

**FY 2020 NEW YORK STATE EXECUTIVE BUDGET**

**HEALTH AND MENTAL HYGEINE  
ARTICLE VII LEGISLATION**

## FY 2020 NEW YORK STATE EXECUTIVE BUDGET

### HEALTH AND MENTAL HYGIENE ARTICLE VII LEGISLATION

#### CONTENTS

<b>PART</b>	<b>DESCRIPTION</b>	<b>STARTING PAGE NUMBER</b>
A	Transportation-related Medicaid Redesign Team recommendations	8
B	Pharmaceutical related Medicaid Redesign Team recommendations	11
C	Managed Care related Medicaid Redesign Team recommendations	18
D	Extend the Medicaid Global Cap	20
E	Extend various provisions of the Public Health and Social Services Laws	21
F	Extend the Physicians Excess Medical Malpractice Program for one year	43
G	Long-term care related Medicaid Redesign Team recommendations	62
H	Hospital related Medicaid Redesign Team recommendations	72
I	Authorize the regulation of pharmacy benefit managers	74
J	Codify of the Affordable Care Act	90
K	Extend enhanced rates for the Medical Indemnity Fund and transfer administration of the Medical Indemnity Fund from the Department of Financial Services to the Department of Health	155
L	Require insurance policies to provide coverage for medically necessary fertility preservation and large group insurance policies to provide coverage for in vitro fertilization	165
M	Enact the Comprehensive Contraception Coverage Act	171
N	Establish a commission to evaluate options for achieving universal access to high-quality, affordable health care in New York	181

<b>PART</b>	<b>DESCRIPTION</b>	<b>STARTING PAGE NUMBER</b>
O	Reduce Department of Health's General Public Health Work Program reimbursement to New York City from 36 percent to 20 percent	182
P	Lower blood lead levels and establish lead based paint standards	184
Q	Authorizing Additional Awards for Statewide II Applications	186
R	Establish the Maternal Mortality Review Board to review and assess the cause of death and factors leading to each death to reduce the risk of maternal mortality and severe maternal morbidity in New York State	187
S	Enact the Reproductive Health Act	194
T	Codification of the NY State of Health Marketplace	202
U	Create an Optional Private Pay Model in the State Office of the Aging	222
V	OMIG Managed Care Program Integrity	223
W	Authorize the Office of Mental Health to continue to recover Medicaid exempt income from providers of community residences	227
X	Establish voluntary jail-based restoration to competency programs within locally-operated jails	228
Y	Defer Human Services COLA	229
Z	Eliminate duplicate license requirements to render integrated services for OPWDD providers and at Article 16 clinics	230
AA	Jurisdictional Changes to Eliminate Duplicative Oversight of Article 28 Hospitals and DOH Summer Camps	235
BB	Behavioral Health Insurance Parity Reforms	237

Legislative Bill Drafting Commission  
12571-01-9

S.           -----  
              Senate  
              -----

IN SENATE--Introduced by Sen

--read twice and ordered printed,  
and when printed to be committed  
to the Committee on

----- A.  
Assembly  
-----

IN ASSEMBLY--Introduced by M. of A.

with M. of A. as co-sponsors

--read once and referred to the  
Committee on

**\*BUDGBI\***

(Enacts into law major components of  
legislation necessary to implement  
the state health and mental hygiene  
budget for the 2019-2020 state  
fiscal year)

-----

BUDGBI, HMH Executive

**AN ACT**

to amend the social services law, in  
relation to reimbursement of trans-  
portation costs, reimbursement of  
emergency transportation services  
and supplemental transportation  
payments; and to repeal certain  
provisions of such law relating  
thereto (Part A); to amend the  
social services law and the public  
health law, in relation to updating  
copayments; to amend the public

**IN SENATE**

**Senate introducer's signature**

The senators whose names are circled below wish to join me in the sponsorship  
of this proposal:

s15 Addabbo	s02 Flanagan	s09 Kaminsky	s25 Montgomery	s23 Savino
s52 Akshar	s55 Funke	s07 Kaplan	s20 Myrie	s32 Sepulveda
s46 Amedore	s59 Gallivan	s26 Kavanagh	s58 O'Mara	s41 Serino
s50 Antonacci	s05 Gaughran	s63 Kennedy	s62 Ortt	s29 Serrano
s36 Bailey	s12 Gianaris	s28 Krueger	s21 Parker	s51 Seward
s30 Benjamin	s22 Gounardes	s24 Lanza	s19 Persaud	s39 Skoufis
s34 Biaggi	s47 Griffo	s01 LaValle	s13 Ramos	s16 Stavisky
s04 Boyle	s40 Harckham	s45 Little	s61 Ranzzenhofer	s35 Stewart-
s44 Breslin	s54 Helming	s11 Liu	s48 Ritchie	Cousins
s08 Brooks	s27 Hoylman	s03 Martinez	s33 Rivera	s49 Tedisco
s38 Carlucci	s31 Jackson	s53 May	s56 Robach	s06 Thomas
s14 Comrie	s60 Jacobs	s37 Mayer	s18 Salazar	s57 Young
s17 Felder	s43 Jordan	s42 Metzger	s10 Sanders	

**IN ASSEMBLY**

**Assembly introducer's signature**

The Members of the Assembly whose names are circled below wish to join me in the  
multi-sponsorship of this proposal:

a049 Abbate	a072 De La Rosa	a029 Hyndman	a144 Norris	a090 Sayegh
a092 Abinanti	a034 DenDekker	a104 Jacobson	a069 O'Donnell	a140 Schimminger
a084 Arroyo	a003 DeStefano	a097 Jaffee	a051 Ortiz	a099 Schmitt
a107 Ashby	a070 Dickens	a011 Jean-Pierre	a091 Otis	a076 Seawright
a035 Aubry	a054 Dilan	a135 Johns	a132 Palmesano	a052 Simon
a120 Barclay	a081 Dinowitz	a115 Jones	a002 Palumbo	a036 Simotas
a030 Barnwell	a147 DiPietro	a077 Joyner	a088 Paulin	a005 Smith
a106 Barrett	a016 D'Urso	a040 Kim	a141 Peoples-	a118 Smullen
a060 Barron	a048 Eichenstein	a131 Kolb	Stokes	a022 Solages
a082 Benedetto	a004 Englebright	a105 Lalor	a058 Perry	a114 Stec
a042 Bichotte	a074 Epstein	a013 Lavine	a023 Pheffer	a110 Steck
a079 Blake	a109 Fahy	a134 Lawrence	Amato	a010 Stern
a117 Blankenbush	a061 Fall	a050 Lentol	a086 Pichardo	a127 Stirpe
a098 Brabenec	a080 Fernandez	a125 Lifton	a089 Pretlow	a102 Tague
a026 Braunstein	a126 Finch	a009 LiPetri	a073 Quart	a071 Taylor
a138 Bronson	a008 Fitzpatrick	a123 Lupardo	a019 Ra	a001 Thiele
a093 Buchwald	a124 Friend	a129 Magnarelli	a012 Raia	a031 Titus
a142 Burke	a046 Frontus	a064 Malliotakis	a006 Ramos	a033 Vanel
a119 Buttenschon	a095 Galef	a130 Manktelow	a018 Raynor	a116 Walczyk
a094 Byrne	a137 Gantt	a108 McDonald	a062 Reilly	a055 Walker
a133 Byrnes	a007 Garbarino	a014 McDonough	a087 Reyes	a143 Wallace
a103 Cahill	a148 Giglio	a146 McMahon	a043 Richardson	a112 Walsh
a044 Carroll	a066 Glick	a017 Mikulin	a078 Rivera	a041 Weinstein
a047 Colton	a150 Goodell	a101 Miller, B.	a068 Rodriguez	a024 Weprin
a032 Cook	a075 Gottfried	a038 Miller, M. G.	a136 Romeo	a059 Williams
a085 Crespo	a021 Griffin	a020 Miller, M. L.	a027 Rosenthal, D.	a113 Woerner
a122 Crouch	a100 Gunther	a015 Montesano	a067 Rosenthal, L.	a056 Wright
a039 Cruz	a139 Hawley	a145 Morinello	a025 Rozic	a096 Zebrowski
a063 Cusick	a083 Heastie	a057 Mosley	a149 Ryan	
a045 Cymbrowitz	a028 Hevesi	a065 Niou	a121 Salka	
a053 Davila	a128 Hunter	a037 Nolan	a111 Santabarbara	

1) Single House Bill (introduced and printed separately in either or  
both houses). Uni-Bill (introduced simultaneously in both houses and printed  
as one bill. Senate and Assembly introducer sign the same copy of the bill).

