer price index plus four percent and minus a pharmacy
24 savings target of eighty-five million dollars.

25 § 6. Subdivision 3 of section 280 of the public health law, as amended
26 by section 8 of part D of chapter 57 of the laws of 2018, is amended to
27 read as follows:

28 3. The department and the division of the budget shall assess on a
29 quarterly basis the projected total amount to be expended in the year on a
30 cash basis by the Medicaid program for each drug, and the projected
31 annual amount of state funds Medicaid drug expenditures on a cash basis
32 for all drugs, which shall be a component of the projected department of
33 health state funds Medicaid expenditures calculated for purposes of
34 sections ninety-one and ninety-two of part H of chapter fifty-nine of
35 the laws of two thousand eleven. For purposes of this section, state
36 funds Medicaid drug expenditures include amounts expended for drugs in
37 both the Medicaid fee-for-service program and Medicaid managed care
38 programs, minus the amount of any drug rebates or supplemental drug
39 rebates received by the department, including rebates pursuant to subdi-
40 vision five of this section with respect to rebate targets. The depart-
41 ment and the division of the budget shall report quarterly to the drug
42 utilization review board the projected state funds Medicaid drug expend-
43 itures including the amounts, in aggregate thereof, attributable to the
44 net cost of: changes in the utilization of drugs by Medicaid recipients;
45 changes in the number of Medicaid recipients; changes to the cost of
46 brand name drugs and changes to the cost of generic drugs. The informa-
47 tion contained in the report shall not be publicly released in a manner
48 that allows for the identification of an individual drug or manufacturer
49 or that is likely to compromise the financial competitive, or proprie-
50 tary nature of the information.

51 (a) In the event the director of the budget determines, based on Medi-
52 caid drug expenditures for the previous quarter or other relevant infor-
53 mation, that the total department of health state funds Medicaid drug
54 expenditure is projected to exceed the annual growth limitation imposed

1 by subdivision two of this section, the commissioner may identify and
2 refer drugs to the drug utilization review board established by section
3 three hundred sixty-nine-bb of the social services law for a recommenda-
4 tion as to whether a target supplemental Medicaid rebate should be paid
5 by the manufacturer of the drug to the department and the target amount
6 of the rebate.

7 (b) If the department intends to refer a drug to the drug utilization
8 review board pursuant to paragraph (a) of this subdivision, the depart-
9 ment shall notify the manufacturer of such drug and shall attempt to
10 reach agreement with the manufacturer on a rebate for the drug prior to
11 referring the drug to the drug utilization review board for review.
12 Such rebate may be based on evidence-based research, including, but not
13 limited to, such research operated or conducted by or for other state
14 governments, the federal government, the governments of other nations,
15 and third party payers or multi-state coalitions, provided that the
16 department shall account for cost offsets including but not limited to
17 the effectiveness of the drug in treating the conditions for which it is
18 prescribed or in improving a patient's health, quality of life, or over-
19 all health outcomes, and the likelihood that use of the drug will reduce
20 the need for other medical care, including hospitalization.

21 (c) In the event that the commissioner and the manufacturer have
22 previously agreed to a supplemental rebate for a drug pursuant to para-
23 graph (b) of this subdivision or paragraph (e) of subdivision seven of
24 section three hundred sixty-seven-a of the social services law, the drug
25 shall not be referred to the drug utilization review board for any
26 further supplemental rebate for the duration of the previous rebate
27 agreement.

28 (d) The department shall consider a drug's actual cost to the state,
29 including current rebate amounts, prior to seeking an additional rebate
30 pursuant to paragraph (b) or (c) of this subdivision [and shall take
31 into consideration whether the manufacturer of the drug is providing
32 significant discounts relative to other drugs covered by the Medicaid
33 program].

34 (e) The commissioner shall be authorized to take the actions described
35 in this section only so long as total Medicaid drug expenditures are
36 projected to exceed the annual growth limitation imposed by subdivision
37 two of this section.

38 § 7. Paragraph (a) of subdivision 5 of section 280 of the public
39 health law, as amended by section 8 of part D of chapter 57 of the laws
40 of 2018, is amended to read as follows:

41 (a) If the drug utilization review board recommends a target rebate
42 amount on a drug referred by the commissioner, the [commissioner shall
43 require] department shall negotiate with the drug's manufacturer for a
44 supplemental rebate to be paid by the [drug's] manufacturer in an amount
45 not to exceed such target rebate amount. [With respect to a] A rebate
46 [required in state fiscal year two thousand seventeen--two thousand
47 eighteen, the rebate] requirement shall apply beginning with the [month
48 of April, two thousand seventeen,] first day of the state fiscal year
49 during which the rebate was required without regard to the date the
50 department enters into the rebate agreement with the manufacturer.

51 § 8. Paragraph (a) of subdivision 7 of section 280 of the public
52 health law, as amended by section 8 of part D of chapter 57 of the laws
53 of 2018, is amended to read as follows:

54 (a) If, after taking into account all rebates and supplemental rebates
55 received by the department, including rebates received to date pursuant
56 to this section, total Medicaid drug expenditures are still projected to

1 exceed the annual growth limitation imposed by subdivision two of this
2 section, the commissioner may: subject any drug of a manufacturer
3 referred to the drug utilization review board under this section to
4 prior approval in accordance with existing processes and procedures when
5 such manufacturer has not entered into a supplemental rebate agreement
6 as required by this section; [directing] direct managed care plans to
7 remove from their Medicaid formularies those drugs that the drug utili-
8 zation review board recommends a target rebate amount for and the
9 manufacturer has failed to enter into a rebate agreement required by
10 this section; [promoting] promote the use of cost effective and clin-
11 ically appropriate drugs other than those of a manufacturer who has a
12 drug that the drug utilization review board recommends a target rebate
13 amount and the manufacturer has failed to enter into a rebate agreement
14 required by this section; [allowing] allow manufacturers to accelerate
15 rebate payments under existing rebate contracts; and such other actions
16 as authorized by law. The commissioner shall provide written notice to
17 the legislature thirty days prior to taking action pursuant to this
18 paragraph, unless action is necessary in the fourth quarter of a fiscal
19 year to prevent total Medicaid drug expenditures from exceeding the
20 limitation imposed by subdivision two of this section, in which case
21 such notice to the legislature may be less than thirty days.

22 § 9. Intentionally omitted.

23 § 10. Intentionally omitted.

24 § 11. Intentionally omitted.

25 § 11-a. The social services law is amended by adding a new section
26 365-i to read as follows:

27 § 365-i. Prescription drugs in medicaid managed care programs. 1.
28 Definitions. (a) The definitions of terms in section two hundred seventy
29 of the public health law shall apply to this section.

30 (b) As used in this section, unless the context clearly requires
31 otherwise:

32 (i) "Managed care provider" means a managed care provider under
33 section three hundred sixty-four-j of this article, a managed long term
34 care plan under section forty-four hundred three-f of the public health
35 law, or any other entity that provides or arranges for the provision of
36 medical assistance services and supplies to participants directly or
37 indirectly (including by referral), including case management, including
38 the managed care provider's authorized agents.

39 (ii) "Participant" means a medical assistance recipient who receives,
40 is required to receive or elects to receive his or her medical assist-
41 ance services from a managed care provider.

42 2. Providing and payment for prescription drugs for medicaid managed
43 care provider participants. Prescription drugs eligible for reimburse-
44 ment under this article prescribed in relation to a service provided by
45 a managed care provider shall be provided and paid for under the
46 preferred drug program and the clinical drug review program under title
47 one of article two-A of the public health law. The managed care provider
48 shall account to and reimburse the department for the net cost to the
49 department for prescription drugs provided to the managed care provid-
50 er's participants. Payment for prescription drugs shall be included in
51 the capitation payments to the managed care provider for services or
52 supplies provided to a managed care provider's participants.

53 § 11-b. Section 270 of the public health law is amended by adding a
54 new subdivision 15 to read as follows:

55 15. "Third-party health care payer" has its ordinary meanings and
56 includes an entity such as a fiscal administrator, or administrative



1 services provider that participates in the administration of a third-
2 party health care payer system.

3 § 11-c. The public health law is amended by adding a new section 274-a
4 to read as follows:

5 § 274-a. Use of preferred drug program and clinical drug review
6 program. The commissioner shall contract with any third-party health
7 care payer that so chooses, to use the preferred drug program and the
8 clinical drug review program to provide and pay for prescription drugs
9 for the third-party health care payer's enrollees. To contract under
10 this section, the third-party health care payer shall provide coverage
11 for prescription drugs authorized under this title. The third-party
12 health care payer shall account to and reimburse the department for the
13 net cost to the department for prescription drugs provided to the third-
14 party health care payer's enrollees. The contract shall include terms
15 required by the commissioner.

16 § 11-d. Section 272 of the public health law is amended by adding a
17 new subdivision 12 to read as follows:

18 12. No prior authorization shall be required under the preferred drug
19 program for: (a) atypical anti-psychotics; (b) anti-depressants; (c)
20 anti-retrovirals used in the treatment of HIV/AIDS; (d) anti-rejection
21 drugs used in the treatment of organ and tissue transplants; (e)
22 seizure, epilepsy, endocrine, hematologic and immunologic therapeutic
23 classes; and (f) any other therapeutic class for the treatment of mental
24 illness or HIV/AIDS, recommended by the committee and approved by the
25 commissioner under this title.

26 § 11-e. Subdivisions 25 and 25-a of section 364-j of the social
27 services law are REPEALED.

28 § 12. This act shall take effect immediately and shall be deemed to
29 have been in full force and effect on and after April 1, 2019.

30 PART C

31 Section 1. Subdivision 2 of section 365-a of the social services law
32 is amended by adding a new paragraph (ff) to read as follows:

33 (ff) evidence-based prevention and support services recognized by the
34 federal Centers for Disease Control (CDC), provided by a community-based
35 organization, and designed to prevent individuals at risk of developing
36 diabetes from developing Type 2 diabetes.

37 § 1-a. Subdivision 2 of section 365-a of the social services law is
38 amended by adding a new paragraph (gg) to read as follows:

39 (gg) medically tailored meals and medical nutrition therapy. As used
40 in this paragraph, "medically tailored meals and medical nutrition ther-
41 apy" means nutritional assessment, nutritional therapy, and nutritional
42 counseling provided by a registered dietician nutritionist, including
43 the provision of any food indicated by the nutritional assessment and
44 the delivery of such food, ordered by a health care professional acting
45 within his or her lawful scope of practice under title eight of the
46 education law, for the purpose of treating one or more chronic condi-
47 tions for an individual who is limited in his or her activities of daily
48 living; and provided that there is federal financial participation in
49 the costs of services provided under this paragraph.

50 § 2. Intentionally omitted.

51 § 3. Intentionally omitted.

52 § 4. This act shall take effect July 1, 2019.

53 PART D

1 Section 1. Subdivision 1 of section 92 of part H of chapter 59 of the
2 laws of 2011, amending the public health law and other laws relating to
3 known and projected department of health state fund medicaid expendi-
4 tures, as amended by section 2 of part K of chapter 57 of the laws of
5 2018, is amended to read as follows:

6 1. For state fiscal years 2011-12 through [2019-20] 2020-2021, the
7 director of the budget, in consultation with the commissioner of health
8 referenced as "commissioner" for purposes of this section, shall assess
9 on a monthly basis, as reflected in monthly reports pursuant to subdivi-
10 sion five of this section known and projected department of health state
11 funds medicaid expenditures by category of service and by geographic
12 regions, as defined by the commissioner, and if the director of the
13 budget determines that such expenditures are expected to cause medicaid
14 disbursements for such period to exceed the projected department of
15 health medicaid state funds disbursements in the enacted budget finan-
16 cial plan pursuant to subdivision 3 of section 23 of the state finance
17 law, the commissioner of health, in consultation with the director of
18 the budget, shall develop a medicaid savings allocation plan to limit
19 such spending to the aggregate limit level specified in the enacted
20 budget financial plan, provided, however, such projections may be
21 adjusted by the director of the budget to account for any changes in the
22 New York state federal medical assistance percentage amount established
23 pursuant to the federal social security act, changes in provider reven-
24 ues, reductions to local social services district medical assistance
25 administration, minimum wage increases, and beginning April 1, 2012 the
26 operational costs of the New York state medical indemnity fund and state
27 costs or savings from the basic health plan. Such projections may be
28 adjusted by the director of the budget to account for increased or expe-
29 dited department of health state funds medicaid expenditures as a result
30 of a natural or other type of disaster, including a governmental decla-
31 ration of emergency.

32 § 2. This act shall take effect immediately and shall be deemed to
33 have been in full force and effect on and after April 1, 2019.

34

PART E

35 Section 1. Section 4 of chapter 505 of the laws of 1995, amending the
36 public health law relating to the operation of department of health
37 facilities, as amended by section 27 of part D of chapter 57 of the laws
38 of 2015, is amended to read as follows:

39 § 4. This act shall take effect immediately; provided, however, that
40 the provisions of paragraph (b) of subdivision 4 of section 409-c of the
41 public health law, as added by section three of this act, shall take
42 effect January 1, 1996 and shall expire and be deemed repealed [twenty-
43 four] twenty-eight years from the effective date thereof.

44 § 2. Subdivision p of section 76 of part D of chapter 56 of the laws
45 of 2013, amending the social services law relating to eligibility condi-
46 tions, is amended to read as follows:

47 p. the amendments [made] to subparagraph [(7)] 7 of paragraph (b) of
48 subdivision 1 of section 366 of the social services law made by section
49 one of this act shall expire and be deemed repealed October 1, [2019]
50 2024.

51 § 3. Section 11 of chapter 884 of the laws of 1990, amending the
52 public health law relating to authorizing bad debt and charity care
53 allowances for certified home health agencies, as amended by section 1

1 of part I of chapter 57 of the laws of 2017, is amended to read as
2 follows:

3 § 11. This act shall take effect immediately and:

4 (a) sections one and three shall expire on December 31, 1996,

5 (b) sections four through ten shall expire on June 30, [2019] 2021,
6 and

7 (c) provided that the amendment to section 2807-b of the public health
8 law by section two of this act shall not affect the expiration of such
9 section 2807-b as otherwise provided by law and shall be deemed to
10 expire therewith.

11 § 4. Section 3 of chapter 303 of the laws of 1999, amending the New
12 York state medical care facilities finance agency act relating to
13 financing health facilities, as amended by section 16 of part D of chap-
14 ter 57 of the laws of 2015, is amended to read as follows:

15 § 3. This act shall take effect immediately, provided, however, that
16 subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of
17 1973, as added by section one of this act, shall expire and be deemed
18 repealed June 30, [2019] 2023; and provided further, however, that the
19 expiration and repeal of such subdivision 15-a shall not affect or
20 impair in any manner any health facilities bonds issued, or any lease or
21 purchase of a health facility executed, pursuant to such subdivision
22 15-a prior to its expiration and repeal and that, with respect to any
23 such bonds issued and outstanding as of June 30, [2019] 2023, the
24 provisions of such subdivision 15-a as they existed immediately prior to
25 such expiration and repeal shall continue to apply through the latest
26 maturity date of any such bonds, or their earlier retirement or redemp-
27 tion, for the sole purpose of authorizing the issuance of refunding
28 bonds to refund bonds previously issued pursuant thereto.

29 § 5. Subdivision (a) of section 40 of part B of chapter 109 of the
30 laws of 2010, amending the social services law relating to transporta-
31 tion costs, as amended by section 8 of part I of chapter 57 of the laws
32 of 2017, is amended to read as follows:

33 (a) sections two, three, three-a, three-b, three-c, three-d, three-e
34 and twenty-one of this act shall take effect July 1, 2010; sections
35 fifteen, sixteen, seventeen, eighteen and nineteen of this act shall
36 take effect January 1, 2011; and provided further that section twenty of
37 this act shall be deemed repealed [eight] ten years after the date the
38 contract entered into pursuant to section 365-h of the social services
39 law, as amended by section twenty of this act, is executed; provided
40 that the commissioner of health shall notify the legislative bill draft-
41 ing commission upon the execution of the contract entered into pursuant
42 to section 367-h of the social services law in order that the commission
43 may maintain an accurate and timely effective data base of the official
44 text of the laws of the state of New York in furtherance of effectuating
45 the provisions of section 44 of the legislative law and section 70-b of
46 the public officers law;

47 § 6. Subdivision (f) of section 129 of part C of chapter 58 of the
48 laws of 2009, amending the public health law relating to payment by
49 governmental agencies for general hospital inpatient services, as
50 amended by section 4 of part D of chapter 59 of the laws of 2016, is
51 amended to read as follows:

52 (f) section twenty-five of this act shall expire and be deemed
53 repealed April 1, [2019] 2022;

54 § 7. Subdivision (c) of section 122 of part E of chapter 56 of the
55 laws of 2013 amending the public health law relating to the general

1 public health work program, as amended by section 5 of part D of chapter
2 59 of the laws of 2016, is amended to read as follows:

3 (c) section fifty of this act shall take effect immediately and shall
4 expire [six] nine years after it becomes law;

5 § 8. Subdivision (i) of section 111 of part H of chapter 59 of the
6 laws of 2011, amending the public health law and other laws relating to
7 known and projected department of health state fund medical expendi-
8 tures, as amended by section 19 of part D of chapter 57 of the laws of
9 2015, is amended to read as follows:

10 (i) the amendments to paragraph (b) and subparagraph (i) of paragraph
11 (g) of subdivision 7 of section 4403-f of the public health law made by
12 section forty-one-b of this act shall expire and be repealed April 1,
13 [2019] 2023;

14 § 9. Subparagraph (vi) of paragraph (b) of subdivision 2 of section
15 2807-d of the public health law, as amended by section 3 of part I of
16 chapter 57 of the laws of 2017, is amended to read as follows:

17 (vi) Notwithstanding any contrary provision of this paragraph or any
18 other provision of law or regulation to the contrary, for residential
19 health care facilities the assessment shall be six percent of each resi-
20 dential health care facility's gross receipts received from all patient
21 care services and other operating income on a cash basis for the period
22 April first, two thousand two through March thirty-first, two thousand
23 three for hospital or health-related services, including adult day
24 services; provided, however, that residential health care facilities'
25 gross receipts attributable to payments received pursuant to title XVIII
26 of the federal social security act (medicare) shall be excluded from the
27 assessment; provided, however, that for all such gross receipts received
28 on or after April first, two thousand three through March thirty-first,
29 two thousand five, such assessment shall be five percent, and further
30 provided that for all such gross receipts received on or after April
31 first, two thousand five through March thirty-first, two thousand nine,
32 and on or after April first, two thousand nine through March thirty-
33 first, two thousand eleven such assessment shall be six percent, and
34 further provided that for all such gross receipts received on or after
35 April first, two thousand eleven through March thirty-first, two thou-
36 sand thirteen such assessment shall be six percent, and further provided
37 that for all such gross receipts received on or after April first, two
38 thousand thirteen through March thirty-first, two thousand fifteen such
39 assessment shall be six percent, and further provided that for all such
40 gross receipts received on or after April first, two thousand fifteen
41 through March thirty-first, two thousand seventeen such assessment shall
42 be six percent, and further provided that for all such gross receipts
43 received on or after April first, two thousand seventeen through March
44 thirty-first, two thousand nineteen such assessment shall be six
45 percent, and further provided that for all such gross receipts received
46 on or after April first, two thousand nineteen through March thirty-
47 first, two thousand twenty-one such assessment shall be six percent.

48 § 10. Subdivision 1 of section 194 of chapter 474 of the laws of 1996,
49 amending the education law and other laws relating to rates for residen-
50 tial health care facilities, as amended by section 4 of part I of chap-
51 ter 57 of the laws of 2017, is amended to read as follows:

52 1. Notwithstanding any inconsistent provision of law or regulation,
53 the trend factors used to project reimbursable operating costs to the
54 rate period for purposes of determining rates of payment pursuant to
55 article 28 of the public health law for residential health care facili-
56 ties for reimbursement of inpatient services provided to patients eligi-

1 ble for payments made by state governmental agencies on and after April
2 1, 1996 through March 31, 1999 and for payments made on and after July
3 1, 1999 through March 31, 2000 and on and after April 1, 2000 through
4 March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and
5 on and after April 1, 2007 through March 31, 2009 and on and after April
6 1, 2009 through March 31, 2011 and on and after April 1, 2011 through
7 March 31, 2013 and on and after April 1, 2013 through March 31, 2015,
8 and on and after April 1, 2015 through March 31, 2017, and on and after
9 April 1, 2017 through March 31, 2019, and on and after April 1, 2019
10 through March 31, 2021 shall reflect no trend factor projections or
11 adjustments for the period April 1, 1996, through March 31, 1997.

12 § 11. Subdivision 1 of section 89-a of part C of chapter 58 of the
13 laws of 2007, amending the social services law and other laws relating
14 to enacting the major components of legislation necessary to implement
15 the health and mental hygiene budget for the 2007-2008 state fiscal
16 year, as amended by section 5 of part I of chapter 57 of the laws of
17 2017, is amended to read as follows:

18 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c
19 of the public health law and section 21 of chapter 1 of the laws of
20 1999, as amended, and any other inconsistent provision of law or regu-
21 lation to the contrary, in determining rates of payments by state
22 governmental agencies effective for services provided beginning April 1,
23 2006, through March 31, 2009, and on and after April 1, 2009 through
24 March 31, 2011, and on and after April 1, 2011 through March 31, 2013,
25 and on and after April 1, 2013 through March 31, 2015, and on and after
26 April 1, 2015 through March 31, 2017, and on and after April 1, 2017
27 through March 31, 2019, and on and after April 1, 2019 through March 31,
28 2021 for inpatient and outpatient services provided by general hospitals
29 and for inpatient services and outpatient adult day health care services
30 provided by residential health care facilities pursuant to article 28 of
31 the public health law, the commissioner of health shall apply a trend
32 factor projection of two and twenty-five hundredths percent attributable
33 to the period January 1, 2006 through December 31, 2006, and on and
34 after January 1, 2007, provided, however, that on reconciliation of such
35 trend factor for the period January 1, 2006 through December 31, 2006
36 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the
37 public health law, such trend factor shall be the final US Consumer
38 Price Index (CPI) for all urban consumers, as published by the US
39 Department of Labor, Bureau of Labor Statistics less twenty-five
40 hundredths of a percentage point.

41 § 12. Subdivision 5-a of section 246 of chapter 81 of the laws of
42 1995, amending the public health law and other laws relating to medical
43 reimbursement and welfare reform, as amended by section 6 of part I of
44 chapter 57 of the laws of 2017, is amended to read as follows:

45 5-a. Section sixty-four-a of this act shall be deemed to have been in
46 full force and effect on and after April 1, 1995 through March 31, 1999
47 and on and after July 1, 1999 through March 31, 2000 and on and after
48 April 1, 2000 through March 31, 2003 and on and after April 1, 2003
49 through March 31, 2007, and on and after April 1, 2007 through March 31,
50 2009, and on and after April 1, 2009 through March 31, 2011, and on and
51 after April 1, 2011 through March 31, 2013, and on and after April 1,
52 2013 through March 31, 2015, and on and after April 1, 2015 through
53 March 31, 2017 and on and after April 1, 2017 through March 31, 2019,
54 and on and after April 1, 2019 through March 31, 2021;

55 § 13. Section 64-b of chapter 81 of the laws of 1995, amending the
56 public health law and other laws relating to medical reimbursement and

1 welfare reform, as amended by section 7 of part I of chapter 57 of the
2 laws of 2017, is amended to read as follows:

3 § 64-b. Notwithstanding any inconsistent provision of law, the
4 provisions of subdivision 7 of section 3614 of the public health law, as
5 amended, shall remain and be in full force and effect on April 1, 1995
6 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on
7 and after April 1, 2000 through March 31, 2003 and on and after April 1,
8 2003 through March 31, 2007, and on and after April 1, 2007 through
9 March 31, 2009, and on and after April 1, 2009 through March 31, 2011,
10 and on and after April 1, 2011 through March 31, 2013, and on and after
11 April 1, 2013 through March 31, 2015, and on and after April 1, 2015
12 through March 31, 2017 and on and after April 1, 2017 through March 31,
13 2019, and on and after April 1, 2019 through March 31, 2021.

14 § 14. Section 4-a of part A of chapter 56 of the laws of 2013, amend-
15 ing chapter 59 of the laws of 2011 amending the public health law and
16 other laws relating to general hospital reimbursement for annual rates,
17 as amended by section 5 of part T of chapter 57 of the laws of 2018, is
18 amended to read as follows:

19 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section
20 2807-c of the public health law, section 21 of chapter 1 of the laws of
21 1999, or any other contrary provision of law, in determining rates of
22 payments by state governmental agencies effective for services provided
23 on and after January 1, 2017 through March 31, [2019] 2021, for inpa-
24 tient and outpatient services provided by general hospitals, for inpa-
25 tient services and adult day health care outpatient services provided by
26 residential health care facilities pursuant to article 28 of the public
27 health law, except for residential health care facilities or units of
28 such facilities providing services primarily to children under twenty-
29 one years of age, for home health care services provided pursuant to
30 article 36 of the public health law by certified home health agencies,
31 long term home health care programs and AIDS home care programs, and for
32 personal care services provided pursuant to section 365-a of the social
33 services law, the commissioner of health shall apply no greater than
34 zero trend factors attributable to the 2017, 2018, [and] 2019, 2020, and
35 2021 calendar years in accordance with paragraph (c) of subdivision 10
36 of section 2807-c of the public health law, provided, however, that such
37 no greater than zero trend factors attributable to such 2017, 2018,
38 [and] 2019, 2020, and 2021 calendar years shall also be applied to rates
39 of payment provided on and after January 1, 2017 through March 31,
40 [2019] 2021 for personal care services provided in those local social
41 services districts, including New York city, whose rates of payment for
42 such services are established by such local social services districts
43 pursuant to a rate-setting exemption issued by the commissioner of
44 health to such local social services districts in accordance with appli-
45 cable regulations; and provided further, however, that for rates of
46 payment for assisted living program services provided on and after Janu-
47 ary 1, 2017 through March 31, [2019] 2021, such trend factors attribut-
48 able to the 2017, 2018, [and] 2019, 2020, and 2021 calendar years shall
49 be established at no greater than zero percent.

