# 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.

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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

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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)

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The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2019-2020 state fiscal year. Each component is wholly contained within a Part identified as Parts A through LL. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for: enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law and adult day health care programs located at a licensed residential health care facility as defined by section twenty-eight hundred one of the public health law or an approved extension site thereof. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

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

social services law made by section one of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith.

PART B

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

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

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

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

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

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

3. The department and the division of the budget shall assess on a quarterly basis the projected total amount to be expended in the year on a cash basis by the Medicaid program for each drug, and the projected annual amount of state funds Medicaid drug expenditures on a cash basis for all drugs, which shall be a component of the projected department of health state funds Medicaid expenditures calculated for purposes of sections ninety-one and ninety-two of part H of chapter fifty-nine of the laws of two thousand eleven. For purposes of this section, state funds Medicaid drug expenditures include amounts expended for drugs in both the Medicaid fee-for-service program and Medicaid managed care programs, minus the amount of any drug rebates or supplemental drug rebates received by the department, including rebates pursuant to subdivision five of this section with respect to rebate targets. The department and the division of the budget shall report quarterly to the drug utilization review board the projected state funds Medicaid drug expenditures including the amounts, in aggregate thereof, attributable to the net cost of: changes in the utilization of drugs by Medicaid recipients; changes in the number of Medicaid recipients; changes to the cost of brand name drugs and changes to the cost of generic drugs. The information contained in the report shall not be publicly released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial competitive, or proprietary nature of the information.

(a) In the event the director of the budget determines, based on Medicaid drug expenditures for the previous quarter or other relevant information, that the total department of health state funds Medicaid drug expenditure is projected to exceed the annual growth limitation imposed

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

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

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

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

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

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

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

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

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

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

§ 9. Intentionally omitted.

§ 10. Intentionally omitted.

§ 11. Intentionally omitted.

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

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

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

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

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

2. Providing and payment for prescription drugs for medicaid managed care provider participants. Prescription drugs eligible for reimbursement under this article prescribed in relation to a service provided by a managed care provider shall be provided and paid for under the preferred drug program and the clinical drug review program under title one of article two-A of the public health law. The managed care provider shall account to and reimburse the department for the net cost to the department for prescription drugs provided to the managed care provider's participants. Payment for prescription drugs shall be included in the capitation payments to the managed care provider for services or supplies provided to a managed care provider's participants.

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

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

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

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

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

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

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

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

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

PART C

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

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

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

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

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

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

PART D

Section 1. Subdivision 1 of section 92 of part H of 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, as amended by section 2 of part K of chapter 57 of the laws of 2018, is amended to read as follows:

1. For state fiscal years 2011-12 through [2019-20] 2020-2021, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner, and if the director of the budget determines that such expenditures are expected to cause medicaid disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, minimum wage increases, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund and state costs or savings from the basic health plan. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

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

## PART E

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

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

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

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

§ 3. Section 11 of 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, as amended by section 1

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

§ 11. This act shall take effect immediately and:

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

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

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

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

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

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

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

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

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

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

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

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

§ 8. Subdivision (i) of section 111 of part H of 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, as amended by section 19 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

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

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

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-one such assessment shall be six percent.

§ 10. Subdivision 1 of section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 4 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

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

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

§ 11. Subdivision 1 of section 89-a of part C of 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, as amended by section 5 of part I of chapter 57 of the laws of 2017, is amended to read as follows:

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

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

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

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

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

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

§ 14. Section 4-a of part A of 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, as amended by section 5 of part T of chapter 57 of the laws of 2018, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2017 through March 31, [2019] 2021, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2017, 2018, [and] 2019, 2020, and 2021 calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2017, 2018, [and] 2019, 2020, and 2021 calendar years shall also be applied to rates of payment provided on and after January 1, 2017 through March 31, [2019] 2021 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations; and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2017 through March 31, [2019] 2021, such trend factors attributable to the 2017, 2018, [and] 2019, 2020, and 2021 calendar years shall be established at no greater than zero percent.