2) Circle names of co-sponsors and return to introduction clerk with 2  
signed copies of bill and 4 copies of memorandum in support (single house);  
or 4 signed copies of bill and 8 copies of memorandum  
in support (uni-bill).

health law, in relation to extending and enhancing the Medicaid drug cap and to reduce unnecessary pharmacy benefit manager costs to the Medicaid program; 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 supplemental medicaid managed care payments (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 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 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, in relation to eliminating the ability of legally responsible spouses to refuse to support non-institutionalized spouses; to create a

state fiscal intermediary for the consumer directed personal assistance program; and to repeal certain provisions of such law relating thereto (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 to repeal certain provisions of such law relating thereto (Part H); to amend the insurance law, in relation to registration and licensing of pharmacy benefit managers (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); to amend the insurance law, in relation to actuarial value requirements and essential health benefits (Subpart B); to amend the insurance law, in relation to coverage for medically necessary abortions, and exceptions thereto (Subpart C); to amend the insurance law, in relation to prescription drug coverage (Subpart D); to amend the insurance law, in relation to discrimination based on sex and gender identity (Subpart E); and to amend the insurance law, in relation to insurance certificate delivery (Subpart F) (Part J); to amend the public health law, in relation to the medical indemnity fund; and 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); to amend the insurance law, in relation to in-vitro fertilization (Part L); to amend the insurance law and the social services law, in relation to requiring health insurance policies to include coverage of all FDA-approved contraceptive drugs, devices, and products, as well as voluntary sterilization procedures, contraceptive education and counseling, and related follow up services and



prohibiting a health insurance policy from imposing any cost-sharing requirements or other restrictions or delays with respect to this coverage (Part M); to establish a universal access commission to consider the options for achieving universal access to health care (Part N); to amend the public health law, in relation to the general public health work program (Part O); to amend the public health law, in relation to lead levels in residential rental properties (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 (Part Q); to amend the public health law, in relation to maternal mortality review boards and the maternal mortality and morbidity advisory council (Part R); to amend the public health law, in relation to enacting the reproductive health act and revising existing provisions of law regarding abortion; to amend the penal law, the criminal procedure law, the county law and the judiciary law, in relation to abortion; to repeal certain provisions of the public health law relating to abortion; to repeal certain provisions of the education law relating to the sale of contraceptives; and to repeal certain provisions of the penal law relating to abortion (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); to amend the elder law, in relation to the private pay program (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 effec-

tiveness thereof (Part W); to amend the criminal procedure law, in relation to authorizing restorations to competency within correctional facility based residential settings; and providing for the repeal of such provisions upon expiration thereof (Part X); to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to the inclusion and development of certain cost of living adjustments (Part Y); to amend the public health law and the mental hygiene law, in relation to integrated services (Part Z); to amend the social services law, in relation to the definition of a facility or a provider agency (Part AA); and to amend the insurance law, in relation to mental health and substance use disorder health insurance parity; to amend the public health law, in relation to health maintenance organizations; and to repeal certain provisions of the insurance law relating thereto (Subpart A); to amend the public health law, in relation to general hospital policies for substance use disorder treatment (Subpart B); to repeal subparagraph (v) of paragraph (a) of subdivision 2 of section 3343-a of the public health law relating to general hospital prescription drug monitoring (Subpart C); to amend the social services law, in relation to court ordered substance use disorder treatment (Subpart D); and to amend the public health law, in relation to including fentanyl analogs as controlled substances (Subpart E) (Part BB)

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 BB. 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

1 authority under section forty-four hundred three-f of the public health  
2 law] a program designated as a Program of All-Inclusive Care for the  
3 Elderly (PACE) as authorized by Federal Public law 105-33, subtitle I of  
4 title IV of the Balanced Budget Act of 1997. Any transportation manager  
5 or managers selected by the commissioner to manage transportation  
6 services shall have proven experience in coordinating transportation  
7 services in a geographic and demographic area similar to the area in New  
8 York state within which the contractor would manage the provision of  
9 services under this section. Such a contract or contracts may include  
10 responsibility for: review, approval and processing of transportation  
11 orders; management of the appropriate level of transportation based on  
12 documented patient medical need; and development of new technologies  
13 leading to efficient transportation services. If the commissioner elects  
14 to assume such responsibility from a local social services district, the  
15 commissioner shall examine and, if appropriate, adopt quality assurance  
16 measures that may include, but are not limited to, global positioning  
17 tracking system reporting requirements and service verification mech-  
18 anisms. Any and all reimbursement rates developed by transportation  
19 managers under this subdivision shall be subject to the review and  
20 approval of the commissioner.

21 § 2. The opening paragraph of subdivision 1 and subdivision 3 of  
22 section 367-s of the social services law, as amended by section 53 of  
23 part B of chapter 57 of the laws of 2015, are amended to read as  
24 follows:

25 Notwithstanding any provision of law to the contrary, a supplemental  
26 medical assistance payment shall be made on an annual basis to providers  
27 of emergency medical transportation services in an aggregate amount not  
28 to exceed four million dollars for two thousand six, six million dollars

1 for two thousand seven, six million dollars for two thousand eight, six  
2 million dollars for the period May first, two thousand fourteen through  
3 March thirty-first, two thousand fifteen, and six million dollars [annu-  
4 ally beginning with] on an annual basis for the period April first, two  
5 thousand fifteen through March thirty-first, two thousand [sixteen]  
6 nineteen pursuant to the following methodology:

7 3. If all necessary approvals under federal law and regulation are not  
8 obtained to receive federal financial participation in the payments  
9 authorized by this section, payments under this section shall be made in  
10 an aggregate amount not to exceed two million dollars for two thousand  
11 six, three million dollars for two thousand seven, three million dollars  
12 for two thousand eight, three million dollars for the period May first,  
13 two thousand fourteen through March thirty-first, two thousand fifteen,  
14 and three million dollars [annually beginning with] on an annual basis  
15 for the period April first, two thousand fifteen through March thirty-  
16 first, two thousand [sixteen] nineteen. In such case, the multiplier  
17 set forth in paragraph (b) of subdivision one of this section shall be  
18 deemed to be two million dollars or three million dollars as applicable  
19 to the annual period.

20 § 3. Subdivision 5 of section 365-h of the social services law is  
21 REPEALED.

22 § 4. This act shall take effect immediately and shall be deemed to  
23 have been in full force and effect on and after April 1, 2019; provided,  
24 however, that section one of this act shall take effect October 1, 2019;  
25 provided, further that the amendments to subdivision 4 of section 365-h  
26 of the social services law made by section one of this act shall not  
27 affect the repeal of such section and shall expire and be deemed  
28 repealed therewith.

1

## PART B

2 Section 1. Paragraph (a) of subdivision 4 of section 365-a of the  
3 social services law, as amended by chapter 493 of the laws of 2010, is  
4 amended to read as follows:

5 (a) drugs which may be dispensed without a prescription as required by  
6 section sixty-eight hundred ten of the education law; provided, however,  
7 that the state commissioner of health may by regulation specify certain  
8 of such drugs which may be reimbursed as an item of medical assistance  
9 in accordance with the price schedule established by such commissioner.  
10 Notwithstanding any other provision of law, [additions] modifications to  
11 the list of drugs reimbursable under this paragraph may be filed as  
12 regulations by the commissioner of health without prior notice and  
13 comment;

14 § 2. Paragraph (c) of subdivision 6 of section 367-a of the social  
15 services law is amended by adding a new subparagraph (v) to read as  
16 follows:

17 (v) Notwithstanding any other provision of this paragraph, co-payments  
18 charged for drugs dispensed without a prescription as required by  
19 section sixty-eight hundred ten of the education law but which are reim-  
20 bursed as an item of medical assistance pursuant to paragraph (a) of  
21 subdivision four of section three hundred sixty-five-a of this title  
22 shall be one dollar.

23 § 3. Paragraph (b) of subdivision 3 of section 273 of the public  
24 health law, as added by section 10 of part C of chapter 58 of the laws  
25 of 2005, is amended to read as follows:

26 (b) In the event that the patient does not meet the criteria in para-  
27 graph (a) of this subdivision, the prescriber may provide additional

1 information to the program to justify the use of a prescription drug  
2 that is not on the preferred drug list. The program shall provide a  
3 reasonable opportunity for a prescriber to reasonably present his or her  
4 justification of prior authorization. [If, after consultation with the  
5 program, the prescriber, in his or her reasonable professional judgment,  
6 determines that the use of a prescription drug that is not on the  
7 preferred drug list is warranted, the prescriber's determination shall  
8 be final.] The program will consider the additional information and the  
9 justification presented to determine whether the use of a prescription  
10 drug that is not on the preferred drug list is warranted.