50 § 15. Paragraph (b) of subdivision 17 of section 2808 of the public
51 health law, as amended by section 21 of part D of chapter 57 of the laws
52 of 2015, is amended to read as follows:

53 (b) Notwithstanding any inconsistent provision of law or regulation to
54 the contrary, for the state fiscal years beginning April first, two
55 thousand ten and ending March thirty-first, two thousand [nineteen]
56 twenty-three, the commissioner shall not be required to revise certified

1 rates of payment established pursuant to this article for rate periods
2 prior to April first, two thousand [nineteen] twenty-three, based on
3 consideration of rate appeals filed by residential health care facili-
4 ties or based upon adjustments to capital cost reimbursement as a result
5 of approval by the commissioner of an application for construction under
6 section twenty-eight hundred two of this article, in excess of an aggre-
7 gate annual amount of eighty million dollars for each such state fiscal
8 year provided, however, that for the period April first, two thousand
9 eleven through March thirty-first, two thousand twelve such aggregate
10 annual amount shall be fifty million dollars. In revising such rates
11 within such fiscal limit, the commissioner shall, in prioritizing such
12 rate appeals, include consideration of which facilities the commissioner
13 determines are facing significant financial hardship as well as such
14 other considerations as the commissioner deems appropriate and, further,
15 the commissioner is authorized to enter into agreements with such facil-
16 ities or any other facility to resolve multiple pending rate appeals
17 based upon a negotiated aggregate amount and may offset such negotiated
18 aggregate amounts against any amounts owed by the facility to the
19 department, including, but not limited to, amounts owed pursuant to
20 section twenty-eight hundred seven-d of this article; provided, however,
21 that the commissioner's authority to negotiate such agreements resolving
22 multiple pending rate appeals as hereinbefore described shall continue
23 on and after April first, two thousand [nineteen] twenty-three. Rate
24 adjustments made pursuant to this paragraph remain fully subject to
25 approval by the director of the budget in accordance with the provisions
26 of subdivision two of section twenty-eight hundred seven of this arti-
27 cle.

28 § 16. Paragraph (a) of subdivision 13 of section 3614 of the public
29 health law, as amended by section 22 of part D of chapter 57 of the laws
30 of 2015, is amended to read as follows:

31 (a) Notwithstanding any inconsistent provision of law or regulation
32 and subject to the availability of federal financial participation,
33 effective April first, two thousand twelve through March thirty-first,
34 two thousand [nineteen] twenty-three, payments by government agencies
35 for services provided by certified home health agencies, except for such
36 services provided to children under eighteen years of age and other
37 discreet groups as may be determined by the commissioner pursuant to
38 regulations, shall be based on episodic payments. In establishing such
39 payments, a statewide base price shall be established for each sixty day
40 episode of care and adjusted by a regional wage index factor and an
41 individual patient case mix index. Such episodic payments may be further
42 adjusted for low utilization cases and to reflect a percentage limita-
43 tion of the cost for high-utilization cases that exceed outlier thresh-
44 olds of such payments.

45 § 17. Subdivision 2 of section 246 of chapter 81 of the laws of 1995,
46 amending the public health law and other laws relating to medical
47 reimbursement and welfare reform, as amended by section 18 of part I of
48 chapter 57 of the laws of 2017, is amended to read as follows:

49 2. Sections five, seven through nine, twelve through fourteen, and
50 eighteen of this act shall be deemed to have been in full force and
51 effect on and after April 1, 1995 through March 31, 1999 and on and
52 after July 1, 1999 through March 31, 2000 and on and after April 1, 2000
53 through March 31, 2003 and on and after April 1, 2003 through March 31,
54 2006 and on and after April 1, 2006 through March 31, 2007 and on and
55 after April 1, 2007 through March 31, 2009 and on and after April 1,
56 2009 through March 31, 2011 and sections twelve, thirteen and fourteen

1 of this act shall be deemed to be in full force and effect on and after
2 April 1, 2011 through March 31, 2015 and on and after April 1, 2015
3 through March 31, 2017 and on and after April 1, 2017 through March 31,
4 2019, and on and after April 1, 2019 through March 31, 2021;

5 § 18. Section 48-a of part A of chapter 56 of the laws of 2013 amend-
6 ing chapter 59 of the laws of 2011 amending the public health law and
7 other laws relating to general hospital reimbursement for annual rates,
8 as amended by section 1 of part P of chapter 57 of the laws of 2017, is
9 amended to read as follows:

10 § 48-a. 1. Notwithstanding any contrary provision of law, the commis-
11 sioners of the office of alcoholism and substance abuse services and the
12 office of mental health are authorized, subject to the approval of the
13 director of the budget, to transfer to the commissioner of health state
14 funds to be utilized as the state share for the purpose of increasing
15 payments under the medicaid program to managed care organizations
16 licensed under article 44 of the public health law or under article 43
17 of the insurance law. Such managed care organizations shall utilize such
18 funds for the purpose of reimbursing providers licensed pursuant to
19 article 28 of the public health law or article 31 or 32 of the mental
20 hygiene law for ambulatory behavioral health services, as determined by
21 the commissioner of health, in consultation with the commissioner of
22 alcoholism and substance abuse services and the commissioner of the
23 office of mental health, provided to medicaid enrolled outpatients and
24 for all other behavioral health services except inpatient included in
25 New York state's Medicaid redesign waiver approved by the centers for
26 medicare and Medicaid services (CMS). Such reimbursement shall be in
27 the form of fees for such services which are equivalent to the payments
28 established for such services under the ambulatory patient group (APG)
29 rate-setting methodology as utilized by the department of health, the
30 office of alcoholism and substance abuse services, or the office of
31 mental health for rate-setting purposes or any such other fees pursuant
32 to the Medicaid state plan or otherwise approved by CMS in the Medicaid
33 redesign waiver; provided, however, that the increase to such fees that
34 shall result from the provisions of this section shall not, in the
35 aggregate and as determined by the commissioner of health, in consulta-
36 tion with the commissioner of alcoholism and substance abuse services
37 and the commissioner of the office of mental health, be greater than the
38 increased funds made available pursuant to this section. The increase
39 of such ambulatory behavioral health fees to providers available under
40 this section shall be for all rate periods on and after the effective
41 date of section [29] 1 of part [B] P of chapter [59] 57 of the laws of
42 [2016] 2017 through March 31, [2020] 2023 for patients in the city of
43 New York, for all rate periods on and after the effective date of
44 section [29] 1 of part [B] P of chapter [59] 57 of the laws of [2016]
45 2017 through [March 31, 2020] March 31, 2023 for patients outside the
46 city of New York, and for all rate periods on and after the effective
47 date of such chapter through [March 31, 2020] March 31, 2023 for all
48 services provided to persons under the age of twenty-one; provided,
49 however, the commissioner of health, in consultation with the commis-
50 sioner of alcoholism and substance abuse services and the commissioner
51 of mental health, may require, as a condition of approval of such ambu-
52 latory behavioral health fees, that aggregate managed care expenditures
53 to eligible providers meet the alternative payment methodology require-
54 ments as set forth in attachment I of the New York state medicaid
55 section one thousand one hundred fifteen medicaid redesign team waiver
56 as approved by the centers for medicare and medicaid services. The



1 commissioner of health shall, in consultation with the commissioner of
2 alcoholism and substance abuse services and the commissioner of mental
3 health, waive such conditions if a sufficient number of providers, as
4 determined by the commissioner, suffer a financial hardship as a conse-
5 quence of such alternative payment methodology requirements, or if he or
6 she shall determine that such alternative payment methodologies signif-
7 icantly threaten individuals access to ambulatory behavioral health
8 services. Such waiver may be applied on a provider specific or industry
9 wide basis. Further, such conditions may be waived, as the commissioner
10 determines necessary, to comply with federal rules or regulations
11 governing these payment methodologies. Nothing in this section shall
12 prohibit managed care organizations and providers from negotiating
13 different rates and methods of payment during such periods described
14 above, subject to the approval of the department of health. The depart-
15 ment of health shall consult with the office of alcoholism and substance
16 abuse services and the office of mental health in determining whether
17 such alternative rates shall be approved. The commissioner of health
18 may, in consultation with the commissioner of alcoholism and substance
19 abuse services and the commissioner of the office of mental health,
20 promulgate regulations, including emergency regulations promulgated
21 prior to October 1, 2015 to establish rates for ambulatory behavioral
22 health services, as are necessary to implement the provisions of this
23 section. Rates promulgated under this section shall be included in the
24 report required under section 45-c of part A of this chapter.

25 2. Notwithstanding any contrary provision of law, the fees paid by
26 managed care organizations licensed under article 44 of the public
27 health law or under article 43 of the insurance law, to providers
28 licensed pursuant to article 28 of the public health law or article 31
29 or 32 of the mental hygiene law, for ambulatory behavioral health
30 services provided to patients enrolled in the child health insurance
31 program pursuant to title [one-A] 1-A of article 25 of the public health
32 law, shall be in the form of fees for such services which are equivalent
33 to the payments established for such services under the ambulatory
34 patient group (APG) rate-setting methodology or any such other fees
35 established pursuant to the Medicaid state plan. The commissioner of
36 health shall consult with the commissioner of alcoholism and substance
37 abuse services and the commissioner of the office of mental health in
38 determining such services and establishing such fees. Such ambulatory
39 behavioral health fees to providers available under this section shall
40 be for all rate periods on and after the effective date of this chapter
41 through [March 31, 2020] March 31, 2023, provided, however, that managed
42 care organizations and providers may negotiate different rates and meth-
43 ods of payment during such periods described above, subject to the
44 approval of the department of health. The department of health shall
45 consult with the office of alcoholism and substance abuse services and
46 the office of mental health in determining whether such alternative
47 rates shall be approved. The report required under section 16-a of part
48 C of chapter 60 of the laws of 2014 shall also include the population of
49 patients enrolled in the child health insurance program pursuant to
50 title [one-A] 1-A of article 25 of the public health law in its examina-
51 tion on the transition of behavioral health services into managed care.

52 § 19. Section 1 of part H of chapter 111 of the laws of 2010 relating
53 to increasing Medicaid payments to providers through managed care organ-
54 izations and providing equivalent fees through an ambulatory patient
55 group methodology, as amended by section 2 of part P of chapter 57 of
56 the laws of 2017, is amended to read as follows:

1 Section 1. a. Notwithstanding any contrary provision of law, the
2 commissioners of mental health and alcoholism and substance abuse
3 services are authorized, subject to the approval of the director of the
4 budget, to transfer to the commissioner of health state funds to be
5 utilized as the state share for the purpose of increasing payments under
6 the medicaid program to managed care organizations licensed under arti-
7 cle 44 of the public health law or under article 43 of the insurance
8 law. Such managed care organizations shall utilize such funds for the
9 purpose of reimbursing providers licensed pursuant to article 28 of the
10 public health law, or pursuant to article 31 or article 32 of the mental
11 hygiene law for ambulatory behavioral health services, as determined by
12 the commissioner of health in consultation with the commissioner of
13 mental health and commissioner of alcoholism and substance abuse
14 services, provided to medicaid enrolled outpatients and for all other
15 behavioral health services except inpatient included in New York state's
16 Medicaid redesign waiver approved by the centers for medicare and Medi-
17 caid services (CMS). Such reimbursement shall be in the form of fees for
18 such services which are equivalent to the payments established for such
19 services under the ambulatory patient group (APG) rate-setting methodol-
20 ogy as utilized by the department of health or by the office of mental
21 health or office of alcoholism and substance abuse services for rate-
22 setting purposes or any such other fees pursuant to the Medicaid state
23 plan or otherwise approved by CMS in the Medicaid redesign waiver;
24 provided, however, that the increase to such fees that shall result from
25 the provisions of this section shall not, in the aggregate and as deter-
26 mined by the commissioner of health in consultation with the commission-
27 ers of mental health and alcoholism and substance abuse services, be
28 greater than the increased funds made available pursuant to this
29 section. The increase of such behavioral health fees to providers avail-
30 able under this section shall be for all rate periods on and after the
31 effective date of section [30] 2 of part [B] P of chapter [59] 57 of the
32 laws of [2016] 2017 through March 31, [2020] 2023 for patients in the
33 city of New York, for all rate periods on and after the effective date
34 of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016]
35 2017 through March 31, [2020] 2023 for patients outside the city of New
36 York, and for all rate periods on and after the effective date of
37 section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016]
38 2017 through March 31, [2020] 2023 for all services provided to persons
39 under the age of twenty-one; provided, however, the commissioner of
40 health, in consultation with the commissioner of alcoholism and
41 substance abuse services and the commissioner of mental health, may
42 require, as a condition of approval of such ambulatory behavioral health
43 fees, that aggregate managed care expenditures to eligible providers
44 meet the alternative payment methodology requirements as set forth in
45 attachment I of the New York state medicaid section one thousand one
46 hundred fifteen medicaid redesign team waiver as approved by the centers
47 for medicare and medicaid services. The commissioner of health shall, in
48 consultation with the commissioner of alcoholism and substance abuse
49 services and the commissioner of mental health, waive such conditions if
50 a sufficient number of providers, as determined by the commissioner,
51 suffer a financial hardship as a consequence of such alternative payment
52 methodology requirements, or if he or she shall determine that such
53 alternative payment methodologies significantly threaten individuals
54 access to ambulatory behavioral health services. Such waiver may be
55 applied on a provider specific or industry wide basis. Further, such
56 conditions may be waived, as the commissioner determines necessary, to



1 comply with federal rules or regulations governing these payment method-
2 ologies. Nothing in this section shall prohibit managed care organiza-
3 tions and providers from negotiating different rates and methods of
4 payment during such periods described, subject to the approval of the
5 department of health. The department of health shall consult with the
6 office of alcoholism and substance abuse services and the office of
7 mental health in determining whether such alternative rates shall be
8 approved. The commissioner of health may, in consultation with the
9 commissioners of mental health and alcoholism and substance abuse
10 services, promulgate regulations, including emergency regulations
11 promulgated prior to October 1, 2013 that establish rates for behavioral
12 health services, as are necessary to implement the provisions of this
13 section. Rates promulgated under this section shall be included in the
14 report required under section 45-c of part A of chapter 56 of the laws
15 of 2013.

16 b. Notwithstanding any contrary provision of law, the fees paid by
17 managed care organizations licensed under article 44 of the public
18 health law or under article 43 of the insurance law, to providers
19 licensed pursuant to article 28 of the public health law or article 31
20 or 32 of the mental hygiene law, for ambulatory behavioral health
21 services provided to patients enrolled in the child health insurance
22 program pursuant to title [one-A] 1-A of article 25 of the public health
23 law, shall be in the form of fees for such services which are equivalent
24 to the payments established for such services under the ambulatory
25 patient group (APG) rate-setting methodology. The commissioner of health
26 shall consult with the commissioner of alcoholism and substance abuse
27 services and the commissioner of the office of mental health in deter-
28 mining such services and establishing such fees. Such ambulatory behav-
29 ioral health fees to providers available under this section shall be for
30 all rate periods on and after the effective date of this chapter through
31 March 31, [2020] 2023, provided, however, that managed care organiza-
32 tions and providers may negotiate different rates and methods of payment
33 during such periods described above, subject to the approval of the
34 department of health. The department of health shall consult with the
35 office of alcoholism and substance abuse services and the office of
36 mental health in determining whether such alternative rates shall be
37 approved. The report required under section 16-a of part C of chapter
38 60 of the laws of 2014 shall also include the population of patients
39 enrolled in the child health insurance program pursuant to title [one-A]
40 1-A of article 25 of the public health law in its examination on the
41 transition of behavioral health services into managed care.

42 c. (1) The commissioner of the department of health, in collaboration
43 with the commissioner of the office of mental health and the commission-
44 er of the office of alcoholism and substance abuse services are directed
45 to convene and jointly chair, either directly or through a designee or
46 designees, a workgroup, which shall include membership that ensures
47 adequate statewide geographic representation selected with equal
48 contributions on such selection from the governor, the speaker of the
49 assembly and temporary president of the senate and be comprised of the
50 following members: (i) professional associations representing substance
51 use, mental health, and/or behavioral health providers; (ii) represen-
52 tatives from professional associations representing providers of peer
53 and recovery-based programs and services; (iii) representatives from
54 professional associations representing medicated assisted treatment
55 providers; (iv) representatives from professional associations repres-
56 enting children's behavioral health providers; (v) representatives from

1 hospital associations; (vi) representatives from associations represent-
2 ing behavioral health consumers and family members; and (vii) any addi-
3 tional stakeholder or expert that the commissioners deem necessary.
4 Members of the workgroup shall serve without compensation, but may be
5 reimbursed for actual costs incurred for participation on such work-
6 group. (2) The workgroup shall conduct an analysis on the ambulatory
7 patient group rates and commercial insurance rates for behavioral health
8 services for the purpose of developing a report that shall provide
9 recommendations on the following: (i) rate adequacy related to the
10 existing ambulatory patient group-based reimbursement provided under
11 medicaid managed care, as well as for commercial insurance rates with
12 regards to services rendered under child health plus, or for services
13 provided by clinics licensed or certified pursuant to article 31 or 32
14 of the mental hygiene law or dually licensed under article 31 or 32 and
15 article 28 of the public health law; (ii) the actual costs of care asso-
16 ciated with the delivery of behavioral health services; (iii) one or
17 more alternative reimbursement models that would adequately compensate
18 clinics licensed or holding an operating certificate under article 31 or
19 32 of the mental hygiene law or dually licensed under article 31 or 32
20 and article 28 of the public health law for their costs of care under
21 medicaid managed care and child health plus; and (iv) any policy or
22 fiscal resources necessary to carry out the recommendations of the
23 report developed pursuant to this section. The report shall be submitted
24 to the governor, the speaker of the assembly and the temporary president
25 of the senate no later than October 1, 2021.

26 § 20. Section 2 of part H of chapter 111 of the laws of 2010, relating
27 to increasing Medicaid payments to providers through managed care organ-
28 izations and providing equivalent fees through an ambulatory patient
29 group methodology, as amended by section 16 of part C of chapter 60 of
30 the laws of 2014, is amended to read as follows:

31 § 2. This act shall take effect immediately and shall be deemed to
32 have been in full force and effect on and after April 1, 2010, and shall
33 expire on [January 1, 2018] March 31, 2023.

34 § 21. Section 10 of chapter 649 of the laws of 1996, amending the
35 public health law, the mental hygiene law and the social services law
36 relating to authorizing the establishment of special needs plans, as
37 amended by section 2 of part D of chapter 59 of the laws of 2016, is
38 amended to read as follows:

39 § 10. This act shall take effect immediately and shall be deemed to
40 have been in full force and effect on and after July 1, 1996; provided,
41 however, that sections one, two and three of this act shall expire and
42 be deemed repealed on March 31, [2020] 2025 provided, however that the
43 amendments to section 364-j of the social services law made by section
44 four of this act shall not affect the expiration of such section and
45 shall be deemed to expire therewith and provided, further, that the
46 provisions of subdivisions 8, 9 and 10 of section 4401 of the public
47 health law, as added by section one of this act; section 4403-d of the
48 public health law as added by section two of this act and the provisions
49 of section seven of this act, except for the provisions relating to the
50 establishment of no more than twelve comprehensive HIV special needs
51 plans, shall expire and be deemed repealed on July 1, 2000.

52 § 22. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of
53 the laws of 1996, amending the education law and other laws relating to
54 rates for residential healthcare facilities, as amended by section 1 of
55 part D of chapter 59 of the laws of 2016, is amended to read as follows:

1 (a) Notwithstanding any inconsistent provision of law or regulation to
2 the contrary, effective beginning August 1, 1996, for the period April
3 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,
4 1998 through March 31, 1999, August 1, 1999, for the period April 1,
5 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000
6 through March 31, 2001, April 1, 2001, for the period April 1, 2001
7 through March 31, 2002, April 1, 2002, for the period April 1, 2002
8 through March 31, 2003, and for the state fiscal year beginning April 1,
9 2005 through March 31, 2006, and for the state fiscal year beginning
10 April 1, 2006 through March 31, 2007, and for the state fiscal year
11 beginning April 1, 2007 through March 31, 2008, and for the state fiscal
12 year beginning April 1, 2008 through March 31, 2009, and for the state
13 fiscal year beginning April 1, 2009 through March 31, 2010, and for the
14 state fiscal year beginning April 1, 2010 through March 31, 2016, and
15 for the state fiscal year beginning April 1, 2016 through March 31,
16 2019, and for the state fiscal year beginning April 1, 2019 through
17 March 31, 2022, the department of health is authorized to pay public
18 general hospitals, as defined in subdivision 10 of section 2801 of the
19 public health law, operated by the state of New York or by the state
20 university of New York or by a county, which shall not include a city
21 with a population of over one million, of the state of New York, and
22 those public general hospitals located in the county of Westchester, the
23 county of Erie or the county of Nassau, additional payments for inpa-
24 tient hospital services as medical assistance payments pursuant to title
25 11 of article 5 of the social services law for patients eligible for
26 federal financial participation under title XIX of the federal social
27 security act in medical assistance pursuant to the federal laws and
28 regulations governing disproportionate share payments to hospitals up to
29 one hundred percent of each such public general hospital's medical
30 assistance and uninsured patient losses after all other medical assist-
31 ance, including disproportionate share payments to such public general
32 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on
33 reported 1994 reconciled data as further reconciled to actual reported
34 1996 reconciled data, and for 1997 based initially on reported 1995
35 reconciled data as further reconciled to actual reported 1997 reconciled
36 data, for 1998 based initially on reported 1995 reconciled data as
37 further reconciled to actual reported 1998 reconciled data, for 1999
38 based initially on reported 1995 reconciled data as further reconciled
39 to actual reported 1999 reconciled data, for 2000 based initially on
40 reported 1995 reconciled data as further reconciled to actual reported
41 2000 data, for 2001 based initially on reported 1995 reconciled data as
42 further reconciled to actual reported 2001 data, for 2002 based initial-
43 ly on reported 2000 reconciled data as further reconciled to actual
44 reported 2002 data, and for state fiscal years beginning on April 1,
45 2005, based initially on reported 2000 reconciled data as further recon-
46 ciled to actual reported data for 2005, and for state fiscal years
47 beginning on April 1, 2006, based initially on reported 2000 reconciled
48 data as further reconciled to actual reported data for 2006, for state
49 fiscal years beginning on and after April 1, 2007 through March 31,
50 2009, based initially on reported 2000 reconciled data as further recon-
51 ciled to actual reported data for 2007 and 2008, respectively, for state
52 fiscal years beginning on and after April 1, 2009, based initially on
53 reported 2007 reconciled data, adjusted for authorized Medicaid rate
54 changes applicable to the state fiscal year, and as further reconciled
55 to actual reported data for 2009, for state fiscal years beginning on
56 and after April 1, 2010, based initially on reported reconciled data



1 from the base year two years prior to the payment year, adjusted for
2 authorized Medicaid rate changes applicable to the state fiscal year,
3 and further reconciled to actual reported data from such payment year,
4 and to actual reported data for each respective succeeding year. The
5 payments may be added to rates of payment or made as aggregate payments
6 to an eligible public general hospital.

7 § 23. This act shall take effect immediately and shall be deemed to
8 have been in full force and effect on and after April 1, 2019; provided
9 that the amendments to section 1 of part H of chapter 111 of the laws of
10 2010 made by section nineteen of this act shall not affect the expira-
11 tion of such section and shall expire therewith; and provided further
12 that section twenty of this act shall be deemed to have been in full
13 force and effect on and after January 1, 2018.

14

PART F

15 Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266
16 of the laws of 1986, amending the civil practice law and rules and other
17 laws relating to malpractice and professional medical conduct, as
18 amended by section 1 of part M of chapter 57 of the laws of 2018, is
19 amended to read as follows:

20 (a) The superintendent of financial services and the commissioner of
21 health or their designee shall, from funds available in the hospital
22 excess liability pool created pursuant to subdivision 5 of this section,
23 purchase a policy or policies for excess insurance coverage, as author-
24 ized by paragraph 1 of subsection (e) of section 5502 of the insurance
25 law; or from an insurer, other than an insurer described in section 5502
26 of the insurance law, duly authorized to write such coverage and actual-
27 ly writing medical malpractice insurance in this state; or shall
28 purchase equivalent excess coverage in a form previously approved by the
29 superintendent of financial services for purposes of providing equiv-
30 alent excess coverage in accordance with section 19 of chapter 294 of
31 the laws of 1985, for medical or dental malpractice occurrences between
32 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,
33 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June
34 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991
35 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July
36 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,
37 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June
38 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998
39 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July
40 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,
41 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June
42 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005
43 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July
44 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,
45 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June
46 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012
47 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July
48 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016,
49 between July 1, 2016 and June 30, 2017, between July 1, 2017 and June
50 30, 2018, [and] between July 1, 2018 and June 30, 2019, and between July
51 1, 2019 and June 30, 2020 or reimburse the hospital where the hospital
52 purchases equivalent excess coverage as defined in subparagraph (i) of
53 paragraph (a) of subdivision 1-a of this section for medical or dental
54 malpractice occurrences between July 1, 1987 and June 30, 1988, between



1 July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990,
2 between July 1, 1990 and June 30, 1991, between July 1, 1991 and June
3 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993
4 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July
5 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997,
6 between July 1, 1997 and June 30, 1998, between July 1, 1998 and June
7 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000
8 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July
9 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004,
10 between July 1, 2004 and June 30, 2005, between July 1, 2005 and June
11 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007
12 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July
13 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011,
14 between July 1, 2011 and June 30, 2012, between July 1, 2012 and June
15 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014
16 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July
17 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and]
18 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and
19 June 30, 2020 for physicians or dentists certified as eligible for each
20 such period or periods pursuant to subdivision 2 of this section by a
21 general hospital licensed pursuant to article 28 of the public health
22 law; provided that no single insurer shall write more than fifty percent
23 of the total excess premium for a given policy year; and provided,
24 however, that such eligible physicians or dentists must have in force an
25 individual policy, from an insurer licensed in this state of primary
26 malpractice insurance coverage in amounts of no less than one million
27 three hundred thousand dollars for each claimant and three million nine
28 hundred thousand dollars for all claimants under that policy during the
29 period of such excess coverage for such occurrences or be endorsed as
30 additional insureds under a hospital professional liability policy which
31 is offered through a voluntary attending physician ("channeling")
32 program previously permitted by the superintendent of financial services
33 during the period of such excess coverage for such occurrences. During
34 such period, such policy for excess coverage or such equivalent excess
35 coverage shall, when combined with the physician's or dentist's primary
36 malpractice insurance coverage or coverage provided through a voluntary
37 attending physician ("channeling") program, total an aggregate level of
38 two million three hundred thousand dollars for each claimant and six
39 million nine hundred thousand dollars for all claimants from all such
40 policies with respect to occurrences in each of such years provided,
41 however, if the cost of primary malpractice insurance coverage in excess
42 of one million dollars, but below the excess medical malpractice insur-
43 ance coverage provided pursuant to this act, exceeds the rate of nine
44 percent per annum, then the required level of primary malpractice insur-
45 ance coverage in excess of one million dollars for each claimant shall
46 be in an amount of not less than the dollar amount of such coverage
47 available at nine percent per annum; the required level of such coverage
48 for all claimants under that policy shall be in an amount not less than
49 three times the dollar amount of coverage for each claimant; and excess
50 coverage, when combined with such primary malpractice insurance cover-
51 age, shall increase the aggregate level for each claimant by one million
52 dollars and three million dollars for all claimants; and provided
53 further, that, with respect to policies of primary medical malpractice
54 coverage that include occurrences between April 1, 2002 and June 30,
55 2002, such requirement that coverage be in amounts no less than one
56 million three hundred thousand dollars for each claimant and three



1 million nine hundred thousand dollars for all claimants for such occur-
2 rences shall be effective April 1, 2002.