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

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

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

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

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

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

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

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

§ 18. Section 48-a of part A of 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, as amended by section 1 of part P of chapter 57 of the laws of 2017, is amended to read as follows:

§ 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of alcoholism and substance abuse services, or the office of mental health for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [29] 1 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2023 for patients in the city of New York, for all rate periods on and after the effective date of section [29] 1 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through [March 31, 2020] March 31, 2023 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through [March 31, 2020] March 31, 2023 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The

commissioner of health shall, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

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

§ 19. Section 1 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, as amended by section 2 of part P of chapter 57 of the laws of 2017, is amended to read as follows:

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2023 for patients in the city of New York, for all rate periods on and after the effective date of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2023 for patients outside the city of New York, and for all rate periods on and after the effective date of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2023 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to

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

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

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

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

§ 20. 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, as amended by section 16 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

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

§ 21. Section 10 of 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, as amended by section 2 of part D of chapter 59 of the laws of 2016, is amended to read as follows:

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

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

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2016, and for the state fiscal year beginning April 1, 2016 through March 31, 2019, and for the state fiscal year beginning April 1, 2019 through March 31, 2022, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data

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

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

PART F

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

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019<u>, and between July 1, 2019 and June 30, 2020</u> or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between

July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019, and between July 1, 2019 and June 30, 2020 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three

million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

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

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019<u>, and between July 1, 2019 and June 30, 2020</u> allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019<u>, and between July 1, 2019 and June 30, 2020</u> allocable to each general hospi-

tal for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, [and between] <u>to the period</u> July 1, 2016 and June 30, 2017, [and] to the period July 1, 2017 to June 30, 2018, [and] to the period July 1, 2018 to June 30, 2019<u>, and to the period July 1, 2019 to June 30, 2020</u>.

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

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to

June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, [and] during the period July 1, 2018 to June 30, 2019, and during the period July 1, 2019 to June 30, 2020 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

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

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July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the peri-

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

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, and covering the period July 1, 2016 to June 30, 2017, and covering the period July 1, 2017 to June 30, 2018, and covering the period July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to June 30, 2020 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

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

professional medical conduct, as amended by section 4 of part M of chapter 57 of the laws of 2018, is amended to read as follows:

§ 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2019;] 2020; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [2019,] 2020, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2019] 2020 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985,

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

§ 5. Section 5 and subdivisions (a) and (e) of section 6 of 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, as amended by section 5 of part M of chapter 57 of the laws of 2018, are amended to read as follows:

§ 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June 15, 2018, [and] June 15, 2019<u>, and June 15, 2020</u> the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019<u>, or July 1, 2019 to June 30, 2020</u> as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019<u>, or July 1, 2019 to June 30, 2020</u> as applicable.

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

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

§ 6. Section 20 of 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 thereto, as amended by section 6 of part M of chapter 57 of the laws of 2018, is amended to read as follows:

§ 20. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand [eighteen,] nineteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand [eighteen;] nineteen; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand [eighteen] nineteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand [eighteen,] nineteen, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand [eighteen,] nineteen, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand [eighteen] nineteen and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand [eighteen] nineteen.

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

## PART G

Section 1. Intentionally Omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

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

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

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

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

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

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

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

10. For any determination of the amount, nature and manner of providing assistance under this article for which an assessment tool is used, the department, in consultation with the independent actuary, representatives of medical assistance recipients, representatives of the managed care programs, representatives of long term care providers and other interested parties, shall evaluate existing assessment tools and develop additional professionally and statistically valid assessment tools to be used to assist in determining the amount, nature and manner of services and care needs of individuals which shall involve consideration of variables including but not limited to physical and behavioral functioning; activities of daily living and instrumental activities of daily living; family, social or geographic determinants of health; primary or secondary diagnoses of cognitive impairment or mental illness; and other appropriate conditions or factors.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## PART H

Section 1. Intentionally Omitted.

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

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

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

§ 3. Intentionally Omitted.

§ 4. Intentionally Omitted.

§ 5. Intentionally Omitted.

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

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

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

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

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

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

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

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

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

(C) No facility shall experience a reduction in indigent care pool payments pursuant to this subdivision that: for the calendar year beginning January first, two thousand thirteen, is greater than two and one-half percent; for the calendar year beginning January first, two thousand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen; is greater than seven and one-half percent, and for the calendar year beginning on January first, two thousand sixteen, is greater than ten percent; and for the calendar year beginning on January first, two thousand seventeen, is greater than twelve and one-half percent; and for the calendar year beginning on January first, two thousand eighteen, is greater than fifteen percent; and for the calendar year beginning on January first, two thousand nineteen, is greater than seventeen and one-half percent; and for the calendar year beginning on January first, two thousand twenty, is greater than twenty percent.