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

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

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

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

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

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

4 3. The department and the division of the budget shall assess on a  
5 quarterly basis the projected total amount to be expended in the year on  
6 a cash basis by the Medicaid program for each drug, and the projected  
7 annual amount of state funds Medicaid drug expenditures on a cash basis  
8 for all drugs, which shall be a component of the projected department of  
9 health state funds Medicaid expenditures calculated for purposes of  
10 sections ninety-one and ninety-two of part H of chapter fifty-nine of  
11 the laws of two thousand eleven. For purposes of this section, state  
12 funds Medicaid drug expenditures include amounts expended for drugs in  
13 both the Medicaid fee-for-service program and Medicaid managed care  
14 programs, minus the amount of any drug rebates or supplemental drug  
15 rebates received by the department, including rebates pursuant to subdi-  
16 vision five of this section with respect to rebate targets. [The depart-  
17 ment and the division of the budget shall report quarterly to the drug  
18 utilization review board the projected state funds Medicaid drug expend-  
19 itures including the amounts, in aggregate thereof, attributable to the  
20 net cost of: changes in the utilization of drugs by Medicaid recipients;  
21 changes in the number of Medicaid recipients; changes to the cost of  
22 brand name drugs and changes to the cost of generic drugs. The informa-  
23 tion contained in the report shall not be publicly released in a manner  
24 that allows for the identification of an individual drug or manufacturer  
25 or that is likely to compromise the financial competitive, or proprie-  
26 tary nature of the information.]

27 (a) In the event the director of the budget determines, based on Medi-  
28 caid drug expenditures for the previous quarter or other relevant infor-



1 mation, that the total department of health state funds Medicaid drug  
2 expenditure is projected to exceed the annual growth limitation imposed  
3 by subdivision two of this section, the commissioner may identify and  
4 refer drugs to the drug utilization review board established by section  
5 three hundred sixty-nine-bb of the social services law for a recommenda-  
6 tion as to whether a target supplemental Medicaid rebate should be paid  
7 by the manufacturer of the drug to the department and the target amount  
8 of the rebate.

9 (b) If the department intends to refer a drug to the drug utilization  
10 review board pursuant to paragraph (a) of this subdivision, the depart-  
11 ment shall notify the manufacturer of such drug and shall attempt to  
12 reach agreement with the manufacturer on a rebate for the drug prior to  
13 referring the drug to the drug utilization review board for review.  
14 Such rebate may be based on evidence-based research, including, but not  
15 limited to, such research operated or conducted by or for other state  
16 governments, the federal government, the governments of other nations,  
17 and third party payers or multi-state coalitions.

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

25 (d)] The department shall consider a drug's actual cost to the state,  
26 including current rebate amounts, prior to seeking an additional rebate  
27 pursuant to paragraph (b) [or (c)] of this subdivision [and shall take  
28 into consideration whether the manufacturer of the drug is providing

1 significant discounts relative to other drugs covered by the Medicaid  
2 program].

3 [(e)] (d) The commissioner shall be authorized to take the actions  
4 described in this section only so long as total Medicaid drug expendi-  
5 tures are projected to exceed the annual growth limitation imposed by  
6 subdivision two of this section.

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

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

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

23 (a) If, after taking into account all rebates and supplemental rebates  
24 received by the department, including rebates received to date pursuant  
25 to this section, total Medicaid drug expenditures are still projected to  
26 exceed the annual growth limitation imposed by subdivision two of this  
27 section, the commissioner may: subject any drug of a manufacturer  
28 referred to the drug utilization review board under this section to

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

19 § 9. Subdivision 8 of section 280 of the public health law, as added  
20 by section 8 of part D of chapter 57 of the laws of 2018, is amended to  
21 read as follows:

22 8. The commissioner shall report by [February] July first annually to  
23 the drug utilization review board on savings achieved through the drug  
24 cap in the last fiscal year. Such report shall provide data on what  
25 savings were achieved through actions pursuant to subdivisions three,  
26 five and seven of this section, respectively, and what savings were  
27 achieved through other means and how such savings were calculated and  
28 implemented.

1     § 10. Section 4406-c of the public health law is amended by adding a  
2 new subdivision 10 to read as follows:

3     10. (a) Any contract or other arrangement entered into by a health  
4 care plan for pharmacy benefit management services on behalf of individ-  
5 uals enrolled in a managed care provider as defined in section three  
6 hundred sixty-four-j of the social services law shall include provisions  
7 that ensure the following:

8     (i) Payment to the pharmacy benefit manager for pharmacy benefit  
9 management services is limited to the actual ingredient costs, a  
10 dispensing fee, and an administrative fee for each claim processed. The  
11 department of health may establish a maximum administrative fee;

12     (ii) The pharmacy benefit manager identifies all sources of income  
13 related to the provision of pharmacy benefit management services on  
14 behalf of the health care plan, including, but not limited to, any  
15 discounts or supplemental rebates, and that any portion of such income  
16 is passed through to the health care plan in full to reduce the report-  
17 able ingredient cost; and

18     (iii) The pharmacy benefit manager shall not retain any portion of  
19 spread pricing. For purposes of this subdivision "spread pricing" means  
20 any amount charged or claimed by the pharmacy benefit manager in excess  
21 of the amount paid to pharmacies on behalf of the health care plan less  
22 an administrative fee as described in this paragraph. Any such excess  
23 amount shall be remitted to the health care plan on a quarterly basis.

24     (b) The commissioner may promulgate regulations as necessary to estab-  
25 lish additional standards for contracts or other arrangements related to  
26 the services described in this subdivision.

27     § 11. Health care plans subject to subdivision 10 of section 4406-c of  
28 the public health law, as added by section ten of this act, shall

1 provide evidence of compliance with such section to the department of  
2 health, and in a manner and form determined by the department of health,  
3 within 90 days and again within 180 days of the effective date of this  
4 act. The department of health shall take no enforcement action with  
5 regards to the requirements of subdivision 10 of section 4406-c of the  
6 public health law, as added by section ten of this act, prior to the  
7 passage of 180 days from the effective date of this act, nor shall  
8 enforcement action be taken related to any non-compliance occurring  
9 prior to the passage of the same 180 days.

10 § 12. This act shall take effect immediately and shall be deemed to  
11 have been in full force and effect on and after April 1, 2019; provided,  
12 however, that sections one and two of this act shall take effect July 1,  
13 2019; and provided further, however, that the amendments to paragraph  
14 (c) of subdivision 6 of section 367-a of the social services law made by  
15 section two of this act shall not affect the repeal of such paragraph  
16 and shall be deemed repealed therewith.

17 PART C

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

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

24 § 2. Subparagraph (ii) of paragraph (d) of subdivision 1 of section  
25 367-a of the social services law, as amended by section 1 of part J1 of  
26 chapter 63 of the laws of 2003, is amended to read as follows:

1 (ii) Amounts payable under this title for medical assistance for items  
2 and services provided to eligible persons who are also beneficiaries  
3 under part B of title XVIII of the federal social security act and items  
4 and services provided to qualified medicare beneficiaries under part B  
5 of title XVIII of the federal social security act shall not [be less  
6 than the amount of any deductible liability of such eligible persons or  
7 for which such eligible persons or such qualified medicare beneficiaries  
8 would be liable under federal law were they not eligible for medical  
9 assistance or were they not qualified medicare beneficiaries with  
10 respect to such benefits under such part B.] exceed the amount that  
11 otherwise would be made under this title if provided to an eligible  
12 person other than a person who is also a beneficiary under part B or is  
13 a qualified medicare beneficiary minus the amount payable under part B.

14 § 3. Subparagraph (iii) of paragraph (d) of subdivision 1 of section  
15 367-a of the social services law, as amended by section 31 of part B of  
16 chapter 57 of the laws of 2015, is amended to read as follows:

17 (iii) With respect to items and services provided to eligible persons  
18 who are also beneficiaries under part B of title XVIII of the federal  
19 social security act and items and services provided to qualified medi-  
20 care beneficiaries under part B of title XVIII of the federal social  
21 security act, the amount payable for services covered under this title  
22 shall be the amount of any co-insurance liability of such eligible  
23 persons pursuant to federal law were they not eligible for medical  
24 assistance or were they not qualified medicare beneficiaries with  
25 respect to such benefits under such part B, but shall not exceed the  
26 amount that otherwise would be made under this title if provided to an  
27 eligible person other than a person who is also a beneficiary under part  
28 B or is a qualified medicare beneficiary minus the amount payable under

1 part B; provided, however, amounts payable under this title for items  
2 and services provided to eligible persons who are also beneficiaries  
3 under part B or to qualified medicare beneficiaries by [an ambulance  
4 service under the authority of an operating certificate issued pursuant  
5 to article thirty of the public health law, a psychologist licensed  
6 under article one hundred fifty-three of the education law, or] a facil-  
7 ity under the authority of an operating certificate issued pursuant to  
8 article sixteen, thirty-one or thirty-two of the mental hygiene law and  
9 with respect to outpatient hospital and clinic items and services  
10 provided by a facility under the authority of an operating certificate  
11 issued pursuant to article twenty-eight of the public health law, shall  
12 not be less than the amount of any co-insurance liability of such eligi-  
13 ble persons or such qualified medicare beneficiaries, or for which such  
14 eligible persons or such qualified medicare beneficiaries would be  
15 liable under federal law were they not eligible for medical assistance  
16 or were they not qualified medicare beneficiaries with respect to such  
17 benefits under part B.