3 § 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986,
4 amending the civil practice law and rules and other laws relating to
5 malpractice and professional medical conduct, as amended by section 2 of
6 part M of chapter 57 of the laws of 2018, is amended to read as follows:

7 (3)(a) The superintendent of financial services shall determine and
8 certify to each general hospital and to the commissioner of health the
9 cost of excess malpractice insurance for medical or dental malpractice
10 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988
11 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July
12 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,
13 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June
14 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995
15 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July
16 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,
17 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June
18 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002
19 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July
20 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,
21 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June
22 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009
23 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July
24 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and
25 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June
26 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1,
27 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and]
28 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and
29 June 30, 2020 allocable to each general hospital for physicians or
30 dentists certified as eligible for purchase of a policy for excess
31 insurance coverage by such general hospital in accordance with subdivi-
32 sion 2 of this section, and may amend such determination and certifi-
33 cation as necessary.

34 (b) The superintendent of financial services shall determine and
35 certify to each general hospital and to the commissioner of health the
36 cost of excess malpractice insurance or equivalent excess coverage for
37 medical or dental malpractice occurrences between July 1, 1987 and June
38 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989
39 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July
40 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,
41 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June
42 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996
43 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July
44 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,
45 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June
46 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003
47 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July
48 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,
49 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June
50 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010
51 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July
52 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014,
53 between July 1, 2014 and June 30, 2015, between July 1, 2015 and June
54 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017
55 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019, and
56 between July 1, 2019 and June 30, 2020 allocable to each general hospi-

1 tal for physicians or dentists certified as eligible for purchase of a
2 policy for excess insurance coverage or equivalent excess coverage by
3 such general hospital in accordance with subdivision 2 of this section,
4 and may amend such determination and certification as necessary. The
5 superintendent of financial services shall determine and certify to each
6 general hospital and to the commissioner of health the ratable share of
7 such cost allocable to the period July 1, 1987 to December 31, 1987, to
8 the period January 1, 1988 to June 30, 1988, to the period July 1, 1988
9 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to
10 the period July 1, 1989 to December 31, 1989, to the period January 1,
11 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990,
12 to the period January 1, 1991 to June 30, 1991, to the period July 1,
13 1991 to December 31, 1991, to the period January 1, 1992 to June 30,
14 1992, to the period July 1, 1992 to December 31, 1992, to the period
15 January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December
16 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period
17 July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June
18 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period
19 January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December
20 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period
21 July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June
22 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period
23 January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December
24 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period
25 July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June
26 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period
27 July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30,
28 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1,
29 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to
30 the period July 1, 2007 and June 30, 2008, to the period July 1, 2008
31 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the
32 period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and
33 June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the
34 period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and
35 June 30, 2015, to the period July 1, 2015 and June 30, 2016, [and
36 between] to the period July 1, 2016 and June 30, 2017, [and] to the
37 period July 1, 2017 to June 30, 2018, [and] to the period July 1, 2018
38 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020.

39 § 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section
40 18 of chapter 266 of the laws of 1986, amending the civil practice law
41 and rules and other laws relating to malpractice and professional
42 medical conduct, as amended by section 3 of part M of chapter 57 of the
43 laws of 2018, are amended to read as follows:

44 (a) To the extent funds available to the hospital excess liability
45 pool pursuant to subdivision 5 of this section as amended, and pursuant
46 to section 6 of part J of chapter 63 of the laws of 2001, as may from
47 time to time be amended, which amended this subdivision, are insuffi-
48 cient to meet the costs of excess insurance coverage or equivalent
49 excess coverage for coverage periods during the period July 1, 1992 to
50 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during
51 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995
52 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,
53 during the period July 1, 1997 to June 30, 1998, during the period July
54 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,
55 2000, during the period July 1, 2000 to June 30, 2001, during the period
56 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to

1 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during
2 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004
3 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,
4 during the period July 1, 2006 to June 30, 2007, during the period July
5 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,
6 2009, during the period July 1, 2009 to June 30, 2010, during the period
7 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June
8 30, 2012, during the period July 1, 2012 to June 30, 2013, during the
9 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to
10 June 30, 2015, during the period July 1, 2015 to June 30, 2016, during
11 the period July 1, 2016 to June 30, 2017, during the period July 1, 2017
12 to June 30, 2018, [and] during the period July 1, 2018 to June 30, 2019,
13 and during the period July 1, 2019 to June 30, 2020 allocated or reallo-
14 cated in accordance with paragraph (a) of subdivision 4-a of this
15 section to rates of payment applicable to state governmental agencies,
16 each physician or dentist for whom a policy for excess insurance cover-
17 age or equivalent excess coverage is purchased for such period shall be
18 responsible for payment to the provider of excess insurance coverage or
19 equivalent excess coverage of an allocable share of such insufficiency,
20 based on the ratio of the total cost of such coverage for such physician
21 to the sum of the total cost of such coverage for all physicians applied
22 to such insufficiency.

23 (b) Each provider of excess insurance coverage or equivalent excess
24 coverage covering the period July 1, 1992 to June 30, 1993, or covering
25 the period July 1, 1993 to June 30, 1994, or covering the period July 1,
26 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,
27 1996, or covering the period July 1, 1996 to June 30, 1997, or covering
28 the period July 1, 1997 to June 30, 1998, or covering the period July 1,
29 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,
30 2000, or covering the period July 1, 2000 to June 30, 2001, or covering
31 the period July 1, 2001 to October 29, 2001, or covering the period
32 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to
33 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or
34 covering the period July 1, 2004 to June 30, 2005, or covering the peri-
35 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to
36 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or
37 covering the period July 1, 2008 to June 30, 2009, or covering the peri-
38 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to
39 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or
40 covering the period July 1, 2012 to June 30, 2013, or covering the peri-
41 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to
42 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or
43 covering the period July 1, 2016 to June 30, 2017, or covering the peri-
44 od July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to
45 June 30, 2019, or covering the period July 1, 2019 to June 30, 2020
46 shall notify a covered physician or dentist by mail, mailed to the
47 address shown on the last application for excess insurance coverage or
48 equivalent excess coverage, of the amount due to such provider from such
49 physician or dentist for such coverage period determined in accordance
50 with paragraph (a) of this subdivision. Such amount shall be due from
51 such physician or dentist to such provider of excess insurance coverage
52 or equivalent excess coverage in a time and manner determined by the
53 superintendent of financial services.

54 (c) If a physician or dentist liable for payment of a portion of the
55 costs of excess insurance coverage or equivalent excess coverage cover-
56 ing the period July 1, 1992 to June 30, 1993, or covering the period

1 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to
2 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or
3 covering the period July 1, 1996 to June 30, 1997, or covering the peri-
4 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to
5 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or
6 covering the period July 1, 2000 to June 30, 2001, or covering the peri-
7 od July 1, 2001 to October 29, 2001, or covering the period April 1,
8 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,
9 2003, or covering the period July 1, 2003 to June 30, 2004, or covering
10 the period July 1, 2004 to June 30, 2005, or covering the period July 1,
11 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,
12 2007, or covering the period July 1, 2007 to June 30, 2008, or covering
13 the period July 1, 2008 to June 30, 2009, or covering the period July 1,
14 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,
15 2011, or covering the period July 1, 2011 to June 30, 2012, or covering
16 the period July 1, 2012 to June 30, 2013, or covering the period July 1,
17 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,
18 2015, or covering the period July 1, 2015 to June 30, 2016, or covering
19 the period July 1, 2016 to June 30, 2017, or covering the period July 1,
20 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,
21 2019, or covering the period July 1, 2019 to June 30, 2020 determined in
22 accordance with paragraph (a) of this subdivision fails, refuses or
23 neglects to make payment to the provider of excess insurance coverage or
24 equivalent excess coverage in such time and manner as determined by the
25 superintendent of financial services pursuant to paragraph (b) of this
26 subdivision, excess insurance coverage or equivalent excess coverage
27 purchased for such physician or dentist in accordance with this section
28 for such coverage period shall be cancelled and shall be null and void
29 as of the first day on or after the commencement of a policy period
30 where the liability for payment pursuant to this subdivision has not
31 been met.

32 (d) Each provider of excess insurance coverage or equivalent excess
33 coverage shall notify the superintendent of financial services and the
34 commissioner of health or their designee of each physician and dentist
35 eligible for purchase of a policy for excess insurance coverage or
36 equivalent excess coverage covering the period July 1, 1992 to June 30,
37 1993, or covering the period July 1, 1993 to June 30, 1994, or covering
38 the period July 1, 1994 to June 30, 1995, or covering the period July 1,
39 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,
40 1997, or covering the period July 1, 1997 to June 30, 1998, or covering
41 the period July 1, 1998 to June 30, 1999, or covering the period July 1,
42 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,
43 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-
44 ing the period April 1, 2002 to June 30, 2002, or covering the period
45 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to
46 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or
47 covering the period July 1, 2005 to June 30, 2006, or covering the peri-
48 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to
49 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or
50 covering the period July 1, 2009 to June 30, 2010, or covering the peri-
51 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to
52 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or
53 covering the period July 1, 2013 to June 30, 2014, or covering the peri-
54 od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to
55 June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or
56 covering the period July 1, 2017 to June 30, 2018, or covering the peri-

1 od July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to
2 June 30, 2020 that has made payment to such provider of excess insurance
3 coverage or equivalent excess coverage in accordance with paragraph (b)
4 of this subdivision and of each physician and dentist who has failed,
5 refused or neglected to make such payment.

6 (e) A provider of excess insurance coverage or equivalent excess
7 coverage shall refund to the hospital excess liability pool any amount
8 allocable to the period July 1, 1992 to June 30, 1993, and to the period
9 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June
10 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the
11 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to
12 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to
13 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000
14 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,
15 and to the period April 1, 2002 to June 30, 2002, and to the period July
16 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,
17 2004, and to the period July 1, 2004 to June 30, 2005, and to the period
18 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June
19 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the
20 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to
21 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to
22 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012
23 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and
24 to the period July 1, 2014 to June 30, 2015, and to the period July 1,
25 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and
26 to the period July 1, 2017 to June 30, 2018, and to the period July 1,
27 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020
28 received from the hospital excess liability pool for purchase of excess
29 insurance coverage or equivalent excess coverage covering the period
30 July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to
31 June 30, 1994, and covering the period July 1, 1994 to June 30, 1995,
32 and covering the period July 1, 1995 to June 30, 1996, and covering the
33 period July 1, 1996 to June 30, 1997, and covering the period July 1,
34 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30,
35 1999, and covering the period July 1, 1999 to June 30, 2000, and cover-
36 ing the period July 1, 2000 to June 30, 2001, and covering the period
37 July 1, 2001 to October 29, 2001, and covering the period April 1, 2002
38 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003,
39 and covering the period July 1, 2003 to June 30, 2004, and covering the
40 period July 1, 2004 to June 30, 2005, and covering the period July 1,
41 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30,
42 2007, and covering the period July 1, 2007 to June 30, 2008, and cover-
43 ing the period July 1, 2008 to June 30, 2009, and covering the period
44 July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to
45 June 30, 2011, and covering the period July 1, 2011 to June 30, 2012,
46 and covering the period July 1, 2012 to June 30, 2013, and covering the
47 period July 1, 2013 to June 30, 2014, and covering the period July 1,
48 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,
49 2016, and covering the period July 1, 2016 to June 30, 2017, and cover-
50 ing the period July 1, 2017 to June 30, 2018, and covering the period
51 July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to
52 June 30, 2020 for a physician or dentist where such excess insurance
53 coverage or equivalent excess coverage is cancelled in accordance with
54 paragraph (c) of this subdivision.

55 § 4. Section 40 of chapter 266 of the laws of 1986, amending the civil
56 practice law and rules and other laws relating to malpractice and

1 professional medical conduct, as amended by section 4 of part M of chap-
2 ter 57 of the laws of 2018, is amended to read as follows:

3 § 40. The superintendent of financial services shall establish rates
4 for policies providing coverage for physicians and surgeons medical
5 malpractice for the periods commencing July 1, 1985 and ending June 30,
6 [2019;] 2020; provided, however, that notwithstanding any other
7 provision of law, the superintendent shall not establish or approve any
8 increase in rates for the period commencing July 1, 2009 and ending June
9 30, 2010. The superintendent shall direct insurers to establish segre-
10 gated accounts for premiums, payments, reserves and investment income
11 attributable to such premium periods and shall require periodic reports
12 by the insurers regarding claims and expenses attributable to such peri-
13 ods to monitor whether such accounts will be sufficient to meet incurred
14 claims and expenses. On or after July 1, 1989, the superintendent shall
15 impose a surcharge on premiums to satisfy a projected deficiency that is
16 attributable to the premium levels established pursuant to this section
17 for such periods; provided, however, that such annual surcharge shall
18 not exceed eight percent of the established rate until July 1, [2019,]
19 2020, at which time and thereafter such surcharge shall not exceed twen-
20 ty-five percent of the approved adequate rate, and that such annual
21 surcharges shall continue for such period of time as shall be sufficient
22 to satisfy such deficiency. The superintendent shall not impose such
23 surcharge during the period commencing July 1, 2009 and ending June 30,
24 2010. On and after July 1, 1989, the surcharge prescribed by this
25 section shall be retained by insurers to the extent that they insured
26 physicians and surgeons during the July 1, 1985 through June 30, [2019]
27 2020 policy periods; in the event and to the extent physicians and
28 surgeons were insured by another insurer during such periods, all or a
29 pro rata share of the surcharge, as the case may be, shall be remitted
30 to such other insurer in accordance with rules and regulations to be
31 promulgated by the superintendent. Surcharges collected from physicians
32 and surgeons who were not insured during such policy periods shall be
33 apportioned among all insurers in proportion to the premium written by
34 each insurer during such policy periods; if a physician or surgeon was
35 insured by an insurer subject to rates established by the superintendent
36 during such policy periods, and at any time thereafter a hospital,
37 health maintenance organization, employer or institution is responsible
38 for responding in damages for liability arising out of such physician's
39 or surgeon's practice of medicine, such responsible entity shall also
40 remit to such prior insurer the equivalent amount that would then be
41 collected as a surcharge if the physician or surgeon had continued to
42 remain insured by such prior insurer. In the event any insurer that
43 provided coverage during such policy periods is in liquidation, the
44 property/casualty insurance security fund shall receive the portion of
45 surcharges to which the insurer in liquidation would have been entitled.
46 The surcharges authorized herein shall be deemed to be income earned for
47 the purposes of section 2303 of the insurance law. The superintendent,
48 in establishing adequate rates and in determining any projected defi-
49 ciency pursuant to the requirements of this section and the insurance
50 law, shall give substantial weight, determined in his discretion and
51 judgment, to the prospective anticipated effect of any regulations
52 promulgated and laws enacted and the public benefit of stabilizing
53 malpractice rates and minimizing rate level fluctuation during the peri-
54 od of time necessary for the development of more reliable statistical
55 experience as to the efficacy of such laws and regulations affecting
56 medical, dental or podiatric malpractice enacted or promulgated in 1985,

1 1986, by this act and at any other time. Notwithstanding any provision
2 of the insurance law, rates already established and to be established by
3 the superintendent pursuant to this section are deemed adequate if such
4 rates would be adequate when taken together with the maximum authorized
5 annual surcharges to be imposed for a reasonable period of time whether
6 or not any such annual surcharge has been actually imposed as of the
7 establishment of such rates.

8 § 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of
9 chapter 63 of the laws of 2001, amending chapter 266 of the laws of
10 1986, amending the civil practice law and rules and other laws relating
11 to malpractice and professional medical conduct, relating to the effec-
12 tiveness of certain provisions of such chapter, as amended by section 5
13 of part M of chapter 57 of the laws of 2018, are amended to read as
14 follows:

15 § 5. The superintendent of financial services and the commissioner of
16 health shall determine, no later than June 15, 2002, June 15, 2003, June
17 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,
18 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,
19 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June
20 15, 2018, [and] June 15, 2019, and June 15, 2020 the amount of funds
21 available in the hospital excess liability pool, created pursuant to
22 section 18 of chapter 266 of the laws of 1986, and whether such funds
23 are sufficient for purposes of purchasing excess insurance coverage for
24 eligible participating physicians and dentists during the period July 1,
25 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003
26 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to
27 June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June
28 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30,
29 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30,
30 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
31 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
32 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,
33 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
34 as applicable.

35 (a) This section shall be effective only upon a determination, pursu-
36 ant to section five of this act, by the superintendent of financial
37 services and the commissioner of health, and a certification of such
38 determination to the state director of the budget, the chair of the
39 senate committee on finance and the chair of the assembly committee on
40 ways and means, that the amount of funds in the hospital excess liabil-
41 ity pool, created pursuant to section 18 of chapter 266 of the laws of
42 1986, is insufficient for purposes of purchasing excess insurance cover-
43 age for eligible participating physicians and dentists during the period
44 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July
45 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,
46 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007
47 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to
48 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June
49 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,
50 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,
51 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,
52 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020
53 as applicable.

54 (e) The commissioner of health shall transfer for deposit to the
55 hospital excess liability pool created pursuant to section 18 of chapter
56 266 of the laws of 1986 such amounts as directed by the superintendent

1 of financial services for the purchase of excess liability insurance
2 coverage for eligible participating physicians and dentists for the
3 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,
4 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,
5 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,
6 2007, as applicable, and the cost of administering the hospital excess
7 liability pool for such applicable policy year, pursuant to the program
8 established in chapter 266 of the laws of 1986, as amended, no later
9 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June
10 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,
11 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,
12 2015, June 15, 2016, June 15, 2017, June 15, 2018, [and] June 15, 2019,
13 and June 15, 2020 as applicable.

14 § 6. Section 20 of part H of chapter 57 of the laws of 2017, amending
15 the New York Health Care Reform Act of 1996 and other laws relating to
16 extending certain provisions thereto, as amended by section 6 of part M
17 of chapter 57 of the laws of 2018, is amended to read as follows:

18 § 20. Notwithstanding any law, rule or regulation to the contrary,
19 only physicians or dentists who were eligible, and for whom the super-
20 intendent of financial services and the commissioner of health, or their
21 designee, purchased, with funds available in the hospital excess liabil-
22 ity pool, a full or partial policy for excess coverage or equivalent
23 excess coverage for the coverage period ending the thirtieth of June,
24 two thousand [eighteen,] nineteen, shall be eligible to apply for such
25 coverage for the coverage period beginning the first of July, two thou-
26 sand [eighteen,] nineteen; provided, however, if the total number of
27 physicians or dentists for whom such excess coverage or equivalent
28 excess coverage was purchased for the policy year ending the thirtieth
29 of June, two thousand [eighteen] nineteen exceeds the total number of
30 physicians or dentists certified as eligible for the coverage period
31 beginning the first of July, two thousand [eighteen,] nineteen, then the
32 general hospitals may certify additional eligible physicians or dentists
33 in a number equal to such general hospital's proportional share of the
34 total number of physicians or dentists for whom excess coverage or
35 equivalent excess coverage was purchased with funds available in the
36 hospital excess liability pool as of the thirtieth of June, two thousand
37 [eighteen,] nineteen, as applied to the difference between the number of
38 eligible physicians or dentists for whom a policy for excess coverage or
39 equivalent excess coverage was purchased for the coverage period ending
40 the thirtieth of June, two thousand [eighteen] nineteen and the number
41 of such eligible physicians or dentists who have applied for excess
42 coverage or equivalent excess coverage for the coverage period beginning
43 the first of July, two thousand [eighteen] nineteen.

44 § 7. This act shall take effect immediately and shall be deemed to
45 have been in full force and effect on and after April 1, 2019.

46

PART G

47 Section 1. Intentionally Omitted.

48 § 2. Intentionally omitted.

49 § 3. Intentionally omitted.

50 § 4. Intentionally omitted.

51 § 5. Intentionally omitted.

52 § 5-a. Paragraph (e) of subdivision 2 of section 365-a of the social
53 services law is amended by adding a new subparagraph (v) to read as
54 follows:



1 (v) service authorization for personal care services shall only be
2 denied or reduced in an amount, duration, or scope that is less than
3 requested if it is found that the recipient's medical, mental, economic,
4 or social circumstances have changed and the social services district
5 reasonably expects that such services are no longer appropriate or can
6 be provided in fewer hours. For proposed discontinuances, this includes
7 but shall not be limited to cases in which: the client's health and
8 safety can no longer be assured with the provision of personal care
9 services; the client's medical condition is no longer stable; the client
10 is no longer self-directing and has no one to assume those responsibil-
11 ities; or the services the client needs exceed the personal care aide's
12 scope of practice. Any decision to deny a service authorization request
13 or to authorize a service in an amount, duration, or scope that is less
14 than requested, shall be made by a health care professional who has
15 appropriate clinical expertise in treating the enrollee's medical,
16 behavioral health, or long-term services and supports needs. The social
17 services district shall notify the client in writing of its decision to
18 authorize, reauthorize, increase, reduce, discontinue or deny personal
19 care services and advise the client of his or her right to a fair hear-
20 ing and aid continuing under section twenty-two of this chapter.

21 § 5-b. Paragraph (d) of subdivision 1 of section 3614-c of the public
22 health law, as amended by section 5 of part S of chapter 57 of the laws
23 of 2017, is amended to read as follows:

24 (d) "Home care aide" means a home health aide, personal care aide,
25 home attendant, personal assistant performing consumer directed personal
26 assistance services pursuant to section three hundred sixty-five-f of
27 the social services law, a person delivering care under the traumatic
28 brain injury program pursuant to section two thousand seven hundred
29 forty of this chapter, or other licensed or unlicensed person whose
30 primary responsibility includes the provision of in-home assistance with
31 activities of daily living, instrumental activities of daily living or
32 health-related tasks; provided, however, that home care aide does not
33 include any individual (i) working on a casual basis, or (ii) (except
34 for a person employed under the consumer directed personal assistance
35 program under section three hundred sixty-five-f of the social services
36 law) who is a relative through blood, marriage or adoption of: (1) the
37 employer; or (2) the person for whom the worker is delivering services,
38 under a program funded or administered by federal, state or local
39 government.

40 § 5-c. Residential health care facilities case mix adjustment work-
41 group. The commissioner of health shall convene and chair a workgroup on
42 case mix adjustments to Medicaid rates of payment of residential health
43 care facilities. The workgroup shall be comprised of residential health
44 care facilities or representatives from such facilities, representatives
45 from the statewide associations and other such experts on case mix as
46 required by the commissioner. The workgroup shall review recent case mix
47 data and related analyses conducted by the department, the department's
48 minimum data set census collection process and case mix adjustments
49 authorized under subdivision 2-c of section twenty-eight hundred eight
50 of the public health law. Such review shall seek to promote a higher
51 degree of accuracy in the minimum data set data, and target abuses. The
52 workgroup shall offer recommendations on how to improve accuracy in the
53 minimum data set collection process, and reduce or eliminate abusive
54 practices. In developing its recommendations, the workgroup shall ensure
55 that the census collection process and case mix adjustment continues to
56 recognize the need to adjust rates for residential health care facili-

1 ties that serve high-need residents. The workgroup shall also consider
2 any changes in federal law and regulation relating to nursing home
3 reimbursement, including adoption of the patient driven payment model,
4 and administrative complexity in revising the census collection and rate
5 promulgation processes. The commissioner and department of health shall
6 be prohibited from reducing or recouping case mix adjustments for peri-
7 ods prior to the implementation of the workgroup recommendations;
8 provided, such limitation shall not apply to audits by the office of the
9 medicaid inspector general, audits conducted by the department of
10 health, or in cases of fraud or abuse. The workgroup shall report its
11 recommendations no later than July 1, 2019. Such recommendations shall
12 be adopted by the commissioner on a prospective basis and rely on
13 assessment data submitted no earlier than such adoption.

14 § 5-d. Section 365-a of the social services law is amended by adding a
15 new subdivision 10 to read as follows:

16 10. For any determination of the amount, nature and manner of provid-
17 ing assistance under this article for which an assessment tool is used,
18 the department, in consultation with the independent actuary, represen-
19 tatives of medical assistance recipients, representatives of the managed
20 care programs, representatives of long term care providers and other
21 interested parties, shall evaluate existing assessment tools and develop
22 additional professionally and statistically valid assessment tools to be
23 used to assist in determining the amount, nature and manner of services
24 and care needs of individuals which shall involve consideration of vari-
25 ables including but not limited to physical and behavioral functioning;
26 activities of daily living and instrumental activities of daily living;
27 family, social or geographic determinants of health; primary or second-
28 ary diagnoses of cognitive impairment or mental illness; and other
29 appropriate conditions or factors.

30 § 5-e. Paragraphs (c) of subdivision 18 of section 364-j of the social
31 services law, as added by sections 40-c and 55 of part B of chapter 57
32 of the laws of 2015, are amended to read as follows:

33 (c) (i) In setting such reimbursement methodologies, the department
34 shall consider costs borne by the managed care program to ensure actuar-
35 ially sound and adequate rates of payment to ensure quality of care for
36 its enrollees and shall comply with all applicable federal and state
37 laws and regulations, including, but not limited to, those relating to
38 wages, labor, and actuarial soundness.

39 [(c)] (ii) The department [of health] shall require the independent
40 actuary selected pursuant to paragraph (b) of this subdivision to
41 provide a complete actuarial memorandum, along with all actuarial
42 assumptions made and all other data, materials and methodologies used in
43 the development of rates, to managed care providers thirty days prior to
44 submission of such rates to the centers for medicare and medicaid
45 services for approval. Managed care providers may request additional
46 review of the actuarial soundness of the rate setting process and/or
47 methodology.