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

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

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

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

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

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

## PART I

Intentionally Omitted

## PART J

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

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

SUBPART A

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

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

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

§ 2. Intentionally omitted.

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

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

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

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

§ 5. Intentionally omitted.

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

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

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

§ 7. Intentionally omitted.

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

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

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

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

§ 10. Intentionally omitted.

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

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

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

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

§ 211. Independent consumer assistance program. The superintendent, in consultation with the commissioner of health, shall designate an independent consumer assistance program that will have the following duties:

(a) The independent consumer assistance program shall:

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

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

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

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

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

(6) assist consumers with disputes eligible for resolution under article six of the financial services law;

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

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

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

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member handbook and any additional consumer facing materials as determined by the superintendent and the commissioner of health.

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

SUBPART B

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

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

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

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

§ 3. Intentionally omitted.

§ 4. Intentionally omitted.

§ 5. Intentionally omitted.

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

(21) Every policy [which] that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas [which] that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein [or which], contain modified protein, or are amino acid based [which] that are medically necessary[, and such coverage for such modified solid food products for any calendar year or for any continuous period of twelve months for any insured individual shall not exceed two thousand five hundred dollars].

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

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

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

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

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

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

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

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

§ 3217-i. Essential health benefits package and limit on cost-sharing. (a) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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

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

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

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

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

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

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

(e) For purposes of this section:

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

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

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

(A) provides for essential health benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 15. Intentionally omitted.

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

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

§ 17. Intentionally omitted.

§ 18. Intentionally omitted.

§ 19. Intentionally omitted.

§ 20. Intentionally omitted.

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

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

§ 22. Intentionally omitted.

§ 23. Intentionally omitted.

§ 24. Intentionally omitted.

§ 25. Intentionally omitted.

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

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

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

(y) Every contract [which] that provides coverage for prescription drugs shall include coverage for the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law has issued a written order. Such written order shall state that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders for which enteral formulas have been proven effective shall include, but are not limited to, inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies including, but not limited to immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Enteral formulas [which] that are medically necessary and taken under written order from a physician for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism as well as severe protein allergic conditions shall include modified solid food products that are low protein, [or which] contain modified protein, or are amino acid based [which] that are medically necessary[, and such coverage for such modified solid food products for any calendar year or for any continuous period of twelve months for any insured individual shall not exceed two thousand five hundred dollars].

§ 28. Intentionally omitted.

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

(ll) Every small group contract or association group contract delivered or issued for delivery in this state that provides coverage for hospital, medical or surgical expense insurance and is not a grandfathered health plan shall provide coverage for the essential health [benefit] benefits package [as required in section 2707(a) of the public

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

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

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

(3) "small group" means a group of fifty or fewer employees or members exclusive of spouses and dependents. Beginning January first, two thousand sixteen, "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

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

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

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

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

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

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

(i) Discontinuance of a class of contract upon not less than ninety days' prior written notice. In exercising the option to discontinue coverage pursuant to this item, the corporation must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and must offer to subscribers or group remitting agents, as may be appropriate, the option to purchase all other individual health insurance coverage currently being offered by the corporation to applicants in that market. Provided, however, the superintendent may, after giving due consideration to the public interest, approve a request made by a corporation for the corporation to satisfy the requirements of this item through the offering of contracts at each level of coverage as defined in subsection (b) of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this article that contains the essential health benefits package described in paragraph [one] three of subsection [(b)] (e) of section four thousand three hundred [twenty-eight] six-h of this [chapter] article by another corporation, insurer or health maintenance organization within the corporation's same holding company system, as defined in article fifteen of this chapter.

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

(1) (A) If any such contract is terminated in accordance with the provisions of paragraph one of subsection (c) of this section, or any such contract is terminated because of a default by the remitting agent in the payment of premiums not cured within the grace period and the remitting agent has not replaced the contract with similar and continuous coverage for the same group whether insured or self-insured, or any such contract is terminated in accordance with the provisions of subparagraph (E) of paragraph two of subsection (c) of this section, or if an individual other than the contract holder is no longer covered under a "family contract" because the individual is no longer within the definition set forth in the contract, or a spouse is no longer covered under the contract because of divorce from the contract holder or annulment of the marriage, or any such contract is terminated because of the death of the contract holder, then such individual, former spouse, or in the case of the death of the contract holder the surviving spouse or other dependents of the deceased contract holder covered under the contract, as the case may be, shall be entitled to convert, without evidence of insurability, upon application therefor and the making of the first payment thereunder within sixty days after the date of termination of such contract, to a contract that contains the essential health benefits package described in paragraph [one] three of subsection [(b)] (e) of section four thousand three hundred [twenty-eight] six-h of this [chapter] article.