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

19 PART D

20 Section 1. Subdivision 1 of section 92 of part H of chapter 59 of the  
21 laws of 2011, amending the public health law and other laws relating to  
22 known and projected department of health state fund medicaid expendi-  
23 tures, as amended by section 2 of part K of chapter 57 of the laws of  
24 2018, is amended to read as follows:

25 1. For state fiscal years 2011-12 through [2019-20] 2020-2021, the  
26 director of the budget, in consultation with the commissioner of health

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

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



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

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

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

13 p. the amendments [made] to subparagraph [(7)] 7 of paragraph (b) of  
14 subdivision 1 of section 366 of the social services law made by section  
15 one of this act shall expire and be deemed repealed October 1, [2019]  
16 2024.

17 § 3. Section 11 of chapter 884 of the laws of 1990, amending the  
18 public health law relating to authorizing bad debt and charity care  
19 allowances for certified home health agencies, as amended by section 1  
20 of part I of chapter 57 of the laws of 2017, is amended to read as  
21 follows:

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

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

24 (b) sections four through ten shall expire on June 30, [2019] 2024,  
25 and

26 (c) provided that the amendment to section 2807-b of the public health  
27 law by section two of this act shall not affect the expiration of such

1 section 2807-b as otherwise provided by law and shall be deemed to  
2 expire therewith.

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

7 § 3. This act shall take effect immediately, provided, however, that  
8 subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of  
9 1973, as added by section one of this act, shall expire and be deemed  
10 repealed June 30, [2019] 2024; and provided further, however, that the  
11 expiration and repeal of such subdivision 15-a shall not affect or  
12 impair in any manner any health facilities bonds issued, or any lease or  
13 purchase of a health facility executed, pursuant to such subdivision  
14 15-a prior to its expiration and repeal and that, with respect to any  
15 such bonds issued and outstanding as of June 30, [2019] 2024, the  
16 provisions of such subdivision 15-a as they existed immediately prior to  
17 such expiration and repeal shall continue to apply through the latest  
18 maturity date of any such bonds, or their earlier retirement or redemp-  
19 tion, for the sole purpose of authorizing the issuance of refunding  
20 bonds to refund bonds previously issued pursuant thereto.

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

25 (a) sections two, three, three-a, three-b, three-c, three-d, three-e  
26 and twenty-one of this act shall take effect July 1, 2010; sections  
27 fifteen, sixteen, seventeen, eighteen and nineteen of this act shall  
28 take effect January 1, 2011; and provided further that section twenty of

1 this act shall be deemed repealed [eight] thirteen years after the date  
2 the contract entered into pursuant to section 365-h of the social  
3 services law, as amended by section twenty of this act, is executed;  
4 provided that the commissioner of health shall notify the legislative  
5 bill drafting commission upon the execution of the contract entered into  
6 pursuant to section 367-h of the social services law in order that the  
7 commission may maintain an accurate and timely effective data base of  
8 the official text of the laws of the state of New York in furtherance of  
9 effectuating the provisions of section 44 of the legislative law and  
10 section 70-b of the public officers law;

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

16 (f) section twenty-five of this act shall expire and be deemed  
17 repealed April 1, [2019] 2024;

18 § 7. Subdivision (c) of section 122 of part E of chapter 56 of the  
19 laws of 2013 amending the public health law relating to the general  
20 public health work program, as amended by section 5 of part D of chapter  
21 59 of the laws of 2016, is amended to read as follows:

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

24 § 8. Subdivision (i) of section 111 of part H of chapter 59 of the  
25 laws of 2011, amending the public health law and other laws relating to  
26 known and projected department of health state fund medical expendi-  
27 tures, as amended by section 19 of part D of chapter 57 of the laws of  
28 2015, is amended to read as follows:

1 (i) the amendments to paragraph (b) and subparagraph (i) of paragraph  
2 (g) of subdivision 7 of section 4403-f of the public health law made by  
3 section forty-one-b of this act shall expire and be repealed April 1,  
4 [2019] 2024;

5 § 9. Subparagraph (vi) of paragraph (b) of subdivision 2 of section  
6 2807-d of the public health law, as amended by section 3 of part I of  
7 chapter 57 of the laws of 2017, is amended to read as follows:

8 (vi) Notwithstanding any contrary provision of this paragraph or any  
9 other provision of law or regulation to the contrary, for residential  
10 health care facilities the assessment shall be six percent of each resi-  
11 dential health care facility's gross receipts received from all patient  
12 care services and other operating income on a cash basis for the period  
13 April first, two thousand two through March thirty-first, two thousand  
14 three for hospital or health-related services, including adult day  
15 services; provided, however, that residential health care facilities'  
16 gross receipts attributable to payments received pursuant to title XVIII  
17 of the federal social security act (medicare) shall be excluded from the  
18 assessment; provided, however, that for all such gross receipts received  
19 on or after April first, two thousand three through March thirty-first,  
20 two thousand five, such assessment shall be five percent, and further  
21 provided that for all such gross receipts received on or after April  
22 first, two thousand five through March thirty-first, two thousand nine,  
23 and on or after April first, two thousand nine through March thirty-  
24 first, two thousand eleven such assessment shall be six percent, and  
25 further provided that for all such gross receipts received on or after  
26 April first, two thousand eleven through March thirty-first, two thou-  
27 sand thirteen such assessment shall be six percent, and further provided  
28 that for all such gross receipts received on or after April first, two

1 thousand thirteen through March thirty-first, two thousand fifteen such  
2 assessment shall be six percent, and further provided that for all such  
3 gross receipts received on or after April first, two thousand fifteen  
4 through March thirty-first, two thousand seventeen such assessment shall  
5 be six percent, and further provided that for all such gross receipts  
6 received on or after April first, two thousand seventeen through March  
7 thirty-first, two thousand nineteen such assessment shall be six  
8 percent, and further provided that for all such gross receipts received  
9 on or after April first, two thousand nineteen through March thirty-  
10 first, two thousand twenty-four such assessment shall be six percent.

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

15 1. Notwithstanding any inconsistent provision of law or regulation,  
16 the trend factors used to project reimbursable operating costs to the  
17 rate period for purposes of determining rates of payment pursuant to  
18 article 28 of the public health law for residential health care facili-  
19 ties for reimbursement of inpatient services provided to patients eligi-  
20 ble for payments made by state governmental agencies on and after April  
21 1, 1996 through March 31, 1999 and for payments made on and after July  
22 1, 1999 through March 31, 2000 and on and after April 1, 2000 through  
23 March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and  
24 on and after April 1, 2007 through March 31, 2009 and on and after April  
25 1, 2009 through March 31, 2011 and on and after April 1, 2011 through  
26 March 31, 2013 and on and after April 1, 2013 through March 31, 2015,  
27 and on and after April 1, 2015 through March 31, 2017, and on and after  
28 April 1, 2017 through March 31, 2019, and on and after April 1, 2019

1 through March 31, 2024 shall reflect no trend factor projections or  
2 adjustments for the period April 1, 1996, through March 31, 1997.

3 § 11. Subdivision 1 of section 89-a of part C of chapter 58 of the  
4 laws of 2007, amending the social services law and other laws relating  
5 to enacting the major components of legislation necessary to implement  
6 the health and mental hygiene budget for the 2007-2008 state fiscal  
7 year, as amended by section 5 of part I of chapter 57 of the laws of  
8 2017, is amended to read as follows:

9 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c  
10 of the public health law and section 21 of chapter 1 of the laws of  
11 1999, as amended, and any other inconsistent provision of law or regu-  
12 lation to the contrary, in determining rates of payments by state  
13 governmental agencies effective for services provided beginning April 1,  
14 2006, through March 31, 2009, and on and after April 1, 2009 through  
15 March 31, 2011, and on and after April 1, 2011 through March 31, 2013,  
16 and on and after April 1, 2013 through March 31, 2015, and on and after  
17 April 1, 2015 through March 31, 2017, and on and after April 1, 2017  
18 through March 31, 2019, and on and after April 1, 2019 through March 31,  
19 2024 for inpatient and outpatient services provided by general hospitals  
20 and for inpatient services and outpatient adult day health care services  
21 provided by residential health care facilities pursuant to article 28 of  
22 the public health law, the commissioner of health shall apply a trend  
23 factor projection of two and twenty-five hundredths percent attributable  
24 to the period January 1, 2006 through December 31, 2006, and on and  
25 after January 1, 2007, provided, however, that on reconciliation of such  
26 trend factor for the period January 1, 2006 through December 31, 2006  
27 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the  
28 public health law, such trend factor shall be the final US Consumer

1 Price Index (CPI) for all urban consumers, as published by the US  
2 Department of Labor, Bureau of Labor Statistics less twenty-five  
3 hundredths of a percentage point.