48 (iii) In fulfilling the requirements of this paragraph, the department
49 shall establish separate rate cells or risk adjustments to reflect the
50 costs of care for specific high-need enrollees in managed care provid-
51 ers. The commissioner shall make any necessary amendments to the state
52 plan for medical assistance under section three hundred sixty-three-a of
53 this title, and submit any applications for waivers of the federal
54 social security act, as may be necessary to ensure federal financial
55 participation. As used in this subparagraph and subparagraph (iv) of
56 this paragraph, "managed care provider" shall mean a managed care

1 provider operating on a full capitation basis or a managed long term
2 care plan operating under section forty-four hundred three-f of the
3 public health law; and "long term care entity" shall mean a home care
4 services agency under article thirty-six of the public health law, a
5 fiscal intermediary in the consumer directed personal assistance
6 program, other long term care provider authorized under a home and
7 community based waiver administered by the department or the office for
8 people with developmental disabilities. The high-need rate cells or
9 risk adjustments established in accordance with this subparagraph shall
10 be consistent with subdivision ten of section three hundred sixty-five-a
11 of this title and include, but shall not be limited to:

12 (A) individuals enrolled with a managed care provider, who remain in
13 the community and who daily receive live-in twenty-four hour personal
14 care or home health services or twelve hours or more of personal care,
15 home health services or home and community support services;

16 (B) such other individuals who, based on the assessment of their care
17 needs, their diagnosis or other factors, are determined to present espe-
18 cially high needs related to factors that would influence the delivery
19 (including but not limited to home location) or their use of services,
20 as may be identified by the department.

21 (iv) Any contract for services under this title by a managed care
22 provider with a long term care entity shall ensure that resources made
23 available by the payer under such contract will support the recruitment,
24 hiring, training and retention of a qualified workforce capable of
25 providing quality care, including compliance with all applicable federal
26 and state laws and regulations, including, but not limited to, those
27 relating to wages and labor. A managed care provider with a long term
28 care entity shall report its method of compliance with this subdivision
29 to the department as a component of cost reports required under section
30 forty-four hundred three-f of the public health law.

31 (v) A long term care entity that contracts with a managed care provid-
32 er shall annually submit written certification to the department as a
33 component of cost reports required under section thirty-six hundred
34 twelve of the public health law and sections three hundred sixty-five-a
35 and three hundred sixty-seven-g of this title, as applicable, as to how
36 it applied the amounts paid in compliance with this subdivision to
37 support the recruitment, hiring, training and retention of a qualified
38 workforce capable of providing quality care and consistent with section
39 three hundred sixty-five-a of this title.

40 § 5-f. Subparagraph (ii) of paragraph (a) and paragraph (g) of subdi-
41 vision 7 and subdivision 8 of section 4403-f of the public health law,
42 subparagraph (ii) of paragraph (a) of subdivision 7 as amended by
43 section 43 of part C of chapter 60 of the laws of 2014, paragraph (g) of
44 subdivision 7 as amended by section 41-b of part H of chapter 59 of the
45 laws of 2011, subparagraph (i) of paragraph (g) of subdivision 7 as
46 amended by section 1 of part GGG of chapter 59 of the laws of 2017,
47 subparagraph (iii) of paragraph (g) of subdivision 7 as amended by
48 section 54 of part A of chapter 56 of the laws of 2013 and subdivision 8
49 as amended by section 21 of part B of chapter 59 of the laws of 2016,
50 are amended to read as follows:

51 (ii) Notwithstanding any inconsistent provision of the social services
52 law to the contrary, the commissioner shall, pursuant to regulation,
53 determine whether and the extent to which the applicable provisions of
54 the social services law or regulations relating to approvals and author-
55 izations of, and utilization limitations on, health and long term care
56 services reimbursed pursuant to title XIX of the federal social security

1 act, including, but not limited to, fiscal assessment requirements, are
2 inconsistent with the flexibility necessary for the efficient adminis-
3 tration of managed long term care plans and such regulations shall
4 provide that such provisions shall not be applicable to enrollees or
5 managed long term care plans, provided that such determinations are
6 consistent with applicable federal law and regulation, and subject to
7 the provisions of [subdivision] subdivisions eight and ten of section
8 three hundred sixty-five-a and paragraph (c) of subdivision eighteen of
9 section three hundred sixty-four-j of the social services law.

10 (g) (i) Managed long term care plans and demonstrations may enroll
11 eligible persons in the plan or demonstration upon the completion of a
12 comprehensive assessment [that shall include, but not be limited to, an
13 evaluation of the medical, social, cognitive, and environmental needs]
14 of each prospective enrollee in such program consistent with section
15 three hundred sixty-five-a of the social services law. This assessment
16 shall also serve as the basis for the development and provision of an
17 appropriate plan of care for the enrollee. Upon approval of federal
18 waivers pursuant to paragraph (b) of this subdivision which require
19 medical assistance recipients who require community-based long term care
20 services to enroll in a plan, and upon approval of the commissioner, a
21 plan may enroll an applicant who is currently receiving home and commu-
22 nity-based services and complete the comprehensive assessment within
23 thirty days of enrollment provided that the plan continues to cover
24 transitional care until such time as the assessment is completed.

25 (ii) The assessment shall be completed by a representative of the
26 managed long term care plan or demonstration, in consultation with the
27 prospective enrollee's health care practitioner as necessary. The
28 commissioner shall prescribe the forms on which the assessment shall be
29 made.

30 (iii) The enrollment application shall be submitted by the managed
31 long term care plan or demonstration to the entity designated by the
32 department prior to the commencement of services under the managed long
33 term care plan or demonstration. Enrollments conducted by a plan or
34 demonstration shall be subject to review and audit by the department or
35 a contractor selected pursuant to paragraph (d) of this subdivision.

36 (iv) Continued enrollment in a managed long term care plan or demon-
37 stration paid for by government funds shall be based upon a compre-
38 hensive assessment [of the medical, social and environmental needs] of the
39 recipient of the services consistent with section three hundred sixty-
40 five-a of this social services law. Such assessment shall be performed
41 at least every six months by the managed long term care plan serving the
42 enrollee. The commissioner shall prescribe the forms on which the
43 assessment will be made.

44 8. Payment rates for managed long term care plan enrollees eligible
45 for medical assistance. The commissioner shall establish payment rates
46 for services provided to enrollees eligible under title XIX of the
47 federal social security act. Such payment rates shall be subject to
48 approval by the director of the division of the budget and shall reflect
49 savings to both state and local governments when compared to costs which
50 would be incurred by such program if enrollees were to receive compara-
51 ble health and long term care services on a fee-for-service basis in the
52 geographic region in which such services are proposed to be provided.
53 Payment rates shall be risk-adjusted to take into account the character-
54 istics of enrollees, or proposed enrollees, including, but not limited
55 to: frailty, disability level, health and functional status, age,
56 gender, the nature of services provided to such enrollees, and other

1 factors as determined by the commissioner. The risk adjusted premiums
2 may also be combined with disincentives or requirements designed to
3 mitigate any incentives to obtain higher payment categories. In setting
4 such payment rates, the commissioner shall consider costs borne by the
5 managed care program to ensure actuarially sound and adequate rates of
6 payment to ensure quality of care and shall comply with all applicable
7 laws and regulations, state and federal, including [regulations as to],
8 but not limited to, those relating to wages, labor and actuarial sound-
9 ness [for medicaid managed care].

10 § 5-g. Subparagraph (i) of paragraph (g) of subdivision 7 of section
11 4403-f of the public health law, as added by section 65-c of part A of
12 chapter 57 of the laws of 2006 and such paragraph as relettered by
13 section 20 of part C of chapter 58 of the laws of 2007, is amended to
14 read as follows:

15 (i) Managed long term care plans and demonstrations may enroll eligi-
16 ble persons in the plan or demonstration upon the completion of a
17 comprehensive assessment [that shall include, but not be limited to, an
18 evaluation of the medical, social and environmental needs] of each
19 prospective enrollee in such program consistent with section three
20 hundred sixty-five-a of the social services law. This assessment shall
21 also serve as the basis for the development and provision of an appro-
22 priate plan of care for the prospective enrollee.

23 § 6. This act shall take effect immediately and shall be deemed to
24 have been in full force and effect on and after April 1, 2019, provided,
25 however that:

26 (a) sections five-e and five-f of this act shall take effect April 1,
27 2020;

28 (b) the amendments to section 364-j of the social services law made by
29 section five-e of this act shall not affect the repeal of such section
30 and shall be deemed repealed therewith;

31 (c) the amendments to section 4403-f of the public health law made by
32 section five-f of this act shall not affect the repeal of such section
33 and shall be deemed repealed therewith; and

34 (d) the amendments to subparagraph (i) of paragraph (g) of subdivision
35 7 of section 4403-f of the public health law made by section five-f of
36 this act shall not affect the expiration and reversion of such subpara-
37 graph, pursuant to subdivision (i) of section 111 of part H of chapter
38 59 of the laws of 2011, as amended, when upon such date the provisions
39 of section five-g of this act shall take effect.

40

PART H

41 Section 1. Intentionally Omitted.

42 § 2. Section 2807 of the public health law is amended by adding a new
43 subdivision 20-a to read as follows:

44 20-a. Notwithstanding any provision of law to the contrary, the
45 commissioners of the department of health, the office of mental health,
46 the office of people with developmental disabilities, and the office of
47 alcoholism and substance abuse services are authorized to waive any
48 regulatory requirements as are necessary, consistent with applicable
49 law, to allow providers that are involved in DSRIP projects or repli-
50 cation and scaling activities, as approved by the authorizing commis-
51 sioner, to avoid duplication of requirements related to such projects or
52 activities and to allow the efficient scaling and replication of DSRIP
53 promising practices, as determined by the authorizing commissioner;
54 provided however, that regulations pertaining to patient safety may not



1 be waived, nor shall any regulations be waived if such waiver would risk
2 patient safety. Any regulatory action under this subdivision shall be
3 limited in scope and manner to waivers already authorized pursuant to
4 this article. Any regulatory action under this subdivision shall be
5 published on the applicable website of the authorizing commissioner and
6 shall include a description of each waiver, including a citation of each
7 regulation waived, and a description of the project of which such relief
8 was granted.

9 § 3. Intentionally Omitted.

10 § 4. Intentionally Omitted.

11 § 5. Intentionally Omitted.

12 § 6. Subdivision 5-d of section 2807-k of the public health law, as
13 amended by section 2 of part A of chapter 57 of the laws of 2018, is
14 amended to read as follows.

15 5-d. (a) Notwithstanding any inconsistent provision of this section,
16 section twenty-eight hundred seven-w of this article or any other
17 contrary provision of law, and subject to the availability of federal
18 financial participation, for periods on and after January first, two
19 thousand thirteen, through March thirty-first, two thousand twenty, all
20 funds available for distribution pursuant to this section, except for
21 funds distributed pursuant to subparagraph (v) of paragraph (b) of
22 subdivision five-b of this section, and all funds available for distrib-
23 ution pursuant to section twenty-eight hundred seven-w of this article,
24 shall be reserved and set aside and distributed in accordance with the
25 provisions of this subdivision.

26 (b) The commissioner shall promulgate regulations, and may promulgate
27 emergency regulations, establishing methodologies for the distribution
28 of funds as described in paragraph (a) of this subdivision and such
29 regulations shall include, but not be limited to, the following:

30 (i) Such regulations shall establish methodologies for determining
31 each facility's relative uncompensated care need amount based on unin-
32 sured inpatient and outpatient units of service from the cost reporting
33 year two years prior to the distribution year, multiplied by the appli-
34 cable medicaid rates in effect January first of the distribution year,
35 as summed and adjusted by a statewide cost adjustment factor and reduced
36 by the sum of all payment amounts collected from such uninsured
37 patients, and as further adjusted by application of a nominal need
38 computation that shall take into account each facility's medicaid inpa-
39 tient share.

40 (ii) Annual distributions pursuant to such regulations for the two
41 thousand thirteen through two thousand [nineteen] twenty calendar years
42 shall be in accord with the following:

43 (A) one hundred thirty-nine million four hundred thousand dollars
44 shall be distributed as Medicaid Disproportionate Share Hospital ("DSH")
45 payments to major public general hospitals; and

46 (B) nine hundred ninety-four million nine hundred thousand dollars as
47 Medicaid DSH payments to eligible general hospitals, other than major
48 public general hospitals.

49 (iii) (A) Such regulations shall establish transition adjustments to
50 the distributions made pursuant to clauses (A) and (B) of subparagraph
51 (ii) of this paragraph such that no facility experiences a reduction in
52 indigent care pool payments pursuant to this subdivision that is greater
53 than the percentages, as specified in clause (C) of this subparagraph as
54 compared to the average distribution that each such facility received
55 for the three calendar years prior to two thousand thirteen pursuant to
56 this section and section twenty-eight hundred seven-w of this article.

1 (B) Such regulations shall also establish adjustments limiting the
2 increases in indigent care pool payments experienced by facilities
3 pursuant to this subdivision by an amount that will be, as determined by
4 the commissioner and in conjunction with such other funding as may be
5 available for this purpose, sufficient to ensure full funding for the
6 transition adjustment payments authorized by clause (A) of this subpara-
7 graph.

8 (C) No facility shall experience a reduction in indigent care pool
9 payments pursuant to this subdivision that: for the calendar year begin-
10 ning January first, two thousand thirteen, is greater than two and one-
11 half percent; for the calendar year beginning January first, two thou-
12 sand fourteen, is greater than five percent; and, for the calendar year
13 beginning on January first, two thousand fifteen; is greater than seven
14 and one-half percent, and for the calendar year beginning on January
15 first, two thousand sixteen, is greater than ten percent; and for the
16 calendar year beginning on January first, two thousand seventeen, is
17 greater than twelve and one-half percent; and for the calendar year
18 beginning on January first, two thousand eighteen, is greater than
19 fifteen percent; and for the calendar year beginning on January first,
20 two thousand nineteen, is greater than seventeen and one-half percent;
21 and for the calendar year beginning on January first, two thousand twen-
22 ty, is greater than twenty percent.

23 (iv) Such regulations shall reserve one percent of the funds available
24 for distribution in the two thousand fourteen and two thousand fifteen
25 calendar years, and for calendar years thereafter, pursuant to this
26 subdivision, subdivision fourteen-f of section twenty-eight hundred
27 seven-c of this article, and sections two hundred eleven and two hundred
28 twelve of chapter four hundred seventy-four of the laws of nineteen
29 hundred ninety-six, in a "financial assistance compliance pool" and
30 shall establish methodologies for the distribution of such pool funds to
31 facilities based on their level of compliance, as determined by the
32 commissioner, with the provisions of subdivision nine-a of this section.

33 (c) The commissioner shall annually report to the governor and the
34 legislature on the distribution of funds under this subdivision includ-
35 ing, but not limited to:

36 (i) the impact on safety net providers, including community providers,
37 rural general hospitals and major public general hospitals;

38 (ii) the provision of indigent care by units of services and funds
39 distributed by general hospitals; and

40 (iii) the extent to which access to care has been enhanced.

41 § 7. This act shall take effect immediately and shall be deemed to
42 have been in full force and effect on and after April 1, 2019, provided,
43 however, that section two of this act shall expire on April 1, 2020.

44 PART I

45 Intentionally Omitted

46 PART J

47 Section 1. This Part enacts into law major components of legislation
48 which are necessary to protect health care consumers; increase access to
49 more affordable quality health insurance coverage; and preserve and
50 foster New York's health insurance markets. Each component is wholly
51 contained within a Subpart identified as Subparts A and B. The effec-
52 tive date for each particular provision contained within such Subpart is

1 set forth in the last section of such Subpart. Any provision in any
2 section contained within a Subpart, including the effective date of the
3 Subpart, which makes a reference to a section "of this act," when used
4 in connection with that particular component, shall be deemed to mean
5 and refer to the corresponding section of the Subpart in which it is
6 found. Section five of this Part sets forth the general effective date
7 of this Part.

8

SUBPART A

9 Section 1. Section 3221 of the insurance law is amended by adding a
10 new subsection (t) to read as follows:

11 (t) (1) Any insurer that delivers or issues for delivery in this state
12 hospital, surgical or medical expense group policies in the small group
13 or large group market shall offer to any employer in this state all such
14 policies in the applicable market, and shall accept at all times
15 throughout the year any employer that applies for any of those policies.

16 (2) The requirements of paragraph one of this subsection shall apply
17 with respect to an employer that applies for coverage either directly
18 from the insurer or through an association or trust to which the insurer
19 has issued coverage and in which the employer participates.

20 § 2. Intentionally omitted.

21 § 3. Subsections (h) and (i) of section 3232 of the insurance law are
22 REPEALED.

23 § 4. Subsections (f) and (g) of section 3232 of the insurance law, as
24 added by chapter 219 of the laws of 2011, are amended to read as
25 follows:

26 (f) [With respect to an individual under age nineteen, an insurer may
27 not impose any pre-existing condition exclusion in an individual or
28 group policy of hospital, medical, surgical or prescription drug expense
29 insurance pursuant to the requirements of section 2704 of the Public
30 Health Service Act, 42 U.S.C. § 300gg-3, as made effective by section
31 1255(2) of the Affordable Care Act, except for an individual under age
32 nineteen covered under an individual policy of hospital, medical, surgi-
33 cal or prescription drug expense insurance that is a grandfathered
34 health plan.

35 (g) Beginning January first, two thousand fourteen, pursuant to
36 section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3, an]
37 An insurer [may] shall not impose any pre-existing condition exclusion
38 in an individual or group policy of hospital, medical, surgical or
39 prescription drug expense insurance [except in an individual policy that
40 is a grandfathered health plan].

41 § 5. Intentionally omitted.

42 § 6. Section 4305 of the insurance law is amended by adding a new
43 subsection (n) to read as follows:

44 (n) (1) Any corporation subject to the provisions of this article that
45 issues hospital, surgical or medical expense contracts in the small
46 group or large group market in this state shall offer to any employer in
47 this state all such contracts in the applicable market, and shall accept
48 at all times throughout the year any employer that applies for any of
49 those contracts.

50 (2) The requirements of paragraph one of this subsection shall apply
51 with respect to an employer that applies for coverage either directly
52 from the corporation or through an association or trust to which the
53 corporation has issued coverage and in which the employer participates.

54 § 7. Intentionally omitted.

1 § 8. Subsections (h) and (i) of section 4318 of the insurance law are
2 REPEALED.

3 § 9. Subsections (f) and (g) of section 4318 of the insurance law, as
4 added by chapter 219 of the laws of 2011, are amended to read as
5 follows:

6 (f) [With respect to an individual under age nineteen, a corporation
7 may not impose any pre-existing condition exclusion in an individual or
8 group contract of hospital, medical, surgical or prescription drug
9 expense insurance pursuant to the requirements of section 2704 of the
10 Public Health Service Act, 42 U.S.C. § 300gg-3, as made effective by
11 section 1255(2) of the Affordable Care Act, except for an individual
12 under age nineteen covered under an individual contract of hospital,
13 medical, surgical or prescription drug expense insurance that is a
14 grandfathered health plan.

15 (g) Beginning January first, two thousand fourteen, pursuant to
16 section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3, a] A
17 corporation [may] shall not impose any pre-existing condition exclusion
18 in an individual or group contract of hospital, medical, surgical or
19 prescription drug expense insurance [except in an individual contract
20 that is a grandfathered health plan].

21 § 10. Intentionally omitted.

22 § 11. Subdivision 1 of section 4406 of the public health law, as
23 amended by section 46-a of part D of chapter 56 of the laws of 2013, is
24 amended to read as follows:

25 1. The contract between a health maintenance organization and an
26 enrollee shall be subject to regulation by the superintendent as if it
27 were a health insurance subscriber contract, and shall include, but not
28 be limited to, all mandated benefits required by article forty-three of
29 the insurance law. Such contract shall fully and clearly state the bene-
30 fits and limitations therein provided or imposed, so as to facilitate
31 understanding and comparisons, and to exclude provisions which may be
32 misleading or unreasonably confusing. Such contract shall be issued to
33 any individual and dependents of such individual and any group of fifty
34 or fewer employees or members, exclusive of spouses and dependents, or
35 to any employee or member of the group, including dependents, applying
36 for such contract at any time throughout the year[, and may include a
37 pre-existing condition provision as provided for in section four thou-
38 sand three hundred eighteen of the insurance law, provided, however,
39 that, the]. An individual direct payment contract shall be issued only
40 in accordance with section four thousand three hundred twenty-eight of
41 the insurance law. The superintendent may, after giving consideration to
42 the public interest, exempt a health maintenance organization from the
43 requirements of this section provided that another health insurer or
44 health maintenance organization within the health maintenance organiza-
45 tion's same holding company system, as defined in article fifteen of the
46 insurance law, including a health maintenance organization operated as a
47 line of business of a health service corporation licensed under article
48 forty-three of the insurance law, offers coverage that, at a minimum,
49 complies with this section and provides all of the consumer protections
50 required to be provided by a health maintenance organization pursuant to
51 this chapter and regulations, including those consumer protections
52 contained in sections four thousand four hundred three and four thousand
53 four hundred eight-a of this chapter. The requirements shall not apply
54 to a health maintenance organization exclusively serving individuals
55 enrolled pursuant to title eleven of article five of the social services
56 law, title eleven-D of article five of the social services law, title

1 one-A of article twenty-five of [the public health law] this chapter or
2 title eighteen of the federal Social Security Act, and, further
3 provided, that such health maintenance organization shall not discontin-
4 ue a contract for an individual receiving comprehensive-type coverage in
5 effect prior to January first, two thousand four who is ineligible to
6 purchase policies offered after such date pursuant to this section or
7 section four thousand three hundred [twenty-two of this article] twen-
8 ty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss
9 in effect prior to January first, two thousand four. [Subject to the
10 creditable coverage requirements of subsection (a) of section four thou-
11 sand three hundred eighteen of the insurance law, the organization may,
12 as an alternative to the use of a pre-existing condition provision, to
13 elect to offer contracts without a pre-existing condition provision to
14 such groups but may require that coverage shall not become effective
15 until after a specified affiliation period of not more than sixty days
16 after the application for coverage is submitted. The organization is
17 not required to provide health care services or benefits during such
18 period and no premium shall be charged for any coverage during the peri-
19 od. After January first, nineteen hundred ninety-six, all individual
20 direct payment contracts shall be issued only pursuant to sections four
21 thousand three hundred twenty-one and four thousand three hundred twen-
22 ty-two of the insurance law. Such contracts may not, with respect to an
23 eligible individual (as defined in section 2741(b) of the federal Public
24 Health Service Act, 42 U.S.C. § 300gg-41(b), impose any pre-existing
25 condition exclusion.]

26 § 11-a. The insurance law is amended by adding a new section 211 to
27 read as follows:

28 § 211. Independent consumer assistance program. The superintendent, in
29 consultation with the commissioner of health, shall designate an inde-
30 pendent consumer assistance program that will have the following duties:

31 (a) The independent consumer assistance program shall:

32 (1) assist consumers with the filing of complaints and appeals,
33 including filing appeals with the internal appeal or grievance process
34 of the group health plans or health insurance issuers involved and
35 providing information about and assisting consumers with the external
36 appeals and administrative hearing process;

37 (2) collect, track, and quantify problems and inquiries encountered by
38 consumers;

39 (3) educate consumers on their rights and responsibilities with
40 respect to group health plans and health insurance coverage;

41 (4) assist consumers with enrollment in a group health plan or health
42 insurance coverage by providing information, referral, and assistance;

43 (5) resolve problems with obtaining premium tax credits under section
44 36B of the Internal Revenue Code of 1986;

45 (6) assist consumers with disputes eligible for resolution under arti-
46 cle six of the financial services law;

47 (7) assist uninsured, insured, or underinsured consumers in accessing
48 appropriate health care services, hospital financial assistance or the
49 resolution of their health care bills; and

50 (8) provide assistance to health consumers on any additional matters
51 related to accessing health insurance coverage and health care services.

52 (b) All New York state regulated health plans shall be required to
53 list the name, phone number, address and email of the state independent
54 consumer assistance programs on notices to consumers of adverse determi-
55 nations and explanation of benefits and in the subscriber agreement,



1 member handbook and any additional consumer facing materials as deter-
2 mined by the superintendent and the commissioner of health.

3 § 12. This act shall take effect immediately, provided that sections
4 one, three, four, six, eight and nine of this act shall apply to all
5 policies and contracts issued, renewed, modified, altered or amended on
6 or after January 1, 2020.

7

SUBPART B

8 Section 1. Subparagraph (A) of paragraph 5 of subsection (c) of
9 section 3216 of the insurance law, as amended by chapter 388 of the laws
10 of 2014, is amended to read as follows:

11 (A) Any family policy providing hospital or surgical expense insurance
12 (but not including such insurance against accidental injury only) shall
13 provide that, in the event such insurance on any person, other than the
14 policyholder, is terminated because the person is no longer within the
15 definition of the family as set forth in the policy but before such
16 person has attained the limiting age, if any, for coverage of adults
17 specified in the policy, such person shall be entitled to have issued to
18 that person by the insurer, without evidence of insurability, upon
19 application therefor and payment of the first premium, within sixty days
20 after such insurance shall have terminated, an individual conversion
21 policy that contains the essential health benefits package described in
22 paragraph [one] three of subsection [(b)] (e) of section [four thousand
23 three hundred twenty-eight of this chapter. The insurer shall offer one
24 policy at each level of coverage as defined in section 1302(d) of the
25 affordable care act, 42 U.S.C. § 18022(d).] three thousand two hundred
26 seventeen-i of this article. The insurer shall offer one policy at each
27 level of coverage as defined in subsection (b) of section three thousand
28 two hundred seventeen-i of this article. The individual may choose any
29 such policy offered by the insurer. Provided, however, the superinten-
30 dent may, after giving due consideration to the public interest, approve
31 a request made by an insurer for the insurer to satisfy the requirements
32 of this subparagraph through the offering of policies that comply with
33 this subparagraph by another insurer, corporation or health maintenance
34 organization within the insurer's holding company system, as defined in
35 article fifteen of this chapter. The conversion privilege afforded here-
36 in shall also be available upon the divorce or annulment of the marriage
37 of the policyholder to the former spouse of such policyholder.

38 § 2. Subparagraph (E) of paragraph 2 of subsection (g) of section 3216
39 of the insurance law, as added by chapter 388 of the laws of 2014, is
40 amended to read as follows:

41 (E) The superintendent may, after giving due consideration to the
42 public interest, approve a request made by an insurer for the insurer to
43 satisfy the requirements of subparagraph (C) of this paragraph through
44 the offering of policies at each level of coverage as defined in
45 subsection (b) of section [1302(d) of the affordable care act, 42 U.S.C.
46 § 18022(d)] three thousand two hundred seventeen-i of this article that
47 contains the essential health benefits package described in paragraph
48 [one] three of subsection [(b)] (e) of section [four thousand three
49 hundred twenty-eight of this chapter] three thousand two hundred seven-
50 teen-i of this article by another insurer, corporation or health mainte-
51 nance organization within the insurer's same holding company system, as
52 defined in article fifteen of this chapter.

53 § 3. Intentionally omitted.

54 § 4. Intentionally omitted.