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

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

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

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

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

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

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

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

§ 4306-h. Essential health benefits package and limit on cost-sharing. (a) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

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

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

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

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

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

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

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

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

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

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

(e) For purposes of this section:

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

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

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

(A) provides for essential health benefits;

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

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

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

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

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

§ 36. Intentionally omitted.

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

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

(e) A qualifying group health insurance contract [issued to a qualifying small employer prior to January first, two thousand fourteen that does not include all essential health benefits required pursuant to section 2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a), shall be discontinued, including grandfathered health plans. For the purposes of this paragraph, "grandfathered health plans" means coverage provided by a corporation to individuals who were enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the affordable care act, 42 U.S.C. § 18011(e). A qualifying small employer shall be transitioned to a plan that provides: (1)] shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan[; and (2) coverage for the essential health benefit package as required in section 2707(a) of the public health service act, 42 U.S.C. § 300gg-6(a)]. The superintendent shall standardize the benefit package and cost sharing requirements of qualified group health insurance contracts consistent with coverage offered through the health benefit exchange established [pursuant to section 1311 of the affordable care act, 42 U.S.C. § 18031] by this state.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 3. Intentionally omitted.

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

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

PART K

Section 1. Intentionally omitted.

§ 2. Intentionally omitted.

§ 3. Intentionally omitted.

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

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

§ 5. Intentionally omitted.

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

PART L

Intentionally Omitted

PART M

Intentionally Omitted

PART N

Intentionally Omitted

PART O

Intentionally Omitted

PART P

Intentionally Omitted

PART Q

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

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

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

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

3. Notwithstanding section one hundred sixty-three of the state finance law or any inconsistent provision of law to the contrary, up to five hundred [twenty-five] fifty million dollars of the funds appropriated for this program shall be awarded without a competitive bid or request for proposal process for grants to health care providers (hereafter "applicants"). Provided, however, that a minimum of: (a) sixty million dollars of total awarded funds shall be made to community-based health care providers, which for purposes of this section shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law; a home care provider certified or licensed pursuant to article thirty-six of this chapter; or hospices licensed or granted an operating certificate pursuant to article forty of this chapter [and]; (b) forty-five million dollars of the total awarded funds shall be made to residential health care facilities; and (c) an additional twenty-five million dollars of total awarded funds shall be made to children's residential treatment facilities licensed pursuant to article thirty-one of the mental hygiene law, a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law, hospices licensed or granted an operating certificate pursuant to article forty of this chapter, and community-based health care providers, which for purposes of this paragraph shall be defined as a diagnostic and treatment center licensed or granted an operating certificate under this article; a mental health clinic licensed or granted an operating certificate under article thirty-one of the mental hygiene law; a substance use disorder treatment clinic licensed or granted an operating certificate under article thirty-two of the mental hygiene law; a primary care provider; and a home care provider certified or licensed pursuant to article thirty-six of this chapter, provided however, when such funds are awarded, priority shall be given to the following applicants first: children's residential treatment facilities licensed pursuant to article thirty-one of the mental hygiene law; a clinic licensed or granted an operating certificate under article sixteen of the mental hygiene law;

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

§ 2. This act shall take effect immediately.

PART R

Intentionally Omitted

PART S

Intentionally Omitted

PART T

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

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

TITLE VII

NY STATE OF HEALTH

Section 268. Statement of policy and purposes.

268-a. Definitions.

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

268-c. Functions of the Marketplace.

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

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

268-f. Marketplace advisory committee.

268-g. Funding of the Marketplace.

268-h. Construction.

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

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

§ 268-a. Definitions. For purposes of this title, the following definitions shall apply:

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

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

3. "Federal act" means the patient protection and affordable care act, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and any regulations or guidance issued thereunder.