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

8 5-a. Section sixty-four-a of this act shall be deemed to have been in  
9 full force and effect on and after April 1, 1995 through March 31, 1999  
10 and on and after July 1, 1999 through March 31, 2000 and on and after  
11 April 1, 2000 through March 31, 2003 and on and after April 1, 2003  
12 through March 31, 2007, and on and after April 1, 2007 through March 31,  
13 2009, and on and after April 1, 2009 through March 31, 2011, and on and  
14 after April 1, 2011 through March 31, 2013, and on and after April 1,  
15 2013 through March 31, 2015, and on and after April 1, 2015 through  
16 March 31, 2017 and on and after April 1, 2017 through March 31, 2019,  
17 and on and after April 1, 2019 through March 31, 2024;

18 § 13. Section 64-b of chapter 81 of the laws of 1995, amending the  
19 public health law and other laws relating to medical reimbursement and  
20 welfare reform, as amended by section 7 of part I of chapter 57 of the  
21 laws of 2017, is amended to read as follows:

22 § 64-b. Notwithstanding any inconsistent provision of law, the  
23 provisions of subdivision 7 of section 3614 of the public health law, as  
24 amended, shall remain and be in full force and effect on April 1, 1995  
25 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on  
26 and after April 1, 2000 through March 31, 2003 and on and after April 1,  
27 2003 through March 31, 2007, and on and after April 1, 2007 through  
28 March 31, 2009, and on and after April 1, 2009 through March 31, 2011,

1 and on and after April 1, 2011 through March 31, 2013, and on and after  
2 April 1, 2013 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, 2024.

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

10 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section  
11 2807-c of the public health law, section 21 of chapter 1 of the laws of  
12 1999, or any other contrary provision of law, in determining rates of  
13 payments by state governmental agencies effective for services provided  
14 on and after January 1, 2017 through March 31, [2019] 2024, for inpa-  
15 tient and outpatient services provided by general hospitals, for inpa-  
16 tient services and adult day health care outpatient services provided by  
17 residential health care facilities pursuant to article 28 of the public  
18 health law, except for residential health care facilities or units of  
19 such facilities providing services primarily to children under twenty-  
20 one years of age, for home health care services provided pursuant to  
21 article 36 of the public health law by certified home health agencies,  
22 long term home health care programs and AIDS home care programs, and for  
23 personal care services provided pursuant to section 365-a of the social  
24 services law, the commissioner of health shall apply no greater than  
25 zero trend factors attributable to the 2017, 2018, [and] 2019, 2020,  
26 2021, 2022, and 2023 calendar years in accordance with paragraph (c) of  
27 subdivision 10 of section 2807-c of the public health law, provided,  
28 however, that such no greater than zero trend factors attributable to



1 such 2017, 2018, [and] 2019, 2020, 2021, 2022, and 2023 calendar years  
2 shall also be applied to rates of payment provided on and after January  
3 1, 2017 through March 31, [2019] 2024 for personal care services  
4 provided in those local social services districts, including New York  
5 city, whose rates of payment for such services are established by such  
6 local social services districts pursuant to a rate-setting exemption  
7 issued by the commissioner of health to such local social services  
8 districts in accordance with applicable regulations; and provided  
9 further, however, that for rates of payment for assisted living program  
10 services provided on and after January 1, 2017 through March 31, [2019]  
11 2024, such trend factors attributable to the 2017, 2018, [and] 2019,  
12 2020, 2021, 2022, and 2023 calendar years shall be established at no  
13 greater than zero percent.

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

17 (b) Notwithstanding any inconsistent provision of law or regulation to  
18 the contrary, for the state fiscal years beginning April first, two  
19 thousand ten and ending March thirty-first, two thousand [nineteen]  
20 twenty-four, the commissioner shall not be required to revise certified  
21 rates of payment established pursuant to this article for rate periods  
22 prior to April first, two thousand [nineteen] twenty-four, based on  
23 consideration of rate appeals filed by residential health care facili-  
24 ties or based upon adjustments to capital cost reimbursement as a result  
25 of approval by the commissioner of an application for construction under  
26 section twenty-eight hundred two of this article, in excess of an aggre-  
27 gate annual amount of eighty million dollars for each such state fiscal  
28 year provided, however, that for the period April first, two thousand

1 eleven through March thirty-first, two thousand twelve such aggregate  
2 annual amount shall be fifty million dollars. In revising such rates  
3 within such fiscal limit, the commissioner shall, in prioritizing such  
4 rate appeals, include consideration of which facilities the commissioner  
5 determines are facing significant financial hardship as well as such  
6 other considerations as the commissioner deems appropriate and, further,  
7 the commissioner is authorized to enter into agreements with such facil-  
8 ities or any other facility to resolve multiple pending rate appeals  
9 based upon a negotiated aggregate amount and may offset such negotiated  
10 aggregate amounts against any amounts owed by the facility to the  
11 department, including, but not limited to, amounts owed pursuant to  
12 section twenty-eight hundred seven-d of this article; provided, however,  
13 that the commissioner's authority to negotiate such agreements resolving  
14 multiple pending rate appeals as hereinbefore described shall continue  
15 on and after April first, two thousand [nineteen] twenty-four. Rate  
16 adjustments made pursuant to this paragraph remain fully subject to  
17 approval by the director of the budget in accordance with the provisions  
18 of subdivision two of section twenty-eight hundred seven of this arti-  
19 cle.

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

23 (a) Notwithstanding any inconsistent provision of law or regulation  
24 and subject to the availability of federal financial participation,  
25 effective April first, two thousand twelve through March thirty-first,  
26 two thousand [nineteen] twenty-four, payments by government agencies for  
27 services provided by certified home health agencies, except for such  
28 services provided to children under eighteen years of age and other

1 discreet groups as may be determined by the commissioner pursuant to  
2 regulations, shall be based on episodic payments. In establishing such  
3 payments, a statewide base price shall be established for each sixty day  
4 episode of care and adjusted by a regional wage index factor and an  
5 individual patient case mix index. Such episodic payments may be further  
6 adjusted for low utilization cases and to reflect a percentage limita-  
7 tion of the cost for high-utilization cases that exceed outlier thresh-  
8 olds of such payments.

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

13 2. Sections five, seven through nine, twelve through fourteen, and  
14 eighteen of this act shall be deemed to have been in full force and  
15 effect on and after April 1, 1995 through March 31, 1999 and on and  
16 after July 1, 1999 through March 31, 2000 and on and after April 1, 2000  
17 through March 31, 2003 and on and after April 1, 2003 through March 31,  
18 2006 and on and after April 1, 2006 through March 31, 2007 and on and  
19 after April 1, 2007 through March 31, 2009 and on and after April 1,  
20 2009 through March 31, 2011 and sections twelve, thirteen and fourteen  
21 of this act shall be deemed to be in full force and effect on and after  
22 April 1, 2011 through March 31, 2015 and on and after April 1, 2015  
23 through March 31, 2017 and on and after April 1, 2017 through March 31,  
24 2019, and on and after April 1, 2019 through March 31, 2024;

25 § 18. Section 48-a of part A of chapter 56 of the laws of 2013 amend-  
26 ing chapter 59 of the laws of 2011 amending the public health law and  
27 other laws relating to general hospital reimbursement for annual rates,

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

3 § 48-a. 1. Notwithstanding any contrary provision of law, the commis-  
4 sioners of the office of alcoholism and substance abuse services and the  
5 office of mental health are authorized, subject to the approval of the  
6 director of the budget, to transfer to the commissioner of health state  
7 funds to be utilized as the state share for the purpose of increasing  
8 payments under the medicaid program to managed care organizations  
9 licensed under article 44 of the public health law or under article 43  
10 of the insurance law. Such managed care organizations shall utilize such  
11 funds for the purpose of reimbursing providers licensed pursuant to  
12 article 28 of the public health law or article 31 or 32 of the mental  
13 hygiene law for ambulatory behavioral health services, as determined by  
14 the commissioner of health, in consultation with the commissioner of  
15 alcoholism and substance abuse services and the commissioner of the  
16 office of mental health, provided to medicaid enrolled outpatients and  
17 for all other behavioral health services except inpatient included in  
18 New York state's Medicaid redesign waiver approved by the centers for  
19 medicare and Medicaid services (CMS). Such reimbursement shall be in  
20 the form of fees for such services which are equivalent to the payments  
21 established for such services under the ambulatory patient group (APG)  
22 rate-setting methodology as utilized by the department of health, the  
23 office of alcoholism and substance abuse services, or the office of  
24 mental health for rate-setting purposes or any such other fees pursuant  
25 to the Medicaid state plan or otherwise approved by CMS in the Medicaid  
26 redesign waiver; provided, however, that the increase to such fees that  
27 shall result from the provisions of this section shall not, in the  
28 aggregate and as determined by the commissioner of health, in consulta-

tion with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [29] 1 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2022 for patients in the city of New York, for all rate periods on and after the effective date of section [29] 1 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through [March 31, 2020] March 31, 2022 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through [March 31, 2020] March 31, 2022 for all services provided to persons under the age of twenty-one; provided, however, the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, may require, as a condition of approval of such ambulatory behavioral health fees, that aggregate managed care expenditures to eligible providers meet the alternative payment methodology requirements as set forth in attachment I of the New York state medicaid section one thousand one hundred fifteen medicaid redesign team waiver as approved by the centers for medicare and medicaid services. The commissioner of health shall, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of mental health, waive such conditions if a sufficient number of providers, as determined by the commissioner, suffer a financial hardship as a consequence of such alternative payment methodology requirements, or if he or she shall determine that such alternative payment methodologies significantly threaten individuals access to ambulatory behavioral health