1 § 5. Intentionally omitted.

2 § 6. Paragraph 21 of subsection (i) of section 3216 of the insurance
3 law, as amended by chapter 469 of the laws of 2018, is amended to read
4 as follows:

5 (21) Every policy [which] that provides coverage for prescription
6 drugs shall include coverage for the cost of enteral formulas for home
7 use, whether administered orally or via tube feeding, for which a physi-
8 cian or other licensed health care provider legally authorized to
9 prescribe under title eight of the education law has issued a written
10 order. Such written order shall state that the enteral formula is clear-
11 ly medically necessary and has been proven effective as a disease-spe-
12 cific treatment regimen. Specific diseases and disorders for which
13 enteral formulas have been proven effective shall include, but are not
14 limited to, inherited diseases of amino acid or organic acid metabolism;
15 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
16 motility such as chronic intestinal pseudo-obstruction; and multiple,
17 severe food allergies including, but not limited to immunoglobulin E and
18 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
19 food protein induced enterocolitis syndrome; eosinophilic disorders; and
20 impaired absorption of nutrients caused by disorders affecting the
21 absorptive surface, function, length, and motility of the gastrointesti-
22 nal tract. Enteral formulas [which] that are medically necessary and
23 taken under written order from a physician for the treatment of specific
24 diseases shall be distinguished from nutritional supplements taken elec-
25 tively. Coverage for certain inherited diseases of amino acid and organ-
26 ic acid metabolism as well as severe protein allergic conditions shall
27 include modified solid food products that are low protein [or which],
28 contain modified protein, or are amino acid based [which] that are
29 medically necessary[, and such coverage for such modified solid food
30 products for any calendar year or for any continuous period of twelve
31 months for any insured individual shall not exceed two thousand five
32 hundred dollars].

33 § 7. Paragraph 30 of subsection (i) of section 3216 of the insurance
34 law, as amended by chapter 377 of the laws of 2014, is amended to read
35 as follows:

36 (30) Every policy [which] that provides medical coverage that includes
37 coverage for physician services in a physician's office and every policy
38 [which] that provides major medical or similar comprehensive-type cover-
39 age shall include coverage for equipment and supplies used for the
40 treatment of ostomies, if prescribed by a physician or other licensed
41 health care provider legally authorized to prescribe under title eight
42 of the education law. Such coverage shall be subject to annual deduct-
43 ibles and coinsurance as deemed appropriate by the superintendent. The
44 coverage required by this paragraph shall be identical to, and shall not
45 enhance or increase the coverage required as part of essential health
46 benefits as [required pursuant to] defined in subsection (a) of section
47 [2707 (a) of the public health services act 42 U.S.C. 300 gg-6(a)] three
48 thousand two hundred seventeen-i of this article.

49 § 8. Subsection (1) of section 3216 of the insurance law, as added by
50 section 42 of part D of chapter 56 of the laws of 2013, is amended to
51 read as follows:

52 (1) [On and after October first, two thousand thirteen, an] An insurer
53 shall not offer individual hospital, medical or surgical expense insur-
54 ance policies unless the policies meet the requirements of subsection
55 (b) of section four thousand three hundred twenty-eight of this chapter.
56 Such policies that are offered within the health benefit exchange estab-

1 lished [pursuant to section 1311 of the affordable care act, 42 U.S.C. §
2 18031, or any regulations promulgated thereunder,] by this state also
3 shall meet any requirements established by the health benefit exchange.

4 § 9. Subsection (m) of section 3216 of the insurance law, as added by
5 section 53 of part D of chapter 56 of the laws of 2013, is amended to
6 read as follows:

7 (m) An insurer shall not be required to offer the policyholder any
8 benefits that must be made available pursuant to this section if the
9 benefits must be covered as essential health benefits. For any policy
10 issued within the health benefit exchange established [pursuant to
11 section 1311 of the affordable care act, 42 U.S.C. § 18031] by this
12 state, an insurer shall not be required to offer the policyholder any
13 benefits that must be made available pursuant to this section. For
14 purposes of this subsection, "essential health benefits" shall have the
15 meaning set forth in subsection (a) of section [1302(b) of the affor-
16 able care act, 42 U.S.C. § 18022(b)] three thousand two hundred seven-
17 teen-i of this article.

18 § 10. The insurance law is amended by adding a new section 3217-i to
19 read as follows:

20 § 3217-i. Essential health benefits package and limit on cost-sharing.

21 (a) For purposes of this article, "essential health benefits" shall mean
22 the following categories of benefits:

- 23 (1) ambulatory patient services;
24 (2) emergency services;
25 (3) hospitalization;
26 (4) maternity and newborn care;
27 (5) mental health and substance use disorder services, including
28 behavioral health treatment;
29 (6) prescription drugs;
30 (7) rehabilitative and habilitative services and devices;
31 (8) laboratory services;
32 (9) preventive and wellness services and chronic disease management;
33 and
34 (10) pediatric services, including oral and vision care.

35 (b) (1) Every individual and small group accident and health insurance
36 policy that provides hospital, surgical, or medical expense coverage and
37 is not a grandfathered health plan shall provide coverage that meets the
38 actuarial requirements of one of the following levels of coverage:

39 (A) Bronze Level. A plan in the bronze level shall provide a level of
40 coverage that is designed to provide benefits that are actuarially
41 equivalent to sixty percent of the full actuarial value of the benefits
42 provided under the plan;

43 (B) Silver Level. A plan in the silver level shall provide a level of
44 coverage that is designed to provide benefits that are actuarially
45 equivalent to seventy percent of the full actuarial value of the bene-
46 fits provided under the plan;

47 (C) Gold Level. A plan in the gold level shall provide a level of
48 coverage that is designed to provide benefits that are actuarially
49 equivalent to eighty percent of the full actuarial value of the benefits
50 provided under the plan; or

51 (D) Platinum Level. A plan in the platinum level shall provide a level
52 of coverage that is designed to provide benefits that are actuarially
53 equivalent to ninety percent of the full actuarial value of the benefits
54 provided under the plan.

1 (2) The superintendent may provide for a variation in the actuarial
2 values used in determining the level of coverage of a plan to account
3 for the differences in actuarial estimates.

4 (3) Every student accident and health insurance policy shall provide
5 coverage that meets at least sixty percent of the full actuarial value
6 of the benefits provided under the policy. The policy's schedule of
7 benefits shall include the level as described in paragraph one of this
8 subsection nearest to, but below the actual actuarial value.

9 (c) Every individual or group accident and health insurance policy
10 that provides hospital, surgical, or medical expense coverage and is not
11 a grandfathered health plan, and every student accident and health
12 insurance policy shall limit the insured's cost-sharing for in-network
13 services in a policy year to not more than the maximum out-of-pocket
14 amount determined by the superintendent for all policies subject to this
15 section. Such amount shall not exceed any annual out-of-pocket limit on
16 cost-sharing set by the United States secretary of health and human
17 services, if available.

18 (d) The superintendent may require the use of model language describ-
19 ing the coverage requirements for any accident and health insurance
20 policy form that is subject to the superintendent's approval pursuant to
21 section three thousand two hundred one of this article.

22 (e) For purposes of this section:

23 (1) "actuarial value" means the percentage of the total expected
24 payments by the insurer for benefits provided to a standard population,
25 without regard to the population to whom the insurer actually provides
26 benefits;

27 (2) "cost-sharing" means annual deductibles, coinsurance, copayments,
28 or similar charges, for covered services;

29 (3) "essential health benefits package" means coverage that:

30 (A) provides for essential health benefits;

31 (B) limits cost-sharing for such coverage in accordance with
32 subsection (c) of this section; and

33 (C) provides one of the levels of coverage described in subsection (b)
34 of this section;

35 (4) "grandfathered health plan" means coverage provided by an insurer
36 in which an individual was enrolled on March twenty-third, two thousand
37 ten for as long as the coverage maintains grandfathered status in
38 accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. §
39 18011(e);

40 (5) "small group" means a group of one hundred or fewer employees or
41 members exclusive of spouses and dependents; and

42 (6) "student accident and health insurance" shall have the meaning set
43 forth in subsection (a) of section three thousand two hundred forty of
44 this article.

45 § 11. Subsection (g) of section 3221 of the insurance law, as amended
46 by chapter 388 of the laws of 2014, is amended to read as follows:

47 (g) For conversion purposes, an insurer shall offer to the employee or
48 member a policy at each level of coverage as defined in subsection (b)
49 of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)]
50 three thousand two hundred seventeen-i of this article that contains the
51 essential health benefits package described in paragraph [one] three of
52 subsection [(b)] (e) of section [four thousand three hundred twenty-
53 eight of this chapter] three thousand two hundred seventeen-i of this
54 article. Provided, however, the superintendent may, after giving due
55 consideration to the public interest, approve a request made by an
56 insurer for the insurer to satisfy the requirements of this subsection

1 and subsections (e) and (f) of this section through the offering of
2 policies that comply with this subsection by another insurer, corpo-
3 ration or health maintenance organization within the insurer's holding
4 company system, as defined in article fifteen of this chapter.

5 § 12. Subsection (h) of section 3221 of the insurance law, as added by
6 section 54 of part D of chapter 56 of the laws of 2013, is amended to
7 read as follows:

8 (h) Every small group policy or association group policy delivered or
9 issued for delivery in this state that provides coverage for hospital,
10 medical or surgical expense insurance and is not a grandfathered health
11 plan shall provide coverage for the essential health [benefit] benefits
12 package [as required in section 2707(a) of the public health service
13 act, 42 U.S.C. § 300gg-6(a)]. For purposes of this subsection:

14 (1) "essential health benefits package" shall have the meaning set
15 forth in paragraph three of subsection (e) of section [1302(a) of the
16 affordable care act, 42 U.S.C. § 18022(a)] three thousand two hundred
17 seventeen-i of this article;

18 (2) "grandfathered health plan" means coverage provided by an insurer
19 in which an individual was enrolled on March twenty-third, two thousand
20 ten for as long as the coverage maintains grandfathered status in
21 accordance with section 1251(e) of the affordable care act, 42 U.S.C. §
22 18011(e);

23 (3) "small group" means a group of [fifty or fewer employees or
24 members exclusive of spouses and dependents; provided, however, that
25 beginning January first, two thousand sixteen, "small group" means a
26 group of] one hundred or fewer employees or members exclusive of spouses
27 and dependents; and

28 (4) "association group" means a group defined in subparagraphs (B),
29 (D), (H), (K), (L) or (M) of paragraph one of subsection (c) of section
30 four thousand two hundred thirty-five of this chapter, provided that:

31 (A) the group includes one or more individual members; or

32 (B) the group includes one or more member employers or other member
33 groups that are small groups.

34 § 13. Subsection (i) of section 3221 of the insurance law, as added by
35 section 54 of part D of chapter 56 of the laws of 2013, is amended to
36 read as follows:

37 (i) An insurer shall not be required to offer the policyholder any
38 benefits that must be made available pursuant to this section if the
39 benefits must be covered pursuant to subsection (h) of this section. For
40 any policy issued within the health benefit exchange established [pursu-
41 ant to section 1311 of the affordable care act, 42 U.S.C. § 18031] by
42 this state, an insurer shall not be required to offer the policyholder
43 any benefits that must be made available pursuant to this section.

44 § 14. Paragraph 11 of subsection (k) of section 3221 of the insurance
45 law, as amended by chapter 469 of the laws of 2018, is amended to read
46 as follows:

47 (11) Every policy [which] that provides coverage for prescription
48 drugs shall include coverage for the cost of enteral formulas for home
49 use, whether administered orally or via tube feeding, for which a physi-
50 cian or other licensed health care provider legally authorized to
51 prescribe under title eight of the education law has issued a written
52 order. Such written order shall state that the enteral formula is clear-
53 ly medically necessary and has been proven effective as a disease-spe-
54 cific treatment regimen. Specific diseases and disorders for which
55 enteral formulas have been proven effective shall include, but are not
56 limited to, inherited diseases of amino-acid or organic acid metabolism;

1 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
2 motility such as chronic intestinal pseudo-obstruction; and multiple,
3 severe food allergies including, but not limited to immunoglobulin E and
4 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
5 food protein induced enterocolitis syndrome; eosinophilic disorders and
6 impaired absorption of nutrients caused by disorders affecting the
7 absorptive surface, function, length, and motility of the gastrointesti-
8 nal tract. Enteral formulas [which] that are medically necessary and
9 taken under written order from a physician for the treatment of specific
10 diseases shall be distinguished from nutritional supplements taken elec-
11 tively. Coverage for certain inherited diseases of amino acid and organ-
12 ic acid metabolism as well as severe protein allergic conditions shall
13 include modified solid food products that are low protein [or which],
14 contain modified protein, or are amino acid based [which] that are
15 medically necessary[, and such coverage for such modified solid food
16 products for any calendar year or for any continuous period of twelve
17 months for any insured individual shall not exceed two thousand five
18 hundred dollars].

19 § 15. Intentionally omitted.

20 § 16. Paragraph 19 of subsection (k) of section 3221 of the insurance
21 law, as amended by chapter 377 of the laws of 2014, is amended to read
22 as follows:

23 (19) Every group or blanket accident and health insurance policy
24 delivered or issued for delivery in this state [which] that provides
25 medical coverage that includes coverage for physician services in a
26 physician's office and every policy [which] that provides major medical
27 or similar comprehensive-type coverage shall include coverage for equip-
28 ment and supplies used for the treatment of ostomies, if prescribed by a
29 physician or other licensed health care provider legally authorized to
30 prescribe under title eight of the education law. Such coverage shall be
31 subject to annual deductibles and coinsurance as deemed appropriate by
32 the superintendent. The coverage required by this paragraph shall be
33 identical to, and shall not enhance or increase the coverage required as
34 part of essential health benefits as [required pursuant to] defined in
35 subsection (a) of section [2707 (a) of the public health services act 42
36 U.S.C. 300 gg-6(a)] three thousand two hundred seventeen-i of this
37 article.

38 § 17. Intentionally omitted.

39 § 18. Intentionally omitted.

40 § 19. Intentionally omitted.

41 § 20. Intentionally omitted.

42 § 21. Subsection (d) of section 3240 of the insurance law, as added by
43 section 41 of part D of chapter 56 of the laws of 2013, is amended to
44 read as follows:

45 (d) A student accident and health insurance policy or contract shall
46 provide coverage for essential health benefits as defined in subsection
47 (a) of section [1302(b) of the affordable care act, 42 U.S.C. §
48 18022(b)] three thousand two hundred seventeen-i or subsection (a) of
49 section four thousand three hundred six-h of this chapter, as
50 applicable.

51 § 22. Intentionally omitted.

52 § 23. Intentionally omitted.

53 § 24. Intentionally omitted.

54 § 25. Intentionally omitted.

1 § 26. Subsection (u-1) of section 4303 of the insurance law, as
2 amended by chapter 377 of the laws of 2014, is amended to read as
3 follows:

4 (u-1) A medical expense indemnity corporation or a health service
5 corporation which provides medical coverage that includes coverage for
6 physician services in a physician's office and every policy which
7 provides major medical or similar comprehensive-type coverage shall
8 include coverage for equipment and supplies used for the treatment of
9 ostomies, if prescribed by a physician or other licensed health care
10 provider legally authorized to prescribe under title eight of the educa-
11 tion law. Such coverage shall be subject to annual deductibles and coin-
12 surance as deemed appropriate by the superintendent. The coverage
13 required by this subsection shall be identical to, and shall not enhance
14 or increase the coverage required as part of essential health benefits
15 as [required pursuant to] defined in subsection (a) of section [2707(a)
16 of the public health services act 42 U.S.C. 300 gg-6(a)] four thousand
17 three hundred six-h of this article.

18 § 27. Subsection (y) of section 4303 of the insurance law, as amended
19 by chapter 469 of the laws of 2018, is amended to read as follows:

20 (y) Every contract [which] that provides coverage for prescription
21 drugs shall include coverage for the cost of enteral formulas for home
22 use, whether administered orally or via tube feeding, for which a physi-
23 cian or other licensed health care provider legally authorized to
24 prescribe under title eight of the education law has issued a written
25 order. Such written order shall state that the enteral formula is clear-
26 ly medically necessary and has been proven effective as a disease-spe-
27 cific treatment regimen. Specific diseases and disorders for which
28 enteral formulas have been proven effective shall include, but are not
29 limited to, inherited diseases of amino-acid or organic acid metabolism;
30 Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal
31 motility such as chronic intestinal pseudo-obstruction; and multiple,
32 severe food allergies including, but not limited to immunoglobulin E and
33 nonimmunoglobulin E-mediated allergies to multiple food proteins; severe
34 food protein induced enterocolitis syndrome; eosinophilic disorders; and
35 impaired absorption of nutrients caused by disorders affecting the
36 absorptive surface, function, length, and motility of the gastrointesti-
37 nal tract. Enteral formulas [which] that are medically necessary and
38 taken under written order from a physician for the treatment of specific
39 diseases shall be distinguished from nutritional supplements taken elec-
40 tively. Coverage for certain inherited diseases of amino acid and organ-
41 ic acid metabolism as well as severe protein allergic conditions shall
42 include modified solid food products that are low protein, [or which]
43 contain modified protein, or are amino acid based [which] that are
44 medically necessary[, and such coverage for such modified solid food
45 products for any calendar year or for any continuous period of twelve
46 months for any insured individual shall not exceed two thousand five
47 hundred dollars].

48 § 28. Intentionally omitted.

49 § 29. Subsection (ll) of section 4303 of the insurance law, as added
50 by section 55 of part D of chapter 56 of the laws of 2013, is amended to
51 read as follows:

52 (ll) Every small group contract or association group contract deliv-
53 ered or issued for delivery in this state that provides coverage for
54 hospital, medical or surgical expense insurance and is not a grandfa-
55 thered health plan shall provide coverage for the essential health
56 [benefit] benefits package [as required in section 2707(a) of the public

1 health service act, 42 U.S.C. § 300gg-6(a)]. For purposes of this
2 subsection:

3 (1) "essential health benefits package" shall have the meaning set
4 forth in paragraph three of subsection (e) of section [1302(a) of the
5 affordable care act, 42 U.S.C. § 18022(a)] four thousand three hundred
6 six-h of this article;

7 (2) "grandfathered health plan" means coverage provided by a corpo-
8 ration in which an individual was enrolled on March twenty-third, two
9 thousand ten for as long as the coverage maintains grandfathered status
10 in accordance with section 1251(e) of the affordable care act, 42 U.S.C.
11 § 18011(e); and

12 (3) "small group" means a group of fifty or fewer employees or members
13 exclusive of spouses and dependents. Beginning January first, two thou-
14 sand sixteen, "small group" means a group of one hundred or fewer
15 employees or members exclusive of spouses and dependents; and

16 (4) "association group" means a group defined in subparagraphs (B),
17 (D), (H), (K), (L) or (M) of paragraph one of subsection (c) of section
18 four thousand two hundred thirty-five of this chapter, provided that:

19 (A) the group includes one or more individual members; or

20 (B) the group includes one or more member employers or other member
21 groups that are small groups.

22 § 30. Subsection (mm) of section 4303 of the insurance law, as added
23 by section 55 of part D of chapter 56 of the laws of 2013, is amended to
24 read as follows:

25 (mm) A corporation shall not be required to offer the contract holder
26 any benefits that must be made available pursuant to this section if
27 such benefits must be covered pursuant to subsection (kk) of this
28 section. For any contract issued within the health benefit exchange
29 established [pursuant to section 1311 of the affordable care act, 42
30 U.S.C. § 18031] by this state, a corporation shall not be required to
31 offer the contract holder any benefits that must be made available
32 pursuant to this section.

33 § 31. Item (i) of subparagraph (C) of paragraph 2 of subsection (c) of
34 section 4304 of the insurance law, as amended by chapter 317 of the laws
35 of 2017, is amended to read as follows:

36 (i) Discontinuance of a class of contract upon not less than ninety
37 days' prior written notice. In exercising the option to discontinue
38 coverage pursuant to this item, the corporation must act uniformly with-
39 out regard to any health status-related factor of enrolled individuals
40 or individuals who may become eligible for such coverage and must offer
41 to subscribers or group remitting agents, as may be appropriate, the
42 option to purchase all other individual health insurance coverage
43 currently being offered by the corporation to applicants in that market.
44 Provided, however, the superintendent may, after giving due consider-
45 ation to the public interest, approve a request made by a corporation
46 for the corporation to satisfy the requirements of this item through the
47 offering of contracts at each level of coverage as defined in subsection
48 (b) of section [1302(d) of the affordable care act, 42 U.S.C. §
49 18022(d)] four thousand three hundred six-h of this article that
50 contains the essential health benefits package described in paragraph
51 [one] three of subsection [(b)] (e) of section four thousand three
52 hundred [twenty-eight] six-h of this [chapter] article by another corpo-
53 ration, insurer or health maintenance organization within the corpo-
54 ration's same holding company system, as defined in article fifteen of
55 this chapter.

1 § 32. Paragraph 1 of subsection (e) of section 4304 of the insurance
2 law, as amended by chapter 388 of the laws of 2014, is amended to read
3 as follows:

4 (1) (A) If any such contract is terminated in accordance with the
5 provisions of paragraph one of subsection (c) of this section, or any
6 such contract is terminated because of a default by the remitting agent
7 in the payment of premiums not cured within the grace period and the
8 remitting agent has not replaced the contract with similar and contin-
9 uous coverage for the same group whether insured or self-insured, or any
10 such contract is terminated in accordance with the provisions of subpar-
11 agraph (E) of paragraph two of subsection (c) of this section, or if an
12 individual other than the contract holder is no longer covered under a
13 "family contract" because the individual is no longer within the defi-
14 nition set forth in the contract, or a spouse is no longer covered under
15 the contract because of divorce from the contract holder or annulment of
16 the marriage, or any such contract is terminated because of the death of
17 the contract holder, then such individual, former spouse, or in the case
18 of the death of the contract holder the surviving spouse or other depen-
19 dents of the deceased contract holder covered under the contract, as the
20 case may be, shall be entitled to convert, without evidence of insura-
21 bility, upon application therefor and the making of the first payment
22 thereunder within sixty days after the date of termination of such
23 contract, to a contract that contains the essential health benefits
24 package described in paragraph [one] three of subsection [(b)] (e) of
25 section four thousand three hundred [twenty-eight] six-h of this [chap-
26 ter] article.

27 (B) The corporation shall offer one contract at each level of coverage
28 as defined in subsection (b) of section [1302(d) of the affordable care
29 act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this
30 article. The individual may choose any such contract offered by the
31 corporation. Provided, however, the superintendent may, after giving due
32 consideration to the public interest, approve a request made by a corpo-
33 ration for the corporation to satisfy the requirements of this paragraph
34 through the offering of contracts that comply with this paragraph by
35 another corporation, insurer or health maintenance organization within
36 the corporation's same holding company system, as defined in article
37 fifteen of this chapter.

38 (C) The effective date of the coverage provided by the converted
39 direct payment contract shall be the date of the termination of coverage
40 under the contract from which conversion was made.

41 § 33. Subsection (1) of section 4304 of the insurance law, as added by
42 section 43 of part D of chapter 56 of the laws of 2013, is amended to
43 read as follows:

44 (1) [On and after October first, two thousand thirteen, a] A corpo-
45 ration shall not offer individual hospital, medical, or surgical expense
46 insurance contracts unless the contracts meet the requirements of
47 subsection (b) of section four thousand three hundred twenty-eight of
48 this article. Such contracts that are offered within the health benefit
49 exchange established [pursuant to section 1311 of the affordable care
50 act, 42 U.S.C. § 18031, or any regulations promulgated thereunder,] by
51 this state also shall meet any requirements established by the health
52 benefit exchange. To the extent that a holder of a special purpose
53 certificate of authority issued pursuant to section four thousand four
54 hundred three-a of the public health law offers individual hospital,
55 medical, or surgical expense insurance contracts, the contracts shall

1 meet the requirements of subsection (b) of section four thousand three
2 hundred twenty-eight of this article.

3 § 34. Subparagraph (A) of paragraph 1 of subsection (d) of section
4 4305 of the insurance law, as amended by chapter 388 of the laws of
5 2014, is amended to read as follows:

6 (A) A group contract issued pursuant to this section shall contain a
7 provision to the effect that in case of a termination of coverage under
8 such contract of any member of the group because of (i) termination for
9 any reason whatsoever of the member's employment or membership, or (ii)
10 termination for any reason whatsoever of the group contract itself
11 unless the group contract holder has replaced the group contract with
12 similar and continuous coverage for the same group whether insured or
13 self-insured, the member shall be entitled to have issued to the member
14 by the corporation, without evidence of insurability, upon application
15 therefor and payment of the first premium made to the corporation within
16 sixty days after termination of the coverage, an individual direct
17 payment contract, covering such member and the member's eligible depen-
18 dents who were covered by the group contract, which provides coverage
19 that contains the essential health benefits package described in para-
20 graph [one] three of subsection [(b)] (e) of section four thousand three
21 hundred [twenty-eight] six-h of this [chapter] article. The corporation
22 shall offer one contract at each level of coverage as defined in
23 subsection (b) of section [1302(d) of the affordable care act, 42 U.S.C.
24 § 18022(d)] four thousand three hundred six-h of this article. The
25 member may choose any such contract offered by the corporation.
26 Provided, however, the superintendent may, after giving due consider-
27 ation to the public interest, approve a request made by a corporation
28 for the corporation to satisfy the requirements of this subparagraph
29 through the offering of contracts that comply with this subparagraph by
30 another corporation, insurer or health maintenance organization within
31 the corporation's same holding company system, as defined in article
32 fifteen of this chapter.

33 § 35. The insurance law is amended by adding a new section 4306-h to
34 read as follows:

35 § 4306-h. Essential health benefits package and limit on cost-sharing.

36 (a) For purposes of this article, "essential health benefits" shall mean
37 the following categories of benefits:

38 (1) ambulatory patient services;

39 (2) emergency services;

40 (3) hospitalization;

41 (4) maternity and newborn care;

42 (5) mental health and substance use disorder services, including
43 behavioral health treatment;

44 (6) prescription drugs;

45 (7) rehabilitative and habilitative services and devices;

46 (8) laboratory services;

47 (9) preventive and wellness services and chronic disease management;

48 and

49 (10) pediatric services, including oral and vision care.