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

(a) accident insurance or disability income insurance, or any combination thereof;

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

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

(d) workers' compensation or similar insurance;

(e) automobile no-fault insurance;

(f) credit insurance;

(g) other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

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

(i) coverage only for a specified disease or illness, hospital indemnity, or other fixed indemnity coverage;

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

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

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

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

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

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

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

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

(a) is eligible to enroll in a qualified health plan offered to individuals through the Marketplace;

(b) resides in this state;

(c) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) certify and/or make available to eligible individuals, health plans certified by the Marketplace pursuant to applicable law, and/or participating in an insurance affordability program pursuant to applicable law, provided that coverage under such plans shall not become effective prior to certification by the Marketplace, and/or approval by the commissioner.

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

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

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

5. Maintain enrollment periods in the best interest of qualified individuals consistent with federal and state law.

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

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

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

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9. Provide the minimum requirements an insurer shall meet to participate in the Marketplace, in the best interest of qualified individuals or eligible individuals;

10. Require qualified health plans and/or other health plans certified by the Marketplace to offer those benefits determined to be essential health benefits pursuant to state law or as required by the Marketplace.

11. Ensure that insurers offering health plans through the Marketplace do not charge an individual enrollee a fee or penalty for termination of coverage.

12. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

13. Maintain an internet website through which enrollees and prospective enrollees of qualified health plans and health plans certified by the Marketplace may obtain standardized comparative information on such plans and insurance affordability programs.

14. Make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 or applicable state law and any cost-sharing reduction under federal or applicable state law.

15. Operate a program under which the Marketplace awards grants to entities to serve as navigators in accordance with applicable federal law and regulations adopted thereunder, and/or a program under which the Marketplace awards grants to entities to provide community based enrollment assistance in accordance with requirements developed by the Marketplace; and/or a program under which the Marketplace certifies New York state licensed producers to provide assistance to eligible individuals and/or small employers pursuant to federal or state law.

16. In accordance with applicable federal and state law, inform individuals of eligibility requirements for the Medicaid program under title XIX of the social security act and the social services law, the children's health insurance program (CHIP) under title XXI of the social security act and this chapter, the basic health program under section three hundred sixty-nine-gg of the social services law, or any applicable state or local public health insurance program and if, through screening of the application by the Marketplace, the Marketplace determines that such individuals are eligible for any such program, enroll such individuals in such program.

17. Grant a certification that an individual is exempt from the requirement to maintain minimum essential coverage pursuant to federal or state law and from any penalties imposed by such requirements because:

(a) there is no affordable health plan available covering the individual, as defined by applicable law; or

(b) the individual meets the requirements for any other such exemption from the requirement to maintain minimum essential coverage or to pay the penalty pursuant to applicable federal or state law.

18. Operate a small business health options program ("SHOP") pursuant to section 1311 of the federal act and applicable state law, through which eligible small employers may select marketplace-certified qualified health plans offered in the small group market, and through which eligible small employers may receive assistance in qualifying for small business tax credits available pursuant to federal and state law.

19. Enter into agreements as necessary with federal and state agencies and other state Marketplaces to carry out its responsibilities under this title, provided such agreements include adequate protections with

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

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

21. Meet program integrity requirements under applicable law, including keeping an accurate accounting of receipts and expenditures and providing reports to the secretary regarding Marketplace related activities in accordance with applicable law.

22. Submit information provided by Marketplace applicants for verification as required by section 1411(c) of the federal act and applicable state law.

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

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

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

(a) The insurer offering the health plan:

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

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

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

(iv) does not charge any cancellation fees or penalties for termination of coverage in violation of applicable law; and

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

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

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

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

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

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

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

(v) meets standards specified and determined by the Marketplace, provided that the standards do not conflict with or prevent the application of federal requirements; and

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

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

2. The Marketplace shall not exclude a health plan:

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

(b) through the imposition of premium price controls by the Marketplace; or

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

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

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

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

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment and disenrollment;

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

(E) data on rating practices;

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

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

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

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

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

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

4. The Marketplace shall not exempt any insurer seeking certification of a health plan, regardless of the type or size of the insurer, from licensing or solvency requirements under the insurance law or this chapter, and shall apply the criteria of this section in a manner that ensures a level playing field for insurers participating in the Marketplace.

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

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

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

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

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

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

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

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

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

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

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

(i) An initial determination of eligibility, including:

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

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) health plan consumer advocates;

(ii) small business consumer representatives;

(iii) health care provider representatives;

(iv) representatives of the health insurance industry;

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

(i) licensed insurance producers; and

(ii) representatives of labor organizations.