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

18 2. Notwithstanding any contrary provision of law, the fees paid by  
19 managed care organizations licensed under article 44 of the public  
20 health law or under article 43 of the insurance law, to providers  
21 licensed pursuant to article 28 of the public health law or article 31  
22 or 32 of the mental hygiene law, for ambulatory behavioral health  
23 services provided to patients enrolled in the child health insurance  
24 program pursuant to title [one-A] 1-A of article 25 of the public health  
25 law, shall be in the form of fees for such services which are equivalent  
26 to the payments established for such services under the ambulatory  
27 patient group (APG) rate-setting methodology or any such other fees  
28 established pursuant to the Medicaid state plan. The commissioner of

1 health shall consult with the commissioner of alcoholism and substance  
2 abuse services and the commissioner of the office of mental health in  
3 determining such services and establishing such fees. Such ambulatory  
4 behavioral health fees to providers available under this section shall  
5 be for all rate periods on and after the effective date of this chapter  
6 through [March 31, 2020] March 31, 2022, provided, however, that managed  
7 care organizations and providers may negotiate different rates and meth-  
8 ods of payment during such periods described above, subject to the  
9 approval of the department of health. The department of health shall  
10 consult with the office of alcoholism and substance abuse services and  
11 the office of mental health in determining whether such alternative  
12 rates shall be approved. The report required under section 16-a of part  
13 C of chapter 60 of the laws of 2014 shall also include the population of  
14 patients enrolled in the child health insurance program pursuant to  
15 title [one-A] 1-A of article 25 of the public health law in its examina-  
16 tion on the transition of behavioral health services into managed care.

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

22 Section 1. a. Notwithstanding any contrary provision of law, the  
23 commissioners of mental health and alcoholism and substance abuse  
24 services are authorized, subject to the approval of the director of the  
25 budget, to transfer to the commissioner of health state funds to be  
26 utilized as the state share for the purpose of increasing payments under  
27 the medicaid program to managed care organizations licensed under arti-  
28 cle 44 of the public health law or under article 43 of the insurance

1 law. Such managed care organizations shall utilize such funds for the  
2 purpose of reimbursing providers licensed pursuant to article 28 of the  
3 public health law, or pursuant to article 31 or article 32 of the mental  
4 hygiene law for ambulatory behavioral health services, as determined by  
5 the commissioner of health in consultation with the commissioner of  
6 mental health and commissioner of alcoholism and substance abuse  
7 services, provided to medicaid enrolled outpatients and for all other  
8 behavioral health services except inpatient included in New York state's  
9 Medicaid redesign waiver approved by the centers for medicare and Medi-  
10 caid services (CMS). Such reimbursement shall be in the form of fees for  
11 such services which are equivalent to the payments established for such  
12 services under the ambulatory patient group (APG) rate-setting methodol-  
13 ogy as utilized by the department of health or by the office of mental  
14 health or office of alcoholism and substance abuse services for rate-  
15 setting purposes or any such other fees pursuant to the Medicaid state  
16 plan or otherwise approved by CMS in the Medicaid redesign waiver;  
17 provided, however, that the increase to such fees that shall result from  
18 the provisions of this section shall not, in the aggregate and as deter-  
19 mined by the commissioner of health in consultation with the commission-  
20 ers of mental health and alcoholism and substance abuse services, be  
21 greater than the increased funds made available pursuant to this  
22 section. The increase of such behavioral health fees to providers avail-  
23 able under this section shall be for all rate periods on and after the  
24 effective date of section [30] 2 of part [B] P of chapter [59] 57 of the  
25 laws of [2016] 2017 through March 31, [2020] 2022 for patients in the  
26 city of New York, for all rate periods on and after the effective date  
27 of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016]  
28 2017 through March 31, [2020] 2022 for patients outside the city of New



1 York, and for all rate periods on and after the effective date of  
2 section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016]  
3 2017 through March 31, [2020] 2022 for all services provided to persons  
4 under the age of twenty-one; provided, however, the commissioner of  
5 health, in consultation with the commissioner of alcoholism and  
6 substance abuse services and the commissioner of mental health, may  
7 require, as a condition of approval of such ambulatory behavioral health  
8 fees, that aggregate managed care expenditures to eligible providers  
9 meet the alternative payment methodology requirements as set forth in  
10 attachment I of the New York state medicaid section one thousand one  
11 hundred fifteen medicaid redesign team waiver as approved by the centers  
12 for medicare and medicaid services. The commissioner of health shall, in  
13 consultation with the commissioner of alcoholism and substance abuse  
14 services and the commissioner of mental health, waive such conditions if  
15 a sufficient number of providers, as determined by the commissioner,  
16 suffer a financial hardship as a consequence of such alternative payment  
17 methodology requirements, or if he or she shall determine that such  
18 alternative payment methodologies significantly threaten individuals  
19 access to ambulatory behavioral health services. Such waiver may be  
20 applied on a provider specific or industry wide basis. Further, such  
21 conditions may be waived, as the commissioner determines necessary, to  
22 comply with federal rules or regulations governing these payment method-  
23 ologies. Nothing in this section shall prohibit managed care organiza-  
24 tions and providers from negotiating different rates and methods of  
25 payment during such periods described, subject to the approval of the  
26 department of health. The department of health shall consult with the  
27 office of alcoholism and substance abuse services and the office of  
28 mental health in determining whether such alternative rates shall be

1 approved. The commissioner of health may, in consultation with the  
2 commissioners of mental health and alcoholism and substance abuse  
3 services, promulgate regulations, including emergency regulations  
4 promulgated prior to October 1, 2013 that establish rates for behavioral  
5 health services, as are necessary to implement the provisions of this  
6 section. Rates promulgated under this section shall be included in the  
7 report required under section 45-c of part A of chapter 56 of the laws  
8 of 2013.

9 b. Notwithstanding any contrary provision of law, the fees paid by  
10 managed care organizations licensed under article 44 of the public  
11 health law or under article 43 of the insurance law, to providers  
12 licensed pursuant to article 28 of the public health law or article 31  
13 or 32 of the mental hygiene law, for ambulatory behavioral health  
14 services provided to patients enrolled in the child health insurance  
15 program pursuant to title [one-A] 1-A of article 25 of the public health  
16 law, shall be in the form of fees for such services which are equivalent  
17 to the payments established for such services under the ambulatory  
18 patient group (APG) rate-setting methodology. The commissioner of health  
19 shall consult with the commissioner of alcoholism and substance abuse  
20 services and the commissioner of the office of mental health in deter-  
21 mining such services and establishing such fees. Such ambulatory behav-  
22 ioral health fees to providers available under this section shall be for  
23 all rate periods on and after the effective date of this chapter through  
24 March 31, [2020] 2022, provided, however, that managed care organiza-  
25 tions and providers may negotiate different rates and methods of payment  
26 during such periods described above, subject to the approval of the  
27 department of health. The department of health shall consult with the  
28 office of alcoholism and substance abuse services and the office of

1 mental health in determining whether such alternative rates shall be  
2 approved. The report required under section 16-a of part C of chapter  
3 60 of the laws of 2014 shall also include the population of patients  
4 enrolled in the child health insurance program pursuant to title [one-A]  
5 1-A of article 25 of the public health law in its examination on the  
6 transition of behavioral health services into managed care.

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

12 § 2. This act shall take effect immediately and shall be deemed to  
13 have been in full force and effect on and after April 1, 2010, and shall  
14 expire on [January 1, 2018] March 31, 2022.

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

20 § 10. This act shall take effect immediately and shall be deemed to  
21 have been in full force and effect on and after July 1, 1996; provided,  
22 however, that sections one, two and three of this act shall expire and  
23 be deemed repealed on March 31, [2020] 2025 provided, however that the  
24 amendments to section 364-j of the social services law made by section  
25 four of this act shall not affect the expiration of such section and  
26 shall be deemed to expire therewith and provided, further, that the  
27 provisions of subdivisions 8, 9 and 10 of section 4401 of the public  
28 health law, as added by section one of this act; section 4403-d of the

1 public health law as added by section two of this act and the provisions  
2 of section seven of this act, except for the provisions relating to the  
3 establishment of no more than twelve comprehensive HIV special needs  
4 plans, shall expire and be deemed repealed on July 1, 2000.