50 (b) (1) Every individual and small group contract that provides hospi-
51 tal, surgical, or medical expense coverage and is not a grandfathered
52 health plan shall provide coverage that meets the actuarial requirements
53 of one of the following levels of coverage:

54 (A) Bronze Level. A plan in the bronze level shall provide a level of
55 coverage that is designed to provide benefits that are actuarially

1 equivalent to sixty percent of the full actuarial value of the benefits
2 provided under the plan;

3 (B) Silver Level. A plan in the silver level shall provide a level of
4 coverage that is designed to provide benefits that are actuarially
5 equivalent to seventy percent of the full actuarial value of the bene-
6 fits provided under the plan;

7 (C) Gold Level. A plan in the gold level shall provide a level of
8 coverage that is designed to provide benefits that are actuarially
9 equivalent to eighty percent of the full actuarial value of the benefits
10 provided under the plan; or

11 (D) Platinum Level. A plan in the platinum level shall provide a level
12 of coverage that is designed to provide benefits that are actuarially
13 equivalent to ninety percent of the full actuarial value of the benefits
14 provided under the plan.

15 (2) The superintendent may provide for a variation in the actuarial
16 values used in determining the level of coverage of a plan to account
17 for the differences in actuarial estimates.

18 (3) Every student accident and health insurance contract shall provide
19 coverage that meets at least sixty percent of the full actuarial value
20 of the benefits provided under the contract. The contract's schedule of
21 benefits shall include the level as described in paragraph one of this
22 subsection nearest to, but below the actual actuarial value.

23 (c) Every individual or group contract that provides hospital, surgi-
24 cal, or medical expense coverage and is not a grandfathered health plan,
25 and every student accident and health insurance contract shall limit the
26 insured's cost-sharing for in-network services in a contract year to not
27 more than the maximum out-of-pocket amount determined by the superinten-
28 dent for all contracts subject to this section. Such amount shall not
29 exceed any annual out-of-pocket limit on cost-sharing set by the United
30 States secretary of health and human services, if available.

31 (d) The superintendent may require the use of model language describ-
32 ing the coverage requirements for any form that is subject to the
33 approval of the superintendent pursuant to section four thousand three
34 hundred eight of this article.

35 (e) For purposes of this section:

36 (1) "actuarial value" means the percentage of the total expected
37 payments by the corporation for benefits provided to a standard popu-
38 lation, without regard to the population to whom the corporation actual-
39 ly provides benefits;

40 (2) "cost-sharing" means annual deductibles, coinsurance, copayments,
41 or similar charges, for covered services;

42 (3) "essential health benefits package" means coverage that:

43 (A) provides for essential health benefits;

44 (B) limits cost-sharing for such coverage in accordance with
45 subsection (c) of this section; and

46 (C) provides one of the levels of coverage described in subsection (b)
47 of this section;

48 (4) "grandfathered health plan" means coverage provided by a corpo-
49 ration in which an individual was enrolled on March twenty-third, two
50 thousand ten for as long as the coverage maintains grandfathered status
51 in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C.
52 § 18011(e);

53 (5) "small group" means a group of one hundred or fewer employees or
54 members exclusive of spouses and dependents; and

1 (6) "student accident and health insurance" shall have the meaning set
2 forth in subsection (a) of section three thousand two hundred forty of
3 this chapter.

4 § 36. Intentionally omitted.

5 § 37. Subsections (d), (e) and (j) of section 4326 of the insurance
6 law, as amended by section 56 of part D of chapter 56 of the laws of
7 2013, are amended to read as follows:

8 (d) A qualifying group health insurance contract shall provide cover-
9 age for the essential health [benefit] benefits package as [required in]
10 defined in paragraph three of subsection (e) of section [2707(a) of the
11 public health service act, 42 U.S.C. § 300gg-6(a). For purposes of this
12 subsection "essential health benefits package" shall have the meaning
13 set forth in section 1302(a) of the affordable care act, 42 U.S.C. §
14 18022(a)] four thousand three hundred six-h of this article.

15 (e) A qualifying group health insurance contract [issued to a qualify-
16 ing small employer prior to January first, two thousand fourteen that
17 does not include all essential health benefits required pursuant to
18 section 2707(a) of the public health service act, 42 U.S.C. §
19 300gg-6(a), shall be discontinued, including grandfathered health plans.
20 For the purposes of this paragraph, "grandfathered health plans" means
21 coverage provided by a corporation to individuals who were enrolled on
22 March twenty-third, two thousand ten for as long as the coverage main-
23 tains grandfathered status in accordance with section 1251(e) of the
24 affordable care act, 42 U.S.C. § 18011(e). A qualifying small employer
25 shall be transitioned to a plan that provides: (1)] shall provide a
26 level of coverage that is designed to provide benefits that are actuari-
27 ally equivalent to eighty percent of the full actuarial value of the
28 benefits provided under the plan[; and (2) coverage for the essential
29 health benefit package as required in section 2707(a) of the public
30 health service act, 42 U.S.C. § 300gg-6(a)]. The superintendent shall
31 standardize the benefit package and cost sharing requirements of quali-
32 fied group health insurance contracts consistent with coverage offered
33 through the health benefit exchange established [pursuant to section
34 1311 of the affordable care act, 42 U.S.C. § 18031] by this state.

35 (j) [Beginning January first, two thousand fourteen, pursuant to
36 section 2704 of the Public Health Service Act, 42 U.S.C. § 300gg-3, a] A
37 corporation shall not impose any pre-existing condition limitation in a
38 qualifying group health insurance contract.

39 § 38. Subsection (m-1) of section 4327 of the insurance law, as
40 amended by section 58 of part D of chapter 56 of the laws of 2013, is
41 amended to read as follows:

42 (m-1) In the event that the superintendent suspends the enrollment of
43 new individuals for qualifying group health insurance contracts, the
44 superintendent shall ensure that small employers seeking to enroll in a
45 qualified group health insurance contract pursuant to section forty-
46 three hundred twenty-six of this article are provided information on and
47 directed to coverage options available through the health benefit
48 exchange established [pursuant to section 1311 of the affordable care
49 act, 42 U.S.C. § 18031] by this state.

50 § 39. Paragraphs 1, 2 and 3 of subsection (b) of section 4328 of the
51 insurance law, as added by section 46 of part D of chapter 56 of the
52 laws of 2013, are amended to read as follows:

53 (1) The individual enrollee direct payment contract offered pursuant
54 to this section shall provide coverage for the essential health [bene-
55 fit] benefits package as [required in] defined in paragraph three of
56 subsection (e) of section [2707(a) of the public health service act, 42

1 U.S.C. § 300gg-6(a). For purposes of this paragraph, "essential health
2 benefits package" shall have the meaning set forth in section 1302(a) of
3 the affordable care act, 42 U.S.C. § 18022(a)] four thousand three
4 hundred six-h of this article.

5 (2) A health maintenance organization shall offer at least one indi-
6 vidual enrollee direct payment contract at each level of coverage as
7 defined in subsection (b) of section [1302(d) of the affordable care
8 act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this
9 article. A health maintenance organization also shall offer one child-
10 only plan, as required by section 1302(f) of the affordable care act, 42
11 U.S.C. § 18022(f), at each level of coverage [as required in section
12 2707(c) of the public health service act, 42 U.S.C. § 300gg-6(c)].

13 (3) Within the health benefit exchange established [pursuant to
14 section 1311 of the affordable care act, 42 U.S.C. § 18031] by this
15 state, a health maintenance organization may offer an individual enrol-
16 lee direct payment contract that is a catastrophic health plan as
17 defined in section 1302(e) of the affordable care act, 42 U.S.C. §
18 18022(e), or any regulations promulgated thereunder.

19 § 40. Subparagraph (A) of paragraph 4 of subsection (b) of section
20 4328 of the insurance law, as added by chapter 11 of the laws of 2016,
21 is amended to read as follows:

22 (A) The individual enrollee direct payment contract offered pursuant
23 to this section shall have the same enrollment periods, including
24 special enrollment periods, as required for an individual direct payment
25 contract offered within the health benefit exchange established [pursu-
26 ant to section 1311 of the affordable care act, 42 U.S.C. § 18031, or
27 any regulations promulgated thereunder] by this state.

28 § 41. Subsection (c) of section 4328 of the insurance law, as added by
29 section 46 of part D of chapter 56 of the laws of 2013, is amended to
30 read as follows:

31 (c) In addition to or in lieu of the individual enrollee direct
32 payment contracts required under this section, all health maintenance
33 organizations issued a certificate of authority under article forty-four
34 of the public health law or licensed under this article may offer indi-
35 vidual enrollee direct payment contracts within the health benefit
36 exchange established [pursuant to section 1311 of the affordable care
37 act, 42 U.S.C. § 18031, or any regulations promulgated thereunder] by
38 this state, subject to any requirements established by the health bene-
39 fit exchange. If a health maintenance organization satisfies the
40 requirements of subsection (a) of this section by offering individual
41 enrollee direct payment contracts, only within the health benefit
42 exchange, the health maintenance organization, not including a holder of
43 a special purpose certificate of authority issued pursuant to section
44 four thousand four hundred three-a of the public health law, shall also
45 offer at least one individual enrollee direct payment contract at each
46 level of coverage as defined in subsection (b) of section [1302 (d) of
47 the affordable care act, 42 U.S.C. § 18022 (d)] four thousand three
48 hundred six-h of this article, outside the health benefit exchange.

49 § 42. This act shall take effect on the first of January next succeed-
50 ing the date on which it shall have become a law and shall apply to all
51 policies and contracts issued, renewed, modified, altered or amended on
52 or after such date.

53 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-
54 sion, section or subpart of this act shall be adjudged by any court of
55 competent jurisdiction to be invalid, such judgment shall not affect,
56 impair, or invalidate the remainder thereof, but shall be confined in

1 its operation to the clause, sentence, paragraph, subdivision, section
2 or subpart thereof directly involved in the controversy in which such
3 judgment shall have been rendered. It is hereby declared to be the
4 intent of the legislature that this act would have been enacted even if
5 such invalid provisions had not been included herein.

6 § 3. Intentionally omitted.

7 § 4. Legislative intent. It is hereby declared to be the intent of the
8 legislature in enacting this act, that the laws of this state provide
9 consumer and market protections at least as robust as those under the
10 federal Patient Protection and Affordable Care Act, public law 111-148,
11 as that law existed and was interpreted on January 19, 2017.

12 § 5. This act shall take effect immediately provided, however, that
13 the applicable effective date of Subparts A and B of this act shall be
14 as specifically set forth in the last section of such Subparts.

15 PART K

16 Section 1. Intentionally omitted.

17 § 2. Intentionally omitted.

18 § 3. Intentionally omitted.

19 § 4. Section 5 of chapter 517 of the laws of 2016, amending the public
20 health law relating to payments from the New York state medical indem-
21 nity fund, as amended by chapter 4 of the laws of 2017, is amended to
22 read as follows:

23 § 5. This act shall take effect on the forty-fifth day after it shall
24 have become a law, provided that the amendments to subdivision 4 of
25 section 2999-j of the public health law made by section two of this act
26 shall take effect on June 30, 2017 and shall expire and be deemed
27 repealed December 31, [2019] 2020.

28 § 5. Intentionally omitted.

29 § 6. This act shall take effect immediately and shall be deemed to
30 have been in full force and effect on and after April 1, 2019.

31 PART L

32 Intentionally Omitted

33 PART M

34 Intentionally Omitted

35 PART N

36 Intentionally Omitted

37 PART O

38 Intentionally Omitted

39 PART P

40 Intentionally Omitted

41 PART Q

1 Section 1. Section 2825-f of the public health law is amended by
2 adding two new subdivisions 4-a and 4-b to read as follows:

3 4-a. Notwithstanding subdivision two of this section or any inconsis-
4 ent provision of law to the contrary, and upon approval of the director
5 of the budget, the commissioner may, subject to the availability of
6 lawful appropriation, award up to three hundred million dollars of the
7 funds made available pursuant to this section for unfunded project
8 applications submitted in response to the request for applications
9 number 17648 issued by the department on January eighth, two thousand
10 eighteen pursuant to section twenty-eight hundred twenty-five-e of this
11 article, provided however that the provisions of subdivisions three and
12 four of this section shall apply.

13 4-b. Authorized amounts to be awarded pursuant to applications submit-
14 ted in response to the request for application number 17648 shall be
15 awarded no later than May first, two thousand nineteen.

16 § 1-a. Subdivision 3 of section 2825-f of the public health law, as
17 amended by section 1 of part UUU of chapter 59 of the laws of 2018, is
18 amended to read as follows:

19 3. Notwithstanding section one hundred sixty-three of the state
20 finance law or any inconsistent provision of law to the contrary, up to
21 five hundred [twenty-five] fifty million dollars of the funds appropri-
22 ated for this program shall be awarded without a competitive bid or
23 request for proposal process for grants to health care providers (here-
24 after "applicants"). Provided, however, that a minimum of: (a) sixty
25 million dollars of total awarded funds shall be made to community-based
26 health care providers, which for purposes of this section shall be
27 defined as a diagnostic and treatment center licensed or granted an
28 operating certificate under this article; a mental health clinic
29 licensed or granted an operating certificate under article thirty-one of
30 the mental hygiene law; a substance use disorder treatment clinic
31 licensed or granted an operating certificate under article thirty-two of
32 the mental hygiene law; a primary care provider; a clinic licensed or
33 granted an operating certificate under article sixteen of the mental
34 hygiene law; a home care provider certified or licensed pursuant to
35 article thirty-six of this chapter; or hospices licensed or granted an
36 operating certificate pursuant to article forty of this chapter [and];
37 (b) forty-five million dollars of the total awarded funds shall be made
38 to residential health care facilities; and (c) an additional twenty-five
39 million dollars of total awarded funds shall be made to children's resi-
40 dential treatment facilities licensed pursuant to article thirty-one of
41 the mental hygiene law, a clinic licensed or granted an operating
42 certificate under article sixteen of the mental hygiene law, hospices
43 licensed or granted an operating certificate pursuant to article forty
44 of this chapter, and community-based health care providers, which for
45 purposes of this paragraph shall be defined as a diagnostic and treat-
46 ment center licensed or granted an operating certificate under this
47 article; a mental health clinic licensed or granted an operating certifi-
48 cate under article thirty-one of the mental hygiene law; a substance
49 use disorder treatment clinic licensed or granted an operating certifi-
50 cate under article thirty-two of the mental hygiene law; a primary care
51 provider; and a home care provider certified or licensed pursuant to
52 article thirty-six of this chapter, provided however, when such funds
53 are awarded, priority shall be given to the following applicants first:
54 children's residential treatment facilities licensed pursuant to article
55 thirty-one of the mental hygiene law; a clinic licensed or granted an
56 operating certificate under article sixteen of the mental hygiene law;



1 and hospices licensed or granted an operating certificate pursuant to
2 article forty of this chapter.

3 § 2. This act shall take effect immediately.

4 PART R

5 Intentionally Omitted

6 PART S

7 Intentionally Omitted

8 PART T

9 Section 1. This act shall be known and may be cited as the "NY State
10 of Health, The Official Health Plan Marketplace Act".

11 § 2. Article 2 of the public health law is amended by adding a new
12 title VII to read as follows:

13 TITLE VII

14 NY STATE OF HEALTH

15 Section 268. Statement of policy and purposes.

16 268-a. Definitions.

17 268-b. Establishment of NY State of Health, The Official Health
18 Plan Marketplace.

19 268-c. Functions of the Marketplace.

20 268-d. Special functions of the Marketplace related to health
21 plan certification and qualified health plan oversight.

22 268-e. Appeals and appeal hearings; judicial review.

23 268-f. Marketplace advisory committee.

24 268-g. Funding of the Marketplace.

25 268-h. Construction.

26 § 268. Statement of policy and purposes. The purpose of this title is
27 to codify the establishment of the health benefit exchange in New York,
28 known as NY State of Health, The Official Health Plan Marketplace
29 (Marketplace), in conformance with Executive Order 42 (Cuomo) issued
30 April 12, 2012. The Marketplace shall continue to perform eligibility
31 determinations for federal and state insurance affordability programs
32 including medical assistance in accordance with section three hundred
33 sixty-six of the social services law, child health plus in accordance
34 with section twenty-five hundred eleven of this chapter, the basic
35 health program in accordance with section three hundred sixty-nine-gg of
36 the social services law, and premium tax credits and cost-sharing
37 reductions, together with performing eligibility determinations for
38 qualified health plans and such other health insurance programs as
39 determined by the commissioner. The Marketplace shall also facilitate
40 enrollment in insurance affordability programs, qualified health plans
41 and other health insurance programs as determined by the commissioner,
42 the purchase and sale of qualified health plans and/or other or addi-
43 tional health plans certified by the Marketplace pursuant to this title,
44 and shall continue to have the authority to operate a small business
45 health options program ("SHOP") to assist eligible small employers in
46 selecting qualified health plans and/or other or additional health plans
47 certified by the Marketplace and to determine small employer eligibility
48 for purposes of small employer tax credits. It is the intent of the
49 legislature, by codifying the Marketplace in state statute, to continue
50 to promote quality and affordable health coverage and care, reduce the

1 number of uninsured persons, provide a transparent marketplace, educate
2 consumers and assist individuals with access to coverage, premium
3 assistance tax credits and cost-sharing reductions. In addition, the
4 legislature declares the intent that the Marketplace continue to be
5 properly integrated with insurance affordability programs, including
6 Medicaid, child health plus and the basic health program, and such other
7 health insurance programs as determined by the commissioner.

8 § 268-a. Definitions. For purposes of this title, the following defi-
9 nitions shall apply:

10 1. "Commissioner" means the commissioner of health of the state of New
11 York.

12 2. "Marketplace" means the "NY State of Health, The official health
13 plan Marketplace" or "Marketplace" established as a health benefit
14 exchange or "marketplace" within the department of health pursuant to
15 Executive Order 42 (Cuomo) issued April 12, 2012 and this title.

16 3. "Federal act" means the patient protection and affordable care act,
17 public law 111-148, as amended by the health care and education recon-
18 ciliation act of 2010, public law 111-152, and any regulations or guid-
19 ance issued thereunder.

20 4. "Health plan" means a policy, contract or certificate, offered or
21 issued by an insurer to provide, deliver, arrange for, pay for or reim-
22 burse any of the costs of health care services. Health plan shall not
23 include the following:

24 (a) accident insurance or disability income insurance, or any combina-
25 tion thereof;

26 (b) coverage issued as a supplement to liability insurance;

27 (c) liability insurance, including general liability insurance and
28 automobile liability insurance;

29 (d) workers' compensation or similar insurance;

30 (e) automobile no-fault insurance;

31 (f) credit insurance;

32 (g) other similar insurance coverage, as specified in federal regu-
33 lations, under which benefits for medical care are secondary or inci-
34 dental to other insurance benefits;

35 (h) limited scope dental or vision benefits, benefits for long-term
36 care insurance, nursing home insurance, home care insurance, or any
37 combination thereof, or such other similar, limited benefits health
38 insurance as specified in federal regulations, if the benefits are
39 provided under a separate policy, certificate or contract of insurance
40 or are otherwise not an integral part of the plan;

41 (i) coverage only for a specified disease or illness, hospital indem-
42 nity, or other fixed indemnity coverage;

43 (j) Medicare supplemental insurance as defined in section 1882(g)(1)
44 of the federal social security act, coverage supplemental to the cover-
45 age provided under chapter 55 of title 10 of the United States Code, or
46 similar supplemental coverage provided under a group health plan if it
47 is offered as a separate policy, certificate or contract of insurance;
48 or

49 (k) the New York state medical indemnity fund established pursuant to
50 title four of article twenty-nine-D of the public health law.

51 5. "Insurer" means an insurance company subject to article forty-two
52 or a corporation subject to article forty-three of the insurance law, or
53 a health maintenance organization certified pursuant to article forty-
54 four of the public health law that contracts or offers to contract to
55 provide, deliver, arrange, pay or reimburse any of the costs of health
56 care services.

1 6. "Stand-Alone dental plan" means a dental services plan that has
2 been issued pursuant to applicable law and certified by the Marketplace
3 in accordance with section two hundred sixty-eight-d of this title.

4 7. "Qualified health plan" means a health plan that is issued pursuant
5 to applicable law and certified by the Marketplace in accordance with
6 section two hundred sixty-eight-d of this title, including a stand-alone
7 dental plan.

8 8. "Insurance affordability program" means Medicaid, child health
9 plus, the basic health program and any other health insurance subsidy
10 program designated as such by the commissioner.

11 9. "Eligible individual" means an individual, including a minor, who
12 is eligible to enroll in an insurance affordability program or other
13 health insurance program as determined by the commissioner.

14 10. "Qualified individual" means, with respect to qualified health
15 plans, an individual, including a minor, who:

16 (a) is eligible to enroll in a qualified health plan offered to indi-
17 viduals through the Marketplace;

18 (b) resides in this state;

19 (c) at the time of enrollment, is not incarcerated, other than incar-
20 ceration pending the disposition of charges; and

21 (d) is, and is reasonably expected to be, for the entire period for
22 which enrollment is sought, a citizen or national of the United States
23 or an alien lawfully present in the United States.

24 11. "Secretary" means the secretary of the United States department of
25 health and human services.

26 12. "SHOP" means the small business health options program operated by
27 the Marketplace to assist eligible small employers in this state in
28 selecting qualified health plans and/or other or additional health plans
29 certified by the Marketplace and to determine small employer eligibility
30 for purposes of small employer tax credits in accordance with applicable
31 federal and state laws and regulations.

32 13. "Small employer" means an employer which offers coverage where the
33 coverage such employer offers would be considered small group coverage
34 under the insurance law and regulations promulgated thereunder, provided
35 that it is not otherwise prohibited under the federal act.

36 14. "Small group market" means the health insurance market under which
37 individuals receive health insurance coverage on behalf of themselves
38 and their dependents through a group health plan maintained by a small
39 employer.

40 15. "Superintendent" means the superintendent of financial services.

41 16. "Essential health benefits" shall mean the categories of benefits
42 defined in subsection (a) of section three thousand two hundred seven-
43 teen-i and subsection (a) of section four thousand three hundred six-h
44 of the insurance law.

45 § 268-b. Establishment of NY State of Health, The Official Health Plan
46 Marketplace. 1. There is hereby established an office within the depart-
47 ment of health to be known as the "NY State of Health, The official
48 health plan Marketplace".

49 2. The purpose of the Marketplace is to facilitate enrollment in
50 health coverage and the purchase and sale of qualified health plans and
51 other health plans certified by the Marketplace; enroll individuals in
52 coverage for which they are eligible in accordance with federal and
53 state law; enable eligible individuals to receive premium tax credits,
54 cost-sharing reductions, and to access insurance affordability programs
55 and other health insurance programs as determined by the commissioner;
56 assist eligible small employers in selecting qualified health plans

1 and/or other, or additional health plans certified by the Marketplace
2 and to qualify for small employer tax credits in accordance with appli-
3 cable law; and to carry out other functions set forth in this title.

4 § 268-c. Functions of the Marketplace. The Marketplace shall:

5 1. (a) Perform eligibility determinations for federal and state insur-
6 ance affordability programs including medical assistance in accordance
7 with section three hundred sixty-six of the social services law, child
8 health plus in accordance with section twenty-five hundred eleven of
9 this chapter, the basic health program in accordance with section three
10 hundred sixty-nine-gg of the social services law, premium tax credits
11 and cost-sharing reductions and qualified health plans in accordance
12 with applicable law and other health insurance programs as determined by
13 the commissioner;

14 (b) certify and make available to qualified individuals, qualified
15 health plans, including dental plans, certified by the Marketplace
16 pursuant to applicable law, provided that coverage under such plans
17 shall not become effective prior to certification by the Marketplace;
18 and

19 (c) certify and/or make available to eligible individuals, health
20 plans certified by the Marketplace pursuant to applicable law, and/or
21 participating in an insurance affordability program pursuant to applica-
22 ble law, provided that coverage under such plans shall not become effec-
23 tive prior to certification by the Marketplace, and/or approval by the
24 commissioner.

25 2. Assign an actuarial value to each Marketplace certified plan
26 offered through the Marketplace in accordance with the criteria devel-
27 oped by the secretary pursuant to federal law or the superintendent
28 pursuant to the insurance law and/or requirements developed by the
29 Marketplace, and determine each health plan's level of coverage in
30 accordance with regulations issued by the secretary pursuant to federal
31 law or the superintendent pursuant to the insurance law.

32 3. Utilize a standardized format for presenting health benefit options
33 in the Marketplace, including the use of the uniform outline of coverage
34 established under section 2715 of the federal public health service act
35 or the insurance law.

36 4. Standardize the benefits available through the Marketplace at each
37 level of coverage defined by the superintendent in the insurance law.

38 5. Maintain enrollment periods in the best interest of qualified indi-
39 viduals consistent with federal and state law.

40 6. Implement procedures for the certification, recertification and
41 decertification of health plans as qualified health plans or health
42 plans approved for sale by the department of financial services or
43 department of health and certified by the Marketplace, consistent with
44 guidelines developed by the secretary pursuant to section 1311(c) of the
45 federal act and requirements developed by the Marketplace.

46 7. Contract for health care coverage offered to qualified individuals
47 through the Marketplace, and in doing so shall seek to provide health
48 care coverage choices that offer the optimal combination of choice,
49 value, quality, and service.

50 8. Contract for health care coverage offered to certain eligible indi-
51 viduals through the Marketplace, pursuant to health insurance programs
52 as determined by the commissioner, and in doing so shall seek to provide
53 health care coverage choices that offer the optimal combination of
54 choice, value, quality, and service;

- 1 9. Provide the minimum requirements an insurer shall meet to partic-
2 ipate in the Marketplace, in the best interest of qualified individuals
3 or eligible individuals;
- 4 10. Require qualified health plans and/or other health plans certified
5 by the Marketplace to offer those benefits determined to be essential
6 health benefits pursuant to state law or as required by the Marketplace.
- 7 11. Ensure that insurers offering health plans through the Marketplace
8 do not charge an individual enrollee a fee or penalty for termination of
9 coverage.
- 10 12. Provide for the operation of a toll-free telephone hotline to
11 respond to requests for assistance.
- 12 13. Maintain an internet website through which enrollees and prospec-
13 tive enrollees of qualified health plans and health plans certified by
14 the Marketplace may obtain standardized comparative information on such
15 plans and insurance affordability programs.
- 16 14. Make available by electronic means a calculator to determine the
17 actual cost of coverage after the application of any premium tax credit
18 under section 36B of the Internal Revenue Code of 1986 or applicable
19 state law and any cost-sharing reduction under federal or applicable
20 state law.
- 21 15. Operate a program under which the Marketplace awards grants to
22 entities to serve as navigators in accordance with applicable federal
23 law and regulations adopted thereunder, and/or a program under which the
24 Marketplace awards grants to entities to provide community based enroll-
25 ment assistance in accordance with requirements developed by the Market-
26 place; and/or a program under which the Marketplace certifies New York
27 state licensed producers to provide assistance to eligible individuals
28 and/or small employers pursuant to federal or state law.
- 29 16. In accordance with applicable federal and state law, inform indi-
30 viduals of eligibility requirements for the Medicaid program under title
31 XIX of the social security act and the social services law, the chil-
32 dren's health insurance program (CHIP) under title XXI of the social
33 security act and this chapter, the basic health program under section
34 three hundred sixty-nine-gg of the social services law, or any applica-
35 ble state or local public health insurance program and if, through
36 screening of the application by the Marketplace, the Marketplace deter-
37 mines that such individuals are eligible for any such program, enroll
38 such individuals in such program.
- 39 17. Grant a certification that an individual is exempt from the
40 requirement to maintain minimum essential coverage pursuant to federal
41 or state law and from any penalties imposed by such requirements
42 because:
- 43 (a) there is no affordable health plan available covering the individ-
44 ual, as defined by applicable law; or
- 45 (b) the individual meets the requirements for any other such exemption
46 from the requirement to maintain minimum essential coverage or to pay
47 the penalty pursuant to applicable federal or state law.
- 48 18. Operate a small business health options program ("SHOP") pursuant
49 to section 1311 of the federal act and applicable state law, through
50 which eligible small employers may select marketplace-certified quali-
51 fied health plans offered in the small group market, and through which
52 eligible small employers may receive assistance in qualifying for small
53 business tax credits available pursuant to federal and state law.
- 54 19. Enter into agreements as necessary with federal and state agencies
55 and other state Marketplaces to carry out its responsibilities under
56 this title, provided such agreements include adequate protections with



1 respect to the confidentiality of any information to be shared and
2 comply with all state and federal laws and regulations.