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

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

§ 268-g. Funding of the Marketplace. 1. The Marketplace shall be funded by state and federal sources as authorized by applicable law, including but not limited to applicable law authorizing the respective insurance affordability programs available through the Marketplace.

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

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

authorized and directed to sub-allocate or transfer special revenue federal funds appropriated to the department for planning and implementing various healthcare and insurance reform initiatives authorized by applicable law. Marketplace moneys sub-allocated or transferred pursuant to this section shall be paid out of the fund upon audit and warrant of the state comptroller on vouchers certified or approved by the Marketplace.

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

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

2. exempt insurers, insurance producers or qualified health plans from this chapter or the insurance law and any regulations promulgated thereunder.

§ 3. Severability. If any provision of this article, or the application thereof to any person or circumstances is held invalid or unconstitutional, that invalidity or unconstitutionality shall not affect other provisions or applications of this article that can be given effect without the invalid or unconstitutional provision or application, and to this end the provisions and application of this article are severable.

§ 4. This act shall take effect immediately.

## PART U

Intentionally Omitted

## PART V

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

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

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

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

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

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

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

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

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

(d) The managed care provider shall be entitled to receive a draft audit report and final audit report containing the results of the Medicaid inspector general's review. If the Medicaid inspector general determines to recover a percentage of the premium as described in paragraph (c) of this subdivision, the managed care provider shall be entitled to notice and an opportunity to be heard in accordance with section twenty-two of this chapter.

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

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

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

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

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

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

§ 5. Intentionally omitted.

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

35. Recovery of overpayments from network providers. (a) Where the Medicaid inspector general during the course of an audit, investigation, or review, or the deputy attorney general for the Medicaid fraud control unit during the course of an investigation or prosecution for Medicaid fraud, identifies improper medical assistance payments made by a managed care provider or managed long term care plan to its subcontractor or subcontractors or provider or providers, the state shall have the right to recover the improper payment from the subcontractor or subcontractors, provider or providers, or the managed care provider or managed long term care plan, provided, however, that the state shall not duplicate the recovery of an improper medical assistance payment from a subcontractor or provider that has been recovered from it by the managed care provider or managed long term care plan.

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

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

## PART W

Section 1. Section 1 of 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, as amended by section 1 of part H of chapter 59 of the laws of 2016, is amended to read as follows:

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

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

§ 2. This act shall take effect immediately.

## PART X

Intentionally Omitted

## PART Y

Intentionally Omitted

## PART Z

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

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, or, in the case of a midwifery birth center, of a midwife, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, midwifery birth center, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings. No provision of this article or any other provision of law shall be construed to: (a) limit the volume of mental health [or], substance use disorder services or developmental disability services that can be provided by a provider of primary care services licensed under this article and authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health [and], the commissioner of the office of alcoholism and substance abuse services and the

commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve; (b) require a provider licensed pursuant to article thirty-one of the mental hygiene law or certified pursuant to article sixteen or article thirty-two of the mental hygiene law to obtain an operating certificate from the department if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner in consultation with the commissioner of the office of mental health [and], the commissioner of the office of alcoholism and substance abuse services and the commissioner of the office for people with developmental disabilities, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

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

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

(b) (i) Methadone, or such other controlled substance designated by the commissioner of health as appropriate for such use, may be administered to an addict, as defined in section thirty-three hundred two of the public health law, by individual physicians, groups of physicians and public or private medical facilities certified pursuant to article twenty-eight or thirty-three of the public health law as part of a chemical dependence program which has been issued an operating certificate by the commissioner pursuant to subdivision (b) of section 32.09 of this article, provided, however, that such administration must be done in accordance with all applicable federal and state laws and regulations. Individual physicians or groups of physicians who have obtained authorization from the federal government to administer buprenorphine to addicts may do so without obtaining an operating certificate from the commissioner. (ii) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or article thirty-one of this chapter or a provider certified pursuant to article sixteen of this chapter to obtain an operating certificate from the office of alcoholism and substance abuse services if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of alcoholism and substance abuse services in consultation with the commissioner of the department of health [and], the commission-

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

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

(g) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article thirty-one or thirty-two of this chapter to obtain an operating certificate from the office for people with developmental disabilities if such provider has been authorized to provide integrated services in accordance with regulations issued by the commissioner of the office for people with developmental disabilities, in consultation with the commissioner of the department of health, the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, including regulations issued pursuant to subdivision seven of section three hundred sixty-five-l of the social services law or part L of chapter fifty-six of the laws of two thousand twelve.