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

9 (a) Notwithstanding any inconsistent provision of law or regulation to  
10 the contrary, effective beginning August 1, 1996, for the period April  
11 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1,  
12 1998 through March 31, 1999, August 1, 1999, for the period April 1,  
13 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000  
14 through March 31, 2001, April 1, 2001, for the period April 1, 2001  
15 through March 31, 2002, April 1, 2002, for the period April 1, 2002  
16 through March 31, 2003, and for the state fiscal year beginning April 1,  
17 2005 through March 31, 2006, and for the state fiscal year beginning  
18 April 1, 2006 through March 31, 2007, and for the state fiscal year  
19 beginning April 1, 2007 through March 31, 2008, and for the state fiscal  
20 year beginning April 1, 2008 through March 31, 2009, and for the state  
21 fiscal year beginning April 1, 2009 through March 31, 2010, and for the  
22 state fiscal year beginning April 1, 2010 through March 31, 2016, and  
23 for the state fiscal year beginning April 1, 2016 through March 31, 2019  
24 and annually thereafter, the department of health is authorized to pay  
25 public general hospitals, as defined in subdivision 10 of section 2801  
26 of the public health law, operated by the state of New York or by the  
27 state university of New York or by a county, which shall not include a  
28 city with a population of over one million, of the state of New York,

1 and those public general hospitals located in the county of Westchester,  
2 the county of Erie or the county of Nassau, additional payments for  
3 inpatient hospital services as medical assistance payments pursuant to  
4 title 11 of article 5 of the social services law for patients eligible  
5 for federal financial participation under title XIX of the federal  
6 social security act in medical assistance pursuant to the federal laws  
7 and regulations governing disproportionate share payments to hospitals  
8 up to one hundred percent of each such public general hospital's medical  
9 assistance and uninsured patient losses after all other medical assist-  
10 ance, including disproportionate share payments to such public general  
11 hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on  
12 reported 1994 reconciled data as further reconciled to actual reported  
13 1996 reconciled data, and for 1997 based initially on reported 1995  
14 reconciled data as further reconciled to actual reported 1997 reconciled  
15 data, for 1998 based initially on reported 1995 reconciled data as  
16 further reconciled to actual reported 1998 reconciled data, for 1999  
17 based initially on reported 1995 reconciled data as further reconciled  
18 to actual reported 1999 reconciled data, for 2000 based initially on  
19 reported 1995 reconciled data as further reconciled to actual reported  
20 2000 data, for 2001 based initially on reported 1995 reconciled data as  
21 further reconciled to actual reported 2001 data, for 2002 based initial-  
22 ly on reported 2000 reconciled data as further reconciled to actual  
23 reported 2002 data, and for state fiscal years beginning on April 1,  
24 2005, based initially on reported 2000 reconciled data as further recon-  
25 ciled to actual reported data for 2005, and for state fiscal years  
26 beginning on April 1, 2006, based initially on reported 2000 reconciled  
27 data as further reconciled to actual reported data for 2006, for state  
28 fiscal years beginning on and after April 1, 2007 through March 31,

1 2009, based initially on reported 2000 reconciled data as further recon-  
2 ciled to actual reported data for 2007 and 2008, respectively, for state  
3 fiscal years beginning on and after April 1, 2009, based initially on  
4 reported 2007 reconciled data, adjusted for authorized Medicaid rate  
5 changes applicable to the state fiscal year, and as further reconciled  
6 to actual reported data for 2009, for state fiscal years beginning on  
7 and after April 1, 2010, based initially on reported reconciled data  
8 from the base year two years prior to the payment year, adjusted for  
9 authorized Medicaid rate changes applicable to the state fiscal year,  
10 and further reconciled to actual reported data from such payment year,  
11 and to actual reported data for each respective succeeding year. The  
12 payments may be added to rates of payment or made as aggregate payments  
13 to an eligible public general hospital.

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

20 PART F

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

1 (a) The superintendent of financial services and the commissioner of  
2 health or their designee shall, from funds available in the hospital  
3 excess liability pool created pursuant to subdivision 5 of this section,  
4 purchase a policy or policies for excess insurance coverage, as author-  
5 ized by paragraph 1 of subsection (e) of section 5502 of the insurance  
6 law; or from an insurer, other than an insurer described in section 5502  
7 of the insurance law, duly authorized to write such coverage and actual-  
8 ly writing medical malpractice insurance in this state; or shall  
9 purchase equivalent excess coverage in a form previously approved by the  
10 superintendent of financial services for purposes of providing equiv-  
11 alent excess coverage in accordance with section 19 of chapter 294 of  
12 the laws of 1985, for medical or dental malpractice occurrences between  
13 July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988,  
14 between July 1, 1988 and June 30, 1989, between July 1, 1989 and June  
15 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991  
16 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July  
17 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995,  
18 between July 1, 1995 and June 30, 1996, between July 1, 1996 and June  
19 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998  
20 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July  
21 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002,  
22 between July 1, 2002 and June 30, 2003, between July 1, 2003 and June  
23 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005  
24 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July  
25 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009,  
26 between July 1, 2009 and June 30, 2010, between July 1, 2010 and June  
27 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012  
28 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July

1 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016,  
2 between July 1, 2016 and June 30, 2017, between July 1, 2017 and June  
3 30, 2018, [and] between July 1, 2018 and June 30, 2019, and between July  
4 1, 2019 and June 30, 2020 or reimburse the hospital where the hospital  
5 purchases equivalent excess coverage as defined in subparagraph (i) of  
6 paragraph (a) of subdivision 1-a of this section for medical or dental  
7 malpractice occurrences between July 1, 1987 and June 30, 1988, between  
8 July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990,  
9 between July 1, 1990 and June 30, 1991, between July 1, 1991 and June  
10 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993  
11 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July  
12 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997,  
13 between July 1, 1997 and June 30, 1998, between July 1, 1998 and June  
14 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000  
15 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July  
16 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004,  
17 between July 1, 2004 and June 30, 2005, between July 1, 2005 and June  
18 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007  
19 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July  
20 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011,  
21 between July 1, 2011 and June 30, 2012, between July 1, 2012 and June  
22 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014  
23 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July  
24 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and]  
25 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and  
26 June 30, 2020 for physicians or dentists certified as eligible for each  
27 such period or periods pursuant to subdivision 2 of this section by a  
28 general hospital licensed pursuant to article 28 of the public health



1 law; provided that no single insurer shall write more than fifty percent  
2 of the total excess premium for a given policy year; and provided,  
3 however, that such eligible physicians or dentists must have in force an  
4 individual policy, from an insurer licensed in this state of primary  
5 malpractice insurance coverage in amounts of no less than one million  
6 three hundred thousand dollars for each claimant and three million nine  
7 hundred thousand dollars for all claimants under that policy during the  
8 period of such excess coverage for such occurrences or be endorsed as  
9 additional insureds under a hospital professional liability policy which  
10 is offered through a voluntary attending physician ("channeling")  
11 program previously permitted by the superintendent of financial services  
12 during the period of such excess coverage for such occurrences. During  
13 such period, such policy for excess coverage or such equivalent excess  
14 coverage shall, when combined with the physician's or dentist's primary  
15 malpractice insurance coverage or coverage provided through a voluntary  
16 attending physician ("channeling") program, total an aggregate level of  
17 two million three hundred thousand dollars for each claimant and six  
18 million nine hundred thousand dollars for all claimants from all such  
19 policies with respect to occurrences in each of such years provided,  
20 however, if the cost of primary malpractice insurance coverage in excess  
21 of one million dollars, but below the excess medical malpractice insur-  
22 ance coverage provided pursuant to this act, exceeds the rate of nine  
23 percent per annum, then the required level of primary malpractice insur-  
24 ance coverage in excess of one million dollars for each claimant shall  
25 be in an amount of not less than the dollar amount of such coverage  
26 available at nine percent per annum; the required level of such coverage  
27 for all claimants under that policy shall be in an amount not less than  
28 three times the dollar amount of coverage for each claimant; and excess

1 coverage, when combined with such primary malpractice insurance cover-  
2 age, shall increase the aggregate level for each claimant by one million  
3 dollars and three million dollars for all claimants; and provided  
4 further, that, with respect to policies of primary medical malpractice  
5 coverage that include occurrences between April 1, 2002 and June 30,  
6 2002, such requirement that coverage be in amounts no less than one  
7 million three hundred thousand dollars for each claimant and three  
8 million nine hundred thousand dollars for all claimants for such occur-  
9 rences shall be effective April 1, 2002.

