

# STATE OF NEW YORK

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2007--B

## IN ASSEMBLY

January 18, 2019

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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



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

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

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

12

## PART A

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

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

47 § 2. Intentionally omitted.

48 § 3. Intentionally omitted.

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

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

4

## PART B

5 Section 1. Intentionally omitted.

6 § 2. Intentionally omitted.

7 § 3. Intentionally omitted.

8 § 4. Intentionally omitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 § 9. Intentionally omitted.

23 § 10. Intentionally omitted.

24 § 11. Intentionally omitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 PART C

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

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

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

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

50 § 2. Intentionally omitted.

51 § 3. Intentionally omitted.

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

53 PART D



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

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

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

34

## PART E

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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





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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

14

## PART F

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

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



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

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

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

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

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



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

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

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



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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

46

## PART G

47 Section 1. Intentionally Omitted.

48 § 2. Intentionally omitted.

49 § 3. Intentionally omitted.

50 § 4. Intentionally omitted.

51 § 5. Intentionally omitted.

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



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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40

## PART H

41 Section 1. Intentionally Omitted.

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

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

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

9 § 3. Intentionally Omitted.

10 § 4. Intentionally Omitted.

11 § 5. Intentionally Omitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 PART I

45 Intentionally Omitted

46 PART J

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

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

8

## SUBPART A

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

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

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

20 § 2. Intentionally omitted.

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

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

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

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

41 § 5. Intentionally omitted.

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

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

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

54 § 7. Intentionally omitted.



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

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

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

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

21 § 10. Intentionally omitted.

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

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

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

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

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

31 (a) The independent consumer assistance program shall:

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

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

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

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

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

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

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

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

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





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

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

7

## SUBPART B

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

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

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

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

53 § 3. Intentionally omitted.

54 § 4. Intentionally omitted.

1 § 5. Intentionally omitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (e) For purposes of this section:

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

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

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

30 (A) provides for essential health benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 § 15. Intentionally omitted.

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

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

38 § 17. Intentionally omitted.

39 § 18. Intentionally omitted.

40 § 19. Intentionally omitted.

41 § 20. Intentionally omitted.

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

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

51 § 22. Intentionally omitted.

52 § 23. Intentionally omitted.

53 § 24. Intentionally omitted.

54 § 25. Intentionally omitted.

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

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

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

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

48 § 28. Intentionally omitted.

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

38 (1) ambulatory patient services;

39 (2) emergency services;

40 (3) hospitalization;

41 (4) maternity and newborn care;

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

44 (6) prescription drugs;

45 (7) rehabilitative and habilitative services and devices;

46 (8) laboratory services;

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

48 and

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

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

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

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

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

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

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

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

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

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

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

35 (e) For purposes of this section:

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

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

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

43 (A) provides for essential health benefits;

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

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

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

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

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

4 § 36. Intentionally omitted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 § 3. Intentionally omitted.

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

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

15 PART K

16 Section 1. Intentionally omitted.

17 § 2. Intentionally omitted.

18 § 3. Intentionally omitted.

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

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

28 § 5. Intentionally omitted.

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

31 PART L

32 Intentionally Omitted

33 PART M

34 Intentionally Omitted

35 PART N

36 Intentionally Omitted

37 PART O

38 Intentionally Omitted

39 PART P

40 Intentionally Omitted

41 PART Q

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

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

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

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

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



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

3 § 2. This act shall take effect immediately.

4 PART R

5 Intentionally Omitted

6 PART S

7 Intentionally Omitted

8 PART T

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

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

13 TITLE VII

14 NY STATE OF HEALTH

15 Section 268. Statement of policy and purposes.

16 268-a. Definitions.

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

19 268-c. Functions of the Marketplace.

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

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

23 268-f. Marketplace advisory committee.

24 268-g. Funding of the Marketplace.

25 268-h. Construction.

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



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

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

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

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

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

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

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

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

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

29 (d) workers' compensation or similar insurance;

30 (e) automobile no-fault insurance;

31 (f) credit insurance;

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

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

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

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

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

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



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

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

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

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

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

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

18 (b) resides in this state;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

22 (a) The insurer offering the health plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 (A) claims payment policies and practices;

44 (B) periodic financial disclosures;

45 (C) data on enrollment and disenrollment;

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

47 (E) data on rating practices;

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (B) eligibility for Medicaid;

18 (C) eligibility for Child Health Plus;

19 (D) eligibility for the Basic Health Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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





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

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

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

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

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

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

25 (i) health plan consumer advocates;

26 (ii) small business consumer representatives;

27 (iii) health care provider representatives;

28 (iv) representatives of the health insurance industry;

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

31 (i) licensed insurance producers; and

32 (ii) representatives of labor organizations.

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

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

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

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

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

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

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

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

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

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

21 § 4. This act shall take effect immediately.

22 PART U

23 Intentionally Omitted

24 PART V

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 § 5. Intentionally omitted.

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

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

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

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

44

#### PART W

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

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

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

10 § 2. This act shall take effect immediately.

11 PART X

12 Intentionally Omitted

13 PART Y

14 Intentionally Omitted

15 PART Z

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

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

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

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

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

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

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

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

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

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

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

29 PART AA

30 Intentionally Omitted

31 PART BB

32 Intentionally Omitted

33 PART CC

34 Intentionally Omitted

35 PART DD

36 Intentionally Omitted

37 PART EE

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

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

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

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

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

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

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

32

## PART FF

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

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

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

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





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

5

## PART GG

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

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

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

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

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

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

18 (iv) Special populations served;

19 (v) Insurance accepted;

20 (vi) Availability of beds and services; and

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

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

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

28

## PART HH

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

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

40 § 2. This act shall take effect immediately.

41

## PART II

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 [Third party insurance and medical] Medical assistance program  
22 payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40

## PART JJ

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

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



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

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

10

## PART KK

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

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

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

44

## PART LL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46 § 4. This act shall take effect immediately.

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

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