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

PART AA

Intentionally Omitted

PART BB

Intentionally Omitted

PART CC

Intentionally Omitted

PART DD

Intentionally Omitted

PART EE

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

§ 33.29 Independent intellectual and developmental disability ombudsman program.

(a) There is hereby established the office of the independent intellectual and developmental disability ombudsman program that will be operated or selected by the office for people with developmental disabilities for the purpose of assisting individuals with an intellectual or developmental disability to ensure that they receive coverage from

managed care organizations that is appropriate in meeting their individual service needs.

(b) Such ombudsman will identify, investigate, refer and resolve complaints that are made by, or on behalf of, consumers relative to coverage under a managed care organization and access to initial and continuing intellectual and developmental disability services and supports; accept, investigate, refer and help to resolve complaints that are made by service providers relative to coverage under managed care organizations of and reimbursement for initial or continuing intellectual and developmental disability services and supports; accept, investigate, refer and help to resolve complaints that are made by or on behalf of consumers or by providers relative to network adequacy for access to intellectual and developmental disability services and supports; and monitor quality of care including outcome measures for intellectual and developmental disability specialized provider led managed care plans and other managed care entities.

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

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

## PART FF

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

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

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

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

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

PART GG

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

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

(2) The directory shall include the following information:

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

(ii) Contact information for each provider or program;

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

(iv) Special populations served;

(v) Insurance accepted;

(vi) Availability of beds and services; and

(vii) Any other information the commissioner deems necessary.

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

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

PART HH

Section 1. Section 4 of 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, as amended by section 1 of part QQ of chapter 58 of the laws of 2018, is amended to read as follows:

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

§ 2. This act shall take effect immediately.

PART II

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 6. The section heading of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

[Third party insurance and medical] <u>Medical</u> assistance program payments.

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

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

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

(ii)] Parents shall provide the municipality and the service coordinator with a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of early intervention services.

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

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

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

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

(d)] (c) A municipality, or its designee, and a provider shall be subrogated, to the extent of the expenditures by such municipality or for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from [third party reimbursement] the medical assistance program. The provider shall submit notice to the insurer or plan administrator of his or her exercise of such right of subrogation upon the provider's assignment as the early intervention service provider for the child. The right of subrogation does not attach to benefits paid or provided [under any health insurance policy or health benefits plan] prior to receipt of written notice of the exercise of subrogation rights [by the insurer or plan administrator providing such benefits]. Notwithstanding any inconsistent provision of this title, except as provided for herein, no third party payor other than the medical assistance program shall be required to reimburse for early intervention services provided under this title.

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

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

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

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

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

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

PART JJ

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

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

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

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

## PART KK

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

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

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

## PART LL

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

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

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

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

(3) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review.

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the non-participating physician's or hospital's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section six hundred four of this article. If an independent dispute resolution entity determines, based on the health care plan's payment and the non-participating physician's or hospital's fee, that a settlement between the health care plan and non-participating physician or hospital is reasonably likely, or that both the health care plan's payment and the non-participating physician's or hospital's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and non-participating physician or hospital may be granted up to ten business days for this negotiation, which shall run concurrently with the thirty day period for dispute resolution.

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

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

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

(c) The determination of an independent dispute resolution entity shall be binding on the health care plan, physician or hospital and patient, and shall be admissible in any court proceeding between the health care plan, physician or hospital or patient, or in any administrative proceeding between this state and the physician or hospital.

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

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

(a) For disputes involving an insured, when the independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating physician or hospital. When the independent dispute resolution entity determines the non-participating physician's or hospital's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan. When a good faith negotiation directed by the independent dispute resolution entity pursuant to paragraph four of subsection (a) of section six hundred five of this article, or paragraph six of subsection (a) of section six hundred seven of this article results in a settlement between the health care plan and non-participating physician or hospital, the health care plan and the non-participating physician or hospital shall evenly divide and share the prorated cost for dispute resolution.

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

§ 604. Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

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

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

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

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

(c) the [physician's] health care provider's usual charge for comparable services with regard to patients in health care plans in which the [physician] health care provider is not participating;

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

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

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

§ 4. This act shall take effect immediately.

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

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

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