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

14 (3) (a) The superintendent of financial services shall determine and  
15 certify to each general hospital and to the commissioner of health the  
16 cost of excess malpractice insurance for medical or dental malpractice  
17 occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988  
18 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July  
19 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992,  
20 between July 1, 1992 and June 30, 1993, between July 1, 1993 and June  
21 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995  
22 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July  
23 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999,  
24 between July 1, 1999 and June 30, 2000, between July 1, 2000 and June  
25 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002  
26 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July  
27 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006,  
28 between July 1, 2006 and June 30, 2007, between July 1, 2007 and June

1 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009  
2 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July  
3 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and  
4 between July 1, 2013 and June 30, 2014, between July 1, 2014 and June  
5 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1,  
6 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and]  
7 between July 1, 2018 and June 30, 2019, and between July 1, 2019 and  
8 June 30, 2020 allocable to each general hospital for physicians or  
9 dentists certified as eligible for purchase of a policy for excess  
10 insurance coverage by such general hospital in accordance with subdivi-  
11 sion 2 of this section, and may amend such determination and certif-  
12 ication as necessary.

13 (b) The superintendent of financial services shall determine and  
14 certify to each general hospital and to the commissioner of health the  
15 cost of excess malpractice insurance or equivalent excess coverage for  
16 medical or dental malpractice occurrences between July 1, 1987 and June  
17 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989  
18 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July  
19 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993,  
20 between July 1, 1993 and June 30, 1994, between July 1, 1994 and June  
21 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996  
22 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July  
23 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000,  
24 between July 1, 2000 and June 30, 2001, between July 1, 2001 and June  
25 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003  
26 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July  
27 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007,  
28 between July 1, 2007 and June 30, 2008, between July 1, 2008 and June

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

1 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period  
2 January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December  
3 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period  
4 July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June  
5 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period  
6 July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30,  
7 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1,  
8 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to  
9 the period July 1, 2007 and June 30, 2008, to the period July 1, 2008  
10 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the  
11 period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and  
12 June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the  
13 period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and  
14 June 30, 2015, to the period July 1, 2015 and June 30, 2016, [and  
15 between] to the period July 1, 2016 and June 30, 2017, [and] to the  
16 period July 1, 2017 to June 30, 2018, [and] to the period July 1, 2018  
17 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020.

18 § 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section  
19 18 of chapter 266 of the laws of 1986, amending the civil practice law  
20 and rules and other laws relating to malpractice and professional  
21 medical conduct, as amended by section 3 of part M of chapter 57 of the  
22 laws of 2018, are amended to read as follows:

23 (a) To the extent funds available to the hospital excess liability  
24 pool pursuant to subdivision 5 of this section as amended, and pursuant  
25 to section 6 of part J of chapter 63 of the laws of 2001, as may from  
26 time to time be amended, which amended this subdivision, are insuffi-  
27 cient to meet the costs of excess insurance coverage or equivalent  
28 excess coverage for coverage periods during the period July 1, 1992 to

1 June 30, 1993, during the period July 1, 1993 to June 30, 1994, during  
2 the period July 1, 1994 to June 30, 1995, during the period July 1, 1995  
3 to June 30, 1996, during the period July 1, 1996 to June 30, 1997,  
4 during the period July 1, 1997 to June 30, 1998, during the period July  
5 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30,  
6 2000, during the period July 1, 2000 to June 30, 2001, during the period  
7 July 1, 2001 to October 29, 2001, during the period April 1, 2002 to  
8 June 30, 2002, during the period July 1, 2002 to June 30, 2003, during  
9 the period July 1, 2003 to June 30, 2004, during the period July 1, 2004  
10 to June 30, 2005, during the period July 1, 2005 to June 30, 2006,  
11 during the period July 1, 2006 to June 30, 2007, during the period July  
12 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30,  
13 2009, during the period July 1, 2009 to June 30, 2010, during the period  
14 July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June  
15 30, 2012, during the period July 1, 2012 to June 30, 2013, during the  
16 period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to  
17 June 30, 2015, during the period July 1, 2015 to June 30, 2016, during  
18 the period July 1, 2016 to June 30, 2017, during the period July 1, 2017  
19 to June 30, 2018, [and] during the period July 1, 2018 to June 30, 2019,  
20 and during the period July 1, 2019 to June 30, 2020 allocated or reallo-  
21 cated in accordance with paragraph (a) of subdivision 4-a of this  
22 section to rates of payment applicable to state governmental agencies,  
23 each physician or dentist for whom a policy for excess insurance cover-  
24 age or equivalent excess coverage is purchased for such period shall be  
25 responsible for payment to the provider of excess insurance coverage or  
26 equivalent excess coverage of an allocable share of such insufficiency,  
27 based on the ratio of the total cost of such coverage for such physician

1 to the sum of the total cost of such coverage for all physicians applied  
2 to such insufficiency.

3 (b) Each provider of excess insurance coverage or equivalent excess  
4 coverage covering the period July 1, 1992 to June 30, 1993, or covering  
5 the period July 1, 1993 to June 30, 1994, or covering the period July 1,  
6 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30,  
7 1996, or covering the period July 1, 1996 to June 30, 1997, or covering  
8 the period July 1, 1997 to June 30, 1998, or covering the period July 1,  
9 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30,  
10 2000, or covering the period July 1, 2000 to June 30, 2001, or covering  
11 the period July 1, 2001 to October 29, 2001, or covering the period  
12 April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to  
13 June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or  
14 covering the period July 1, 2004 to June 30, 2005, or covering the peri-  
15 od July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to  
16 June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or  
17 covering the period July 1, 2008 to June 30, 2009, or covering the peri-  
18 od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to  
19 June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or  
20 covering the period July 1, 2012 to June 30, 2013, or covering the peri-  
21 od July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to  
22 June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or  
23 covering the period July 1, 2016 to June 30, 2017, or covering the peri-  
24 od July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to  
25 June 30, 2019, or covering the period July 1, 2019 to June 30, 2020  
26 shall notify a covered physician or dentist by mail, mailed to the  
27 address shown on the last application for excess insurance coverage or  
28 equivalent excess coverage, of the amount due to such provider from such

1 physician or dentist for such coverage period determined in accordance  
2 with paragraph (a) of this subdivision. Such amount shall be due from  
3 such physician or dentist to such provider of excess insurance coverage  
4 or equivalent excess coverage in a time and manner determined by the  
5 superintendent of financial services.

6 (c) If a physician or dentist liable for payment of a portion of the  
7 costs of excess insurance coverage or equivalent excess coverage cover-  
8 ing the period July 1, 1992 to June 30, 1993, or covering the period  
9 July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to  
10 June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or  
11 covering the period July 1, 1996 to June 30, 1997, or covering the peri-  
12 od July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to  
13 June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or  
14 covering the period July 1, 2000 to June 30, 2001, or covering the peri-  
15 od July 1, 2001 to October 29, 2001, or covering the period April 1,  
16 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30,  
17 2003, or covering the period July 1, 2003 to June 30, 2004, or covering  
18 the period July 1, 2004 to June 30, 2005, or covering the period July 1,  
19 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30,  
20 2007, or covering the period July 1, 2007 to June 30, 2008, or covering  
21 the period July 1, 2008 to June 30, 2009, or covering the period July 1,  
22 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30,  
23 2011, or covering the period July 1, 2011 to June 30, 2012, or covering  
24 the period July 1, 2012 to June 30, 2013, or covering the period July 1,  
25 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30,  
26 2015, or covering the period July 1, 2015 to June 30, 2016, or covering  
27 the period July 1, 2016 to June 30, 2017, or covering the period July 1,  
28 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,



1 2019, or covering the period July 1, 2019 to June 30, 2020 determined in  
2 accordance with paragraph (a) of this subdivision fails, refuses or  
3 neglects to make payment to the provider of excess insurance coverage or  
4 equivalent excess coverage in such time and manner as determined by the  
5 superintendent of financial services pursuant to paragraph (b) of this  
6 subdivision, excess insurance coverage or equivalent excess coverage  
7 purchased for such physician or dentist in accordance with this section  
8 for such coverage period shall be cancelled and shall be null and void  
9 as of the first day on or after the commencement of a policy period  
10 where the liability for payment pursuant to this subdivision has not  
11 been met.

12 (d) Each provider of excess insurance coverage or equivalent excess  
13 coverage shall notify the superintendent of financial services and the  
14 commissioner of health or their designee of each physician and dentist  
15 eligible for purchase of a policy for excess insurance coverage or  
16 equivalent excess coverage covering the period July 1, 1992 to June 30,  
17 1993, or covering the period July 1, 1993 to June 30, 1994, or covering  
18 the period July 1, 1994 to June 30, 1995, or covering the period July 1,  
19 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30,  
20 1997, or covering the period July 1, 1997 to June 30, 1998, or covering  
21 the period July 1, 1998 to June 30, 1999, or covering the period July 1,  
22 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,  
23 2001, or covering the period July 1, 2001 to October 29, 2001, or cover-  
24 ing the period April 1, 2002 to June 30, 2002, or covering the period  
25 July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to  
26 June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or  
27 covering the period July 1, 2005 to June 30, 2006, or covering the peri-  
28 od July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to

1 June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or  
2 covering the period July 1, 2009 to June 30, 2010, or covering the peri-  
3 od July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to  
4 June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or  
5 covering the period July 1, 2013 to June 30, 2014, or covering