3 20. Perform duties required by the secretary, the secretary of the
4 United States department of the treasury or the commissioner related to
5 determining eligibility for premium tax credits or reduced cost-sharing
6 under applicable federal or state law.

7 21. Meet program integrity requirements under applicable law, includ-
8 ing keeping an accurate accounting of receipts and expenditures and
9 providing reports to the secretary regarding Marketplace related activ-
10 ities in accordance with applicable law.

11 22. Submit information provided by Marketplace applicants for verifi-
12 cation as required by section 1411(c) of the federal act and applicable
13 state law.

14 23. Establish rules and regulations that do not conflict with or
15 prevent the application of regulations promulgated by the secretary.

16 24. Determine eligibility, provide notices, and provide opportunities
17 for appeal and redetermination in accordance with the requirements of
18 federal and state law.

19 § 268-d. Special functions of the Marketplace related to health plan
20 certification and qualified health plan oversight. 1. Health plans
21 certified by the Marketplace shall meet the following requirements:

22 (a) The insurer offering the health plan:

23 (i) is licensed or certified by the superintendent or commissioner, in
24 good standing to offer health insurance coverage in this state, and
25 meets the requirements established by the Marketplace;

26 (ii) offers at least one qualified health plan and/or other or addi-
27 tional health plans authorized for sale by the department of financial
28 services or the department in each of the silver and gold levels as
29 required by state law, provided, however, that the Marketplace may
30 require additional benefit levels to be offered by all insurers partic-
31 ipating in the Marketplace;

32 (iii) has filed with and received approval from the superintendent of
33 its premium rates and policy or contract forms pursuant to the insurance
34 law and/or this chapter;

35 (iv) does not charge any cancellation fees or penalties for termi-
36 nation of coverage in violation of applicable law; and

37 (v) complies with the regulations developed by the secretary under
38 section 1311(c) of the federal act and such other requirements as the
39 Marketplace may establish.

40 (b) The health plan: (i) provides the essential health benefits pack-
41 age described in state law or required by the Marketplace and includes
42 such additional benefits as are mandated by state law, except that the
43 health plan shall not be required to provide essential benefits that
44 duplicate the minimum benefits of qualified dental plans if:

45 (A) the Marketplace has determined that at least one qualified dental
46 plan or dental plan approved by the department of financial services or
47 the department is available to supplement the health plan's coverage;
48 and

49 (B) the insurer makes prominent disclosure at the time it offers the
50 health plan, in a form approved by the Marketplace, that the plan does
51 not provide the full range of essential pediatric benefits, and that
52 qualified dental plans or dental plans approved by the department of
53 financial services or department of health providing those benefits and
54 other dental benefits not covered by the plan are offered through the
55 Marketplace;



1 (ii) provides at least a bronze level of coverage as defined by state
2 law, unless the plan is certified as a qualified catastrophic plan, as
3 defined in section 1302(e) of the federal act and the insurance law, and
4 shall only be offered to individuals eligible for catastrophic coverage;

5 (iii) has cost-sharing requirements, including deductibles, which do
6 not exceed the limits established under section 1302(c) of the federal
7 act, state law and any requirements of the Marketplace;

8 (iv) complies with regulations promulgated by the secretary pursuant
9 to section 1311(c) of the federal act and applicable state law, which
10 include minimum standards in the areas of marketing practices, network
11 adequacy, essential community providers in underserved areas, accredi-
12 tation, quality improvement, uniform enrollment forms and descriptions
13 of coverage and information on quality measures for health benefit plan
14 performance;

15 (v) meets standards specified and determined by the Marketplace,
16 provided that the standards do not conflict with or prevent the applica-
17 tion of federal requirements; and

18 (vi) complies with the insurance law and this chapter requirements
19 applicable to health insurance issued in this state and any regulations
20 promulgated pursuant thereto that do not conflict with or prevent the
21 application of federal requirements; and

22 (c) The Marketplace determines that making the health plan available
23 through the Marketplace is in the interest of qualified individuals in
24 this state.

25 2. The Marketplace shall not exclude a health plan:

26 (a) on the basis that the health plan is a fee-for-service plan;

27 (b) through the imposition of premium price controls by the Market-
28 place; or

29 (c) on the basis that the health plan provides treatments necessary to
30 prevent patients' deaths in circumstances the Marketplace determines are
31 inappropriate or too costly.

32 3. The Marketplace shall require each insurer certified or seeking
33 certification of a health plan as a qualified health plan or plan
34 approved for sale by the department of financial services or the depart-
35 ment to:

36 (a) submit a justification for any premium increase pursuant to appli-
37 cable law prior to implementation of such increase. The insurer shall
38 prominently post the information on its internet website. Such rate
39 increases shall be subject to the prior approval of the superintendent
40 pursuant to the insurance law;

41 (b) (i) make available to the public and submit to the Marketplace, the
42 secretary and the superintendent, accurate and timely disclosure of:

43 (A) claims payment policies and practices;

44 (B) periodic financial disclosures;

45 (C) data on enrollment and disenrollment;

46 (D) data on the number of claims that are denied;

47 (E) data on rating practices;

48 (F) information on cost-sharing and payments with respect to any out-
49 of-network coverage;

50 (G) information on enrollee and participant rights under title I of
51 the federal act; and

52 (H) other information as determined appropriate by the secretary or
53 otherwise required by the Marketplace;

54 (ii) the information shall be provided in plain language, as that term
55 is defined in section 1311(e) (3) (B) of the federal act and state law,



1 and in guidance jointly issued thereunder by the secretary and the
2 federal secretary of labor; and

3 (c) provide to individuals, in a timely manner upon the request of the
4 individual, the amount of cost-sharing, including deductibles, copay-
5 ments, and coinsurance, under the individual's health plan or coverage
6 that the individual would be responsible for paying with respect to the
7 furnishing of a specific item or service by a participating provider. At
8 a minimum, this information shall be made available to the individual
9 through an internet website and through other means for individuals
10 without access to the internet.

11 4. The Marketplace shall not exempt any insurer seeking certification
12 of a health plan, regardless of the type or size of the insurer, from
13 licensing or solvency requirements under the insurance law or this chap-
14 ter, and shall apply the criteria of this section in a manner that
15 ensures a level playing field for insurers participating in the Market-
16 place.

17 5. (a) The provisions of this article that apply to qualified health
18 plans and plans approved for sale by the department of financial
19 services and the department also shall apply to the extent relevant to
20 qualified dental plans approved for sale by the department of financial
21 services or the department, except as modified in accordance with the
22 provisions of paragraphs (b) and (c) of this subdivision or otherwise
23 required by the Marketplace.

24 (b) The qualified dental plan or dental plan approved for sale by the
25 department of financial services and/or the department shall be limited
26 to dental and oral health benefits, without substantially duplicating
27 the benefits typically offered by health benefit plans without dental
28 coverage, and shall include, at a minimum, the essential pediatric
29 dental benefits prescribed by the secretary pursuant to section
30 1302(b)(1)(J) of the federal act, and such other dental benefits as the
31 Marketplace or secretary may specify in regulations.

32 (c) Insurers may jointly offer a comprehensive plan through the
33 Marketplace in which an insurer provides the dental benefits through a
34 qualified dental plan or plan approved by the department of financial
35 services or the department and an insurer provides the other benefits
36 through a qualified health plan, provided that the plans are priced
37 separately and also are made available for purchase separately at the
38 same price.

39 § 268-e. Appeals and appeal hearings; judicial review. 1. Any appli-
40 cant or enrollee, or any individual authorized to act on behalf of any
41 such applicant or enrollee, may appeal to the department from determi-
42 nations of department officials or failures to make determinations upon
43 grounds specified in subdivision four of this section. The department
44 must review the appeal de novo and give such person an opportunity for
45 an appeal hearing. The department may also, on its own motion, review
46 any decision made or any case in which a decision has not been made by
47 the Marketplace or a social services official within the time specified
48 by law or regulations of the department. The department may make such
49 additional investigation as it may deem necessary, and the commissioner
50 must make such determination as is justified and in accordance with
51 applicable law.

52 2. Regarding any appeal pursuant to this section, with or without an
53 appeal hearing, the commissioner may designate and authorize one or more
54 appropriate members of his staff to consider and decide such appeals.
55 Any staff member so designated and authorized will have authority to
56 decide such appeals on behalf of the commissioner with the same force

1 and effect as if the commissioner had made the decisions. Appeal hear-
2 ings must be held on behalf of the commissioner by members of his staff
3 who are employed for such purposes or who have been designated and
4 authorized by the commissioner.

5 3. Persons entitled to appeal to the department pursuant to this
6 section must include:

7 (a) applicants for or enrollees in insurance affordability programs
8 and qualified health plans; and

9 (b) other persons entitled to an opportunity for an appeal hearing as
10 directed by the commissioner.

11 4. An applicant or enrollee has the right to appeal at least the
12 following issues:

13 (a) An eligibility determination made in accordance with this article
14 and applicable law, including:

15 (i) An initial determination of eligibility, including:

16 (A) eligibility to enroll in a qualified health plan;

17 (B) eligibility for Medicaid;

18 (C) eligibility for Child Health Plus;

19 (D) eligibility for the Basic Health Program;

20 (E) the amount of advance payments of the premium tax credit and level
21 of cost-sharing reductions;

22 (F) the amount of any other subsidy that may be available under law;
23 and

24 (G) eligibility for such other health insurance programs as determined
25 by the commissioner; and

26 (ii) a re-determination of eligibility of the programs under this
27 subdivision.

28 (b) An eligibility determination for an exemption for any mandate to
29 purchase health insurance.

30 (c) A failure by NY State of Health to provide timely written notice
31 of an eligibility determination made in accordance with applicable law.

32 5. The department may, subject to the discretion of the commissioner,
33 promulgate such regulations, consistent with federal or state law, as
34 may be necessary to implement the provisions of this section.

35 6. Regarding every decision of an appeal pursuant to this section, the
36 department must inform every party, and his or her representative, if
37 any, of the availability of judicial review and the time limitation to
38 pursue future review.

39 7. Applicants and enrollees of qualified health plans, with or without
40 advance payments of the premium tax credit and cost-sharing reductions,
41 also have the right to appeal to the United States Department of Health
42 and Human Services appeal entity:

43 (a) appeals decisions issued by NY State of Health upon the exhaustion
44 of the NY State of Health appeals process; and

45 (b) a denial of a request to vacate a dismissal made by the NY State
46 of Health appeals entity.

47 8. The department must include notice of the right to appeal as
48 provided by subdivision four of this section and instructions regarding
49 how to file an appeal in any eligibility determination issued to the
50 applicant or enrollee in accordance with applicable law. Such notice
51 shall include:

52 (a) an explanation of the applicant or enrollee's appeal rights;

53 (b) a description of the procedures by which the applicant or enrollee
54 may request an appeal;

1 (c) information on the applicant or enrollee's right to represent
2 himself or herself, or to be represented by legal counsel or another
3 representative;

4 (d) an explanation of the circumstances under which the appellant's
5 eligibility may be maintained or reinstated pending an appeal decision;
6 and

7 (e) an explanation that an appeal decision for one household member
8 may result in a change in eligibility for other household members and
9 that such a change will be handled as a redetermination of eligibility
10 for all household members in accordance with the standards specified in
11 applicable law.

12 § 268-f. Marketplace advisory committee. 1. There is hereby created
13 the marketplace advisory committee, which shall consider and advise the
14 department and commissioner on matters concerning the provision of
15 health care coverage through the NY State of Health or Health Plan
16 Marketplace.

17 2. The marketplace advisory committee shall be composed of up to twen-
18 ty-eight members consisting of twenty-four members appointed by the
19 commissioner, two members appointed by the speaker of the assembly, and
20 two members appointed by the temporary president of the senate. The
21 advisory committee shall at all times be representative of each
22 geographic area of the state and include:

23 (a) representatives from the following categories, but not more than
24 six from any single category:

25 (i) health plan consumer advocates;

26 (ii) small business consumer representatives;

27 (iii) health care provider representatives;

28 (iv) representatives of the health insurance industry;

29 (b) representatives from the following categories, but not more than
30 two from either category:

31 (i) licensed insurance producers; and

32 (ii) representatives of labor organizations.

33 3. The executive director of the Marketplace shall select the chair of
34 the advisory committee from among the members of such committee and
35 shall designate an officer or employee of the department to assist the
36 marketplace advisory committee in the performance of its duties under
37 this section. The Marketplace shall adopt rules for the governance of
38 the advisory committee, which shall meet as frequently as its business
39 may require and at such other times as determined by the chair to be
40 necessary.

41 4. Members of the advisory committee shall serve without compensation
42 for their services as members, but each shall be allowed the necessary
43 and actual expenses incurred in the performance of his or her duties
44 under this section.

45 § 268-g. Funding of the Marketplace. 1. The Marketplace shall be fund-
46 ed by state and federal sources as authorized by applicable law, includ-
47 ing but not limited to applicable law authorizing the respective insur-
48 ance affordability programs available through the Marketplace.

49 2. The accounts of the Marketplace shall be subject to supervision of
50 the comptroller and such accounts shall include receipts, expenditures,
51 contracts and other matters which pertain to the fiscal soundness of the
52 Marketplace.

53 3. Notwithstanding any law to the contrary, and in accordance with
54 section four of the state finance law, upon request of the director of
55 the budget, in consultation with the commissioner, the superintendent
56 and the executive director of the Marketplace, the comptroller is hereby



1 authorized and directed to sub-allocate or transfer special revenue
2 federal funds appropriated to the department for planning and implement-
3 ing various healthcare and insurance reform initiatives authorized by
4 applicable law. Marketplace moneys sub-allocated or transferred pursu-
5 ant to this section shall be paid out of the fund upon audit and warrant
6 of the state comptroller on vouchers certified or approved by the
7 Marketplace.

8 § 268-h. Construction. Nothing in this article, and no action taken by
9 the Marketplace pursuant hereto, shall be construed to:

10 1. preempt or supersede the authority of the superintendent or the
11 commissioner; or

12 2. exempt insurers, insurance producers or qualified health plans from
13 this chapter or the insurance law and any regulations promulgated there-
14 under.

15 § 3. Severability. If any provision of this article, or the applica-
16 tion thereof to any person or circumstances is held invalid or unconsti-
17 tutional, that invalidity or unconstitutionality shall not affect other
18 provisions or applications of this article that can be given effect
19 without the invalid or unconstitutional provision or application, and to
20 this end the provisions and application of this article are severable.

21 § 4. This act shall take effect immediately.

22 PART U

23 Intentionally Omitted

24 PART V

25 Section 1. Paragraph (d) of subdivision 32 of section 364-j of the
26 social services law, as added by section 15 of part B of chapter 59 of
27 the laws of 2016, is amended to read as follows:

28 (d) (i) Penalties under this subdivision may be applied to any and all
29 circumstances described in paragraph (b) of this subdivision until the
30 managed care organization complies with the requirements for submission
31 of encounter data.

32 (ii) No penalties for late, incomplete or inaccurate encounter data
33 shall be assessed against managed care organizations in addition to
34 those provided for in this subdivision, provided, however, that nothing
35 in this paragraph shall prohibit the imposition of penalties, in cases
36 of fraud or abuse, otherwise authorized by law.

37 § 2. Section 364-j of the social services law is amended by adding a
38 new subdivision 34 read as follows:

39 34. Any payment made pursuant to the state's managed care program,
40 including payments made by managed long term care plans, shall be deemed
41 a payment by the state's medical assistance program, provided that this
42 subdivision shall not permit the imposition of a lien or recovery
43 against property of an individual or estate under section one hundred
44 one, one hundred four, one hundred four-b, three hundred sixty-six,
45 three hundred sixty-seven-a or three hundred sixty-nine of this chapter
46 on account of medical assistance payments where appropriate recovery is
47 made against the individual's managed care provider or provider of
48 medical assistance program items or services.

49 § 3. Section 364-j of the social services law is amended by adding a
50 new subdivision 36 to read as follows:

1 36. Medicaid Program Integrity Reviews. (a) For purposes of this
2 subdivision, managed care provider shall also include managed long term
3 care plans.

4 (b) The Medicaid inspector general shall conduct periodic reviews of
5 the contractual performance of each managed care provider as it relates
6 to the managed care provider's program integrity obligations under its
7 contract with the department. The Medicaid inspector general, in consul-
8 tation with the commissioner, shall publish on its website, a list of
9 those contractual obligations which may be subject to review and how
10 they shall be evaluated, including benchmarks, prior to commencing any
11 review. A Medicaid program integrity review of a managed care provider
12 may be completed no more than annually and may include a review of
13 internal controls, compliance with contractual standards which prevent
14 fraud, waste, or abuse, updates on changes in managed care enrollee
15 status, and a review of timely and accurate payment or suspension of
16 payment. However, if the Medicaid inspector general determines that a
17 subsequent review is necessary, a second review may occur within one
18 year.

19 (c) If, as a result of his or her review, the Medicaid inspector
20 general determines that a managed care provider is not meeting its
21 program integrity obligations, the Medicaid inspector general may
22 recover from the managed care provider up to two percent of the Medicaid
23 premiums paid to the managed care provider for the period under review.
24 Any premium recovery under this subdivision shall be a percentage of the
25 administrative component of the Medicaid premium calculated by the
26 department and may be recovered by the department in the same manner it
27 recovers overpayments.

28 (d) The managed care provider shall be entitled to receive a draft
29 audit report and final audit report containing the results of the Medi-
30 caid inspector general's review. If the Medicaid inspector general
31 determines to recover a percentage of the premium as described in para-
32 graph (c) of this subdivision, the managed care provider shall be enti-
33 tled to notice and an opportunity to be heard in accordance with section
34 twenty-two of this chapter.

35 § 4. Subdivision 3 of section 363-d of the social services law, as
36 amended by section 44 of part C of chapter 58 of the laws of 2007, is
37 amended to read as follows:

38 3. Upon enrollment in the medical assistance program, a provider shall
39 certify to the department that the provider satisfactorily meets the
40 requirements of this section. Additionally, the commissioner of health
41 and Medicaid inspector general shall have the authority to determine at
42 any time if a provider has a compliance program that satisfactorily
43 meets the requirements of this section.

44 (a) A compliance program that is accepted by the federal department of
45 health and human services office of inspector general and remains in
46 compliance with the standards promulgated by such office shall be deemed
47 in compliance with the provisions of this section, so long as such plans
48 adequately address medical assistance program risk areas and compliance
49 issues.

50 (b) A compliance program that meets Federal requirements for managed
51 care provider compliance programs, as specified in the contract or
52 contracts between the department and the Medicaid managed care provider
53 shall be deemed in compliance with the provisions in this section, so
54 long as such programs adequately address medical assistance program risk
55 areas and compliance issues. For purposes of this section, a managed
56 care provider is as defined in paragraph (c) of subdivision one of

1 section three hundred sixty-four-j of this chapter, and includes managed
2 long term care plans.

3 (c) In the event that the commissioner of health or the Medicaid
4 inspector general finds that the provider does not have a satisfactory
5 program within ninety days after the effective date of the regulations
6 issued pursuant to subdivision four of this section, the provider may be
7 subject to any sanctions or penalties permitted by federal or state laws
8 and regulations, including revocation of the provider's agreement to
9 participate in the medical assistance program.

10 § 5. Intentionally omitted.

11 § 6. Section 364-j of the social services law is amended by adding a
12 new subdivision 35 to read as follows:

13 35. Recovery of overpayments from network providers. (a) Where the
14 Medicaid inspector general during the course of an audit, investigation,
15 or review, or the deputy attorney general for the Medicaid fraud control
16 unit during the course of an investigation or prosecution for Medicaid
17 fraud, identifies improper medical assistance payments made by a managed
18 care provider or managed long term care plan to its subcontractor or
19 subcontractors or provider or providers, the state shall have the right
20 to recover the improper payment from the subcontractor or subcontrac-
21 tors, provider or providers, or the managed care provider or managed
22 long term care plan, provided, however, that the state shall not dupli-
23 cate the recovery of an improper medical assistance payment from a
24 subcontractor or provider that has been recovered from it by the managed
25 care provider or managed long term care plan.

26 (b) Where the state is unsuccessful in recovering an overpayment from
27 the subcontractor or subcontractors or provider or providers, the Medi-
28 icaid inspector general may require the managed care provider or managed
29 long term care plan to recover the improper medical assistance payment
30 identified in paragraph (a) of this subdivision on behalf of the state.
31 The managed care provider or managed long term care plan shall remit to
32 the state the full amount of the identified improper payment no later
33 than six months after receiving notice of the improper payment from the
34 state.

35 § 7. This act shall take effect immediately and shall be deemed to
36 have been in full force and effect on and after April 1, 2019; provided,
37 however, that the amendments to section 364-j of the social services law
38 made by sections one, two, three, and six of this act shall not affect
39 the repeal of such section and shall be deemed repealed therewith;
40 provided further, that section three of this act shall apply to a
41 contract or contracts in effect as of January 1, 2015 and any review
42 period in section three of this act shall not begin before January 1,
43 2018.

44

PART W

45 Section 1. Section 1 of part D of chapter 111 of the laws of 2010
46 relating to the recovery of exempt income by the office of mental health
47 for community residences and family-based treatment programs, as amended
48 by section 1 of part H of chapter 59 of the laws of 2016, is amended to
49 read as follows:

50 Section 1. The office of mental health is authorized to recover fund-
51 ing from community residences and family-based treatment providers
52 licensed by the office of mental health, consistent with contractual
53 obligations of such providers, and notwithstanding any other inconsis-
54 tent provision of law to the contrary, in an amount equal to 50 percent

1 of the income received by such providers which exceeds the fixed amount
2 of annual Medicaid revenue limitations, as established by the commis-
3 sioner of mental health. Recovery of such excess income shall be for the
4 following fiscal periods: for programs in counties located outside of
5 the city of New York, the applicable fiscal periods shall be January 1,
6 2003 through December 31, 2009 and January 1, 2011 through December 31,
7 [2019] 2022; and for programs located within the city of New York, the
8 applicable fiscal periods shall be July 1, 2003 through June 30, 2010
9 and July 1, 2011 through June 30, [2019] 2022.

10 § 2. This act shall take effect immediately.

11 PART X

12 Intentionally Omitted

13 PART Y

14 Intentionally Omitted

15 PART Z

16 Section 1. Subdivision 1 of section 2801 of the public health law, as
17 amended by section 1 of subpart B of part S of chapter 57 of the laws of
18 2018, is amended to read as follows:

19 1. "Hospital" means a facility or institution engaged principally in
20 providing services by or under the supervision of a physician or, in the
21 case of a dental clinic or dental dispensary, of a dentist, or, in the
22 case of a midwifery birth center, of a midwife, for the prevention,
23 diagnosis or treatment of human disease, pain, injury, deformity or
24 physical condition, including, but not limited to, a general hospital,
25 public health center, diagnostic center, treatment center, dental clin-
26 ic, dental dispensary, rehabilitation center other than a facility used
27 solely for vocational rehabilitation, nursing home, tuberculosis hospi-
28 tal, chronic disease hospital, maternity hospital, midwifery birth
29 center, lying-in-asylum, out-patient department, out-patient lodge,
30 dispensary and a laboratory or central service facility serving one or
31 more such institutions, but the term hospital shall not include an
32 institution, sanitarium or other facility engaged principally in provid-
33 ing services for the prevention, diagnosis or treatment of mental disa-
34 bility and which is subject to the powers of visitation, examination,
35 inspection and investigation of the department of mental hygiene except
36 for those distinct parts of such a facility which provide hospital
37 service. The provisions of this article shall not apply to a facility or
38 institution engaged principally in providing services by or under the
39 supervision of the bona fide members and adherents of a recognized reli-
40 gious organization whose teachings include reliance on spiritual means
41 through prayer alone for healing in the practice of the religion of such
42 organization and where services are provided in accordance with those
43 teachings. No provision of this article or any other provision of law
44 shall be construed to: (a) limit the volume of mental health [or],
45 substance use disorder services or developmental disability services
46 that can be provided by a provider of primary care services licensed
47 under this article and authorized to provide integrated services in
48 accordance with regulations issued by the commissioner in consultation
49 with the commissioner of the office of mental health [and], the commis-
50 sioner of the office of alcoholism and substance abuse services and the

1 commissioner of the office for people with developmental disabilities,
2 including regulations issued pursuant to subdivision seven of section
3 three hundred sixty-five-1 of the social services law or part L of chap-
4 ter fifty-six of the laws of two thousand twelve; (b) require a provider
5 licensed pursuant to article thirty-one of the mental hygiene law or
6 certified pursuant to article sixteen or article thirty-two of the
7 mental hygiene law to obtain an operating certificate from the depart-
8 ment if such provider has been authorized to provide integrated services
9 in accordance with regulations issued by the commissioner in consulta-
10 tion with the commissioner of the office of mental health [and], the
11 commissioner of the office of alcoholism and substance abuse services
12 and the commissioner of the office for people with developmental disa-
13 bilities, including regulations issued pursuant to subdivision seven of
14 section three hundred sixty-five-1 of the social services law or part L
15 of chapter fifty-six of the laws of two thousand twelve.

16 § 2. Subdivision (f) of section 31.02 of the mental hygiene law, as
17 added by section 2 of subpart B of part S of chapter 57 of the laws of
18 2018, is amended to read as follows:

19 (f) No provision of this article or any other provision of law shall
20 be construed to require a provider licensed pursuant to article twenty-
21 eight of the public health law or certified pursuant to article sixteen
22 or article thirty-two of this chapter to obtain an operating certificate
23 from the office of mental health if such provider has been authorized to
24 provide integrated services in accordance with regulations issued by the
25 commissioner of the office of mental health in consultation with the
26 commissioner of the department of health [and], the commissioner of the
27 office of alcoholism and substance abuse services and the commissioner
28 of the office for people with developmental disabilities, including
29 regulations issued pursuant to subdivision seven of section three
30 hundred sixty-five-1 of the social services law or part L of chapter
31 fifty-six of the laws of two thousand twelve.

32 § 3. Subdivision (b) of section 32.05 of the mental hygiene law, as
33 amended by section 3 of subpart B of part S of chapter 57 of the laws of
34 2018, is amended to read as follow:

35 (b) (i) Methadone, or such other controlled substance designated by
36 the commissioner of health as appropriate for such use, may be adminis-
37 tered to an addict, as defined in section thirty-three hundred two of
38 the public health law, by individual physicians, groups of physicians
39 and public or private medical facilities certified pursuant to article
40 twenty-eight or thirty-three of the public health law as part of a chem-
41 ical dependence program which has been issued an operating certificate
42 by the commissioner pursuant to subdivision (b) of section 32.09 of this
43 article, provided, however, that such administration must be done in
44 accordance with all applicable federal and state laws and regulations.
45 Individual physicians or groups of physicians who have obtained authori-
46 zation from the federal government to administer buprenorphine to
47 addicts may do so without obtaining an operating certificate from the
48 commissioner. (ii) No provision of this article or any other provision
49 of law shall be construed to require a provider licensed pursuant to
50 article twenty-eight of the public health law or article thirty-one of
51 this chapter or a provider certified pursuant to article sixteen of this
52 chapter to obtain an operating certificate from the office of alcoholism
53 and substance abuse services if such provider has been authorized to
54 provide integrated services in accordance with regulations issued by the
55 commissioner of alcoholism and substance abuse services in consultation
56 with the commissioner of the department of health [and], the commission-

1 er of the office of mental health and the commissioner of the office for
2 people with developmental disabilities, including regulations issued
3 pursuant to subdivision seven of section three hundred sixty-five-1 of
4 the social services law or part L of chapter fifty-six of the laws of
5 two thousand twelve.

6 § 4. Section 16.03 of the mental hygiene law is amended by adding a
7 new subdivision (g) to read as follows:

8 (g) No provision of this article or any other provision of law shall
9 be construed to require a provider licensed pursuant to article twenty-
10 eight of the public health law or certified pursuant to article thirty-
11 one or thirty-two of this chapter to obtain an operating certificate
12 from the office for people with developmental disabilities if such
13 provider has been authorized to provide integrated services in accord-
14 ance with regulations issued by the commissioner of the office for
15 people with developmental disabilities, in consultation with the commis-
16 sioner of the department of health, the commissioner of the office of
17 mental health and the commissioner of the office of alcoholism and
18 substance abuse services, including regulations issued pursuant to
19 subdivision seven of section three hundred sixty-five-1 of the social
20 services law or part L of chapter fifty-six of the laws of two thousand
21 twelve.

22 § 5. This act shall take effect October 1, 2019; provided, however,
23 that the commissioner of the department of health, the commissioner of
24 the office of mental health, the commissioner of the office of alcohol-
25 ism and substance abuse services, and the commissioner of the office for
26 people with developmental disabilities are authorized to issue any rule
27 or regulation necessary for the implementation of this act on or before
28 its effective date.

29 PART AA

30 Intentionally Omitted

31 PART BB

32 Intentionally Omitted

33 PART CC

34 Intentionally Omitted

35 PART DD

36 Intentionally Omitted

37 PART EE

38 Section 1. The mental hygiene law is amended by adding a new section
39 33.29 to read as follows:

40 § 33.29 Independent intellectual and developmental disability ombudsman
41 program.

42 (a) There is hereby established the office of the independent intel-
43 lectual and developmental disability ombudsman program that will be
44 operated or selected by the office for people with developmental disa-
45 bilities for the purpose of assisting individuals with an intellectual
46 or developmental disability to ensure that they receive coverage from

1 managed care organizations that is appropriate in meeting their individ-
2 ual service needs.

3 (b) Such ombudsman will identify, investigate, refer and resolve
4 complaints that are made by, or on behalf of, consumers relative to
5 coverage under a managed care organization and access to initial and
6 continuing intellectual and developmental disability services and
7 supports; accept, investigate, refer and help to resolve complaints that
8 are made by service providers relative to coverage under managed care
9 organizations of and reimbursement for initial or continuing intellectu-
10 al and developmental disability services and supports; accept, investi-
11 gate, refer and help to resolve complaints that are made by or on behalf
12 of consumers or by providers relative to network adequacy for access to
13 intellectual and developmental disability services and supports; and
14 monitor quality of care including outcome measures for intellectual and
15 developmental disability specialized provider led managed care plans and
16 other managed care entities.

17 (c) Notwithstanding sections one hundred twelve and one hundred
18 sixty-three of the state finance law and section one hundred forty-two
19 of the economic development law, or any other inconsistent provision of
20 law, funds available for expenditure pursuant to this section for the
21 establishment of an ombudsman program for intellectual and developmental
22 disability, may be allocated and distributed by the commissioner of the
23 office for people with developmental disabilities, subject to the
24 approval of the director of the budget, without a competitive bid or
25 request for proposal process for the establishment of an ombudsman
26 program for intellectual and developmental disability. Provided, howev-
27 er, that such allocation or distribution must be based on objective
28 criteria and an allocation methodology that is approved by the director
29 of the budget.

30 § 2. This act shall take effect on the one hundred eightieth day after
31 it shall have become a law.

32

PART FF

33 Section 1. Subdivision (d) of section 13.17 of the mental hygiene law,
34 as added by section 1 of part Q of chapter 59 of the laws of 2016, para-
35 graph 1 as amended by section 1 of part II of chapter 57 of the laws of
36 2018, is amended to read as follows:

37 (d) In the event of a closure [or], transfer, or suspension of service
38 of a state-operated individualized residential alternative (IRA), the
39 commissioner shall:

40 1. provide appropriate and timely notification to the temporary presi-
41 dent of the senate, and the speaker of the assembly, and to appropriate
42 representatives of impacted labor organizations. Such notification to
43 the representatives of impacted labor organizations shall be made as
44 soon as practicable, but no less than ninety days prior to such closure
45 [or], transfer, or suspension of service except in the case of exigent
46 circumstances impacting the health, safety, or welfare of the residents
47 of the IRA as determined by the office. Provided, however, that nothing
48 herein shall limit the ability of the office to effectuate such closure
49 [or], transfer, or suspension of service; and

50 2. make reasonable efforts to confer with the affected workforce and
51 any other party he or she deems appropriate to inform such affected
52 workforce, the residents of the IRA, and their family members, where
53 appropriate, of the proposed closure [or], transfer, or suspension of
54 service plan.



1 § 2. This act shall take effect immediately; provided, however, that
2 the amendments to subdivision (d) of section 13.17 of the mental hygiene
3 law made by section one of this act shall not affect the repeal of such
4 subdivision and shall be deemed repealed therewith.

5

PART GG

6 Section 1. Section 19.09 of the mental hygiene law is amended by
7 adding a new subdivision (k) to read as follows:

8 (k) (1) The office shall maintain on its website a publicly available
9 directory of all providers and programs operated, licensed, or certified
10 by the office and shall be searchable by the information required by
11 paragraph two of this subdivision.

12 (2) The directory shall include the following information:

13 (i) Location or locations of each provider or program;

14 (ii) Contact information for each provider or program;

15 (iii) Services offered by each provider or program at each location of
16 such provider or program if more than one, as well as which medications
17 are available at any medication-assisted treatment provider;

18 (iv) Special populations served;

19 (v) Insurance accepted;

20 (vi) Availability of beds and services; and

21 (vii) Any other information the commissioner deems necessary.

22 (3) The office may utilize an existing directory to satisfy the
23 requirements of this subdivision.

24 § 2. This act shall take effect on the one hundred eightieth day after
25 it shall have become a law, provided, however, that the office of alco-
26 holism and substance abuse services may promulgate rules and regulations
27 as shall be necessary to implement this act.

28

PART HH

29 Section 1. Section 4 of chapter 495 of the laws of 2004, amending the
30 insurance law and the public health law relating to the New York state
31 health insurance continuation assistance demonstration project, as
32 amended by section 1 of part QQ of chapter 58 of the laws of 2018, is
33 amended to read as follows:

34 § 4. This act shall take effect on the sixtieth day after it shall
35 have become a law; provided, however, that this act shall remain in
36 effect until July 1, [2019] 2020 when upon such date the provisions of
37 this act shall expire and be deemed repealed; provided, further, that a
38 displaced worker shall be eligible for continuation assistance retroac-
39 tive to July 1, 2004.

40 § 2. This act shall take effect immediately.

41

PART II

42 Section 1. The public health law is amended by adding a new section
43 2807-o to read as follows:

44 § 2807-o. Early intervention services pool. 1. Definitions. The
45 following words or phrases as used in this section shall have the
46 following meanings:

47 (a) "Early intervention services" shall mean services delivered to an
48 eligible child, pursuant to an individualized family service plan under
49 the early intervention program.



1 (b) "Early intervention program" shall mean the early intervention
2 program for toddlers with disabilities and their families as created by
3 title two-A of article twenty-five of this chapter.

4 (c) "Municipality" shall mean any county outside of the city of New
5 York or the city of New York.

6 2. Payments for early intervention services. (a) The commissioner
7 shall, from funds allocated for such purpose under paragraph (g) of
8 subdivision six of section twenty-eight hundred seven-s of this article,
9 make payments to municipalities and the state for the delivery of early
10 intervention services.

11 (b) Payments under this subdivision shall be made to municipalities
12 and the state by the commissioner. Each municipality and the state of
13 New York shall receive a share of such payments equal to its propor-
14 tionate share of the total approved statewide dollars not reimbursable
15 by the medical assistance program paid to providers of early inter-
16 vention services by the state and municipalities on account of early
17 intervention services in the last complete state fiscal year for which
18 such data is available.

19 § 2. Subdivision 6 of section 2807-s of the public health law is
20 amended by adding two new paragraphs (g) and (h) to read as follows:

21 (g) A further gross statewide amount for the state fiscal year two
22 thousand twenty and each state fiscal year thereafter shall be sixteen
23 million dollars.

24 (h) The amount specified in paragraph (g) of this subdivision shall be
25 allocated under section twenty-eight hundred seven-o of this article
26 among the municipalities and the state of New York based on each munici-
27 pality's share and the state's share of early intervention program
28 expenditures not reimbursable by the medical assistance program for the
29 latest twelve month period for which such data is available.

30 § 3. Subdivision 7 of section 2807-s of the public health law is
31 amended by adding a new paragraph (d) to read as follows:

32 (d) funds shall be added to the funds collected by the commissioner
33 for distribution in accordance with section twenty-eight hundred seven-o
34 of this article, in the following amount: sixteen million dollars for
35 the period beginning April first, two thousand twenty, and continuing
36 each state fiscal year thereafter.

37 § 4. Subdivision 1 of section 2557 of the public health law, as
38 amended by section 4 of part C of chapter 1 of the laws of 2002, is
39 amended to read as follows:

40 1. The approved costs for an eligible child who receives an evaluation
41 and early intervention services pursuant to this title shall be a charge
42 upon the municipality wherein the eligible child resides or, where the
43 services are covered by the medical assistance program, upon the social
44 services district of fiscal responsibility with respect to those eligi-
45 ble children who are also eligible for medical assistance. All approved
46 costs shall be paid in the first instance and at least quarterly by the
47 appropriate governing body or officer of the municipality upon vouchers
48 presented and audited in the same manner as the case of other claims
49 against the municipality. Notwithstanding the insurance law or regu-
50 lations thereunder relating to the permissible exclusion of payments for
51 services under governmental programs, no such exclusion shall apply with
52 respect to payments made pursuant to this title. Notwithstanding the
53 insurance law or any other law or agreement to the contrary, benefits
54 under this title shall be considered secondary to [any plan of insurance
55 or state government benefit] the medical assistance program under which
56 an eligible child may have coverage. [Nothing in this section shall

1 increase or enhance coverages provided for within an insurance contract
2 subject to the provisions of this title.]

3 § 5. Subdivision 2 of section 2557 of the public health law, as
4 amended by section 9-a of part A of chapter 56 of the laws of 2012, is
5 amended to read as follows:

6 2. The department shall reimburse the approved costs paid by a munici-
7 pality for the purposes of this title, other than those reimbursable by
8 the medical assistance program [or by third party payors], in an amount
9 of fifty percent of the amount expended in accordance with the rules and
10 regulations of the commissioner; provided, however, that in the
11 discretion of the department and with the approval of the director of
12 the division of the budget, the department may reimburse municipalities
13 in an amount greater than fifty percent of the amount expended. Such
14 state reimbursement to the municipality shall not be paid prior to April
15 first of the year in which the approved costs are paid by the munici-
16 pality, provided, however that, subject to the approval of the director
17 of the budget, the department may pay such state aid reimbursement to
18 the municipality prior to such date.

19 § 6. The section heading of section 2559 of the public health law, as
20 added by chapter 428 of the laws of 1992, is amended to read as follows:
21 [Third party insurance and medical] Medical assistance program
22 payments.

23 § 7. Subdivision 3 of section 2559 of the public health law, as added
24 by chapter 428 of the laws of 1992, paragraphs (a), (c) and (d) as
25 amended by section 11 of part A of chapter 56 of the laws of 2012 and
26 paragraph (b) as further amended by section 104 of part A of chapter 62
27 of the laws of 2011, is amended to read as follows:

28 3. (a) [Providers of evaluations and early intervention services,
29 hereinafter collectively referred to in this subdivision as "provider"
30 or "providers", shall in the first instance and where applicable, seek
31 payment from all third party payors including governmental agencies
32 prior to claiming payment from a given municipality for evaluations
33 conducted under the program and for services rendered to eligible chil-
34 dren, provided that, the obligation to seek payment shall not apply to a
35 payment from a third party payor who is not prohibited from applying
36 such payment, and will apply such payment, to an annual or lifetime
37 limit specified in the insured's policy.

38 (i) Parents shall provide the municipality and service coordinator
39 information on any insurance policy, plan or contract under which an
40 eligible child has coverage.

41 (ii) Parents shall provide the municipality and the service coordina-
42 tor with a written referral from a primary care provider as documenta-
43 tion, for eligible children, of the medical necessity of early inter-
44 vention services.

45 [(iii) providers] (b) Providers shall utilize the department's fiscal
46 agent and data system for claiming payment for evaluations and services
47 rendered under the early intervention program.

48 [(b) The commissioner, in consultation with the director of budget and
49 the superintendent of financial services, shall promulgate regulations
50 providing public reimbursement for deductibles and copayments which are
51 imposed under an insurance policy or health benefit plan to the extent
52 that such deductibles and copayments are applicable to early inter-
53 vention services.

54 (c) Payments made for early intervention services under an insurance
55 policy or health benefit plan, including payments made by the medical
56 assistance program or other governmental third party payor, which are

1 provided as part of an IFSP pursuant to section twenty-five hundred
2 forty-five of this title shall not be applied by the insurer or plan
3 administrator against any maximum lifetime or annual limits specified in
4 the policy or health benefits plan, pursuant to section eleven of the
5 chapter of the laws of nineteen hundred ninety-two which added this
6 title.

7 (d)] (c) A municipality, or its designee, and a provider shall be
8 subrogated, to the extent of the expenditures by such municipality or
9 for early intervention services furnished to persons eligible for bene-
10 fits under this title, to any rights such person may have or be entitled
11 to from [third party reimbursement] the medical assistance program. The
12 provider shall submit notice to the insurer or plan administrator of his
13 or her exercise of such right of subrogation upon the provider's assign-
14 ment as the early intervention service provider for the child. The right
15 of subrogation does not attach to benefits paid or provided [under any
16 health insurance policy or health benefits plan] prior to receipt of
17 written notice of the exercise of subrogation rights [by the insurer or
18 plan administrator providing such benefits]. Notwithstanding any incon-
19 sistent provision of this title, except as provided for herein, no third
20 party payor other than the medical assistance program shall be required
21 to reimburse for early intervention services provided under this title.

22 § 8. Subdivision 3 of section 2543 of the public health law is
23 REPEALED.

24 § 9. Section 3235-a of the insurance law is REPEALED.

25 § 10. Subparagraph (F) of paragraph 25 of subsection (i) of section
26 3216 of the insurance law is REPEALED.

27 § 11. Subparagraph (F) of paragraph 17 of subsection (1) of section
28 3221 of the insurance law is REPEALED.

29 § 12. Paragraph 6 of subsection (ee) of section 4303 of the insurance
30 law is REPEALED.

31 § 13. This act shall take effect immediately, and shall be deemed to
32 have been in full force and effect on and after April 1, 2019; provided,
33 however, that the amendments to section 2807-s of the public health law
34 made by sections two and three of this act shall not affect the expira-
35 tion of such section and shall be deemed to expire therewith. Effective
36 immediately, the addition, amendment and/or repeal of any rule or regu-
37 lation necessary for the implementation of this act on its effective
38 date are authorized to be made and completed by the commissioner of
39 health, on or before such effective date.

40

PART JJ

41 Section 1. Section 364-j of the social services law is amended by
42 adding a new subdivision 34 to read as follows:

43 34. Notwithstanding any other section of law to the contrary, the
44 office of mental health in consultation with the department of health,
45 shall provide a continuation of enhanced rates of payment set at twen-
46 ty-five percent above the rate approved for children's mental health
47 rehabilitation services added to the Medicaid state plan in January of
48 two thousand nineteen, including other licensed practitioner services,
49 community psychiatric support and treatment services, and psychosocial
50 rehabilitation services, assuming such children's mental health rehabil-
51 itation services are provided by individuals acting within their lawful
52 scope of practice as defined under the education law. Such extension
53 shall be provided from July first, two thousand nineteen until December
54 thirty-first, two thousand nineteen. To the extent such funds made



1 available to provide such enhanced rates of payment have not been fully
2 expended by December thirty-first, two thousand nineteen, such funds
3 shall be utilized to continue to provide for an enhanced rate of payment
4 set at an amount deemed appropriate by the commissioner of the office of
5 mental health in consultation with the commissioner.

6 § 2. This act shall take effect immediately; provided that the amend-
7 ments made to section 364-j of the social services law by section one of
8 this act shall not affect the repeal of such section and shall be deemed
9 repealed therewith.

10

PART KK

11 Section 1. Subdivision 7 of section 2510 of the public health law, as
12 amended by chapter 428 of the laws of 2013, is amended to read as
13 follows:

14 7. "Covered health care services" means: the services of physicians,
15 optometrists, nurses, nurse practitioners, midwives and other related
16 professional personnel which are provided on an outpatient basis,
17 including routine well-child visits; diagnosis and treatment of illness
18 and injury; inpatient health care services; laboratory tests; diagnostic
19 x-rays; prescription and non-prescription drugs and durable medical
20 equipment; radiation therapy; chemotherapy; hemodialysis; outpatient
21 blood clotting factor products and other treatments and services
22 furnished in connection with the care of hemophilia and other blood
23 clotting protein deficiencies; emergency room services; hospice
24 services; emergency, preventive and routine dental care, including
25 medically necessary orthodontia but excluding cosmetic surgery; emergen-
26 cy, preventive and routine vision care, including eyeglasses; speech and
27 hearing services; and, inpatient and outpatient mental health, chil-
28 dren's mental health rehabilitation services added to the medicaid state
29 plan in January of two thousand nineteen, including other licensed prac-
30 titioner services, community psychiatric support and treatment services,
31 and psychosocial rehabilitation services, assuming such children's
32 mental health rehabilitations services are provided by individuals
33 acting within their lawful scope of practice as established under the
34 education law; alcohol and substance abuse services as defined by the
35 commissioner in consultation with the superintendent. "Covered health
36 care services" shall not include drugs, procedures and supplies for the
37 treatment of erectile dysfunction when provided to, or prescribed for
38 use by, a person who is required to register as a sex offender pursuant
39 to article six-C of the correction law, provided that any denial of
40 coverage of such drugs, procedures or supplies shall provide the patient
41 with the means of obtaining additional information concerning both the
42 denial and the means of challenging such denial.

43 § 2. This act shall take effect January 1, 2020.

44

PART LL

45 Section 1. Section 605 of the financial services law, as added by
46 section 26 of part H of chapter 60 of the laws of 2014, is amended to
47 read as follows:

48 § 605. Dispute resolution for emergency services. (a) Emergency
49 services for an insured. (1) When a health care plan receives a bill for
50 emergency services from a non-participating physician or hospital,
51 including a bill for inpatient services which follow an emergency room
52 visit, the health care plan shall pay an amount that it determines is



1 reasonable for the emergency services rendered by the non-participating
2 physician or hospital, in accordance with section three thousand two
3 hundred twenty-four-a of the insurance law, except for the insured's
4 co-payment, coinsurance or deductible, if any, and shall ensure that the
5 insured shall incur no greater out-of-pocket costs for the emergency
6 services than the insured would have incurred with a participating
7 physician or hospital pursuant to subsection (c) of section three thou-
8 sand two hundred forty-one of the insurance law.

9 (2) A non-participating physician or hospital or a health care plan
10 may submit a dispute regarding a fee or payment for emergency services
11 for review to an independent dispute resolution entity. In cases where
12 a health care plan submits a dispute regarding a fee for payment of a
13 non-participating hospital's emergency services, the health care plan
14 shall, after the initial payment, pay any additional amounts it deter-
15 mines is reasonable directly to the non-participating hospital.

16 (3) The independent dispute resolution entity shall make a determi-
17 nation within thirty days of receipt of the dispute for review.

18 (4) In determining a reasonable fee for the services rendered, an
19 independent dispute resolution entity shall select either the health
20 care plan's payment or the non-participating physician's or hospital's
21 fee. The independent dispute resolution entity shall determine which
22 amount to select based upon the conditions and factors set forth in
23 section six hundred four of this article. If an independent dispute
24 resolution entity determines, based on the health care plan's payment
25 and the non-participating physician's or hospital's fee, that a settle-
26 ment between the health care plan and non-participating physician or
27 hospital is reasonably likely, or that both the health care plan's
28 payment and the non-participating physician's or hospital's fee repre-
29 sent unreasonable extremes, then the independent dispute resolution
30 entity may direct both parties to attempt a good faith negotiation for
31 settlement. The health care plan and non-participating physician or
32 hospital may be granted up to ten business days for this negotiation,
33 which shall run concurrently with the thirty day period for dispute
34 resolution.

35 (b) Emergency services for a patient that is not an insured. (1) A
36 patient that is not an insured or the patient's physician may submit a
37 dispute regarding a fee for emergency services for review to an inde-
38 pendent dispute resolution entity upon approval of the superintendent.

39 (2) An independent dispute resolution entity shall determine a reason-
40 able fee for the services based upon the same conditions and factors set
41 forth in section six hundred four of this article.

42 (3) A patient that is not an insured shall not be required to pay the
43 physician's or hospital's fee in order to be eligible to submit the
44 dispute for review to an independent dispute resolution entity.

45 (c) The determination of an independent dispute resolution entity
46 shall be binding on the health care plan, physician or hospital and
47 patient, and shall be admissible in any court proceeding between the
48 health care plan, physician or hospital or patient, or in any adminis-
49 trative proceeding between this state and the physician or hospital.

50 (d) The provisions of this section shall not apply to hospitals who
51 had at least sixty percent of inpatient discharges annually which
52 consisted of Medicaid, uninsured, and dual eligible individuals as
53 determined by the department of health in its determination of safety
54 net hospitals.



1 § 2. Subsection (a) of section 608 of the financial services law, as
2 added by section 26 of part H of chapter 60 of the laws of 2014, is
3 amended to read as follows:

4 (a) For disputes involving an insured, when the independent dispute
5 resolution entity determines the health care plan's payment is reason-
6 able, payment for the dispute resolution process shall be the responsi-
7 bility of the non-participating physician or hospital. When the inde-
8 pendent dispute resolution entity determines the non-participating
9 physician's or hospital's fee is reasonable, payment for the dispute
10 resolution process shall be the responsibility of the health care plan.
11 When a good faith negotiation directed by the independent dispute resol-
12 ution entity pursuant to paragraph four of subsection (a) of section six
13 hundred five of this article, or paragraph six of subsection (a) of
14 section six hundred seven of this article results in a settlement
15 between the health care plan and non-participating physician or
16 hospital, the health care plan and the non-participating physician or
17 hospital shall evenly divide and share the prorated cost for dispute
18 resolution.

19 § 3. Section 604 of the financial services law, as added by section 26
20 of part H of chapter 60 of the laws of 2014, is amended to read as
21 follows:

22 § 604. Criteria for determining a reasonable fee. In determining the
23 appropriate amount to pay for a health care service, an independent
24 dispute resolution entity shall consider all relevant factors, includ-
25 ing:

26 (a) whether there is a gross disparity between the fee charged by the
27 [physician] health care provider for services rendered as compared to:

28 (1) fees paid to the involved [physician] health care provider for the
29 same services rendered by the [physician] health care provider to other
30 patients in health care plans in which the [physician] health care
31 provider is not participating, and

32 (2) in the case of a dispute involving a health care plan, fees paid
33 by the health care plan to reimburse similarly qualified [physicians]
34 health care providers for the same services in the same region who are
35 not participating with the health care plan;

36 (b) the level of training, education and experience of the [physician]
37 health care provider;

38 (c) the [physician's] health care provider's usual charge for compara-
39 ble services with regard to patients in health care plans in which the
40 [physician] health care provider is not participating;

41 (d) the circumstances and complexity of the particular case, including
42 time and place of the service;

43 (e) individual patient characteristics, with regard to physician
44 services; and

45 (f) the usual and customary cost of the service.

46 § 4. This act shall take effect immediately.

47 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-
48 sion, section or part of this act shall be adjudged by any court of
49 competent jurisdiction to be invalid, such judgment shall not affect,
50 impair, or invalidate the remainder thereof, but shall be confined in
51 its operation to the clause, sentence, paragraph, subdivision, section
52 or part thereof directly involved in the controversy in which such judg-
53 ment shall have been rendered. It is hereby declared to be the intent of
54 the legislature that this act would have been enacted even if such
55 invalid provisions had not been included herein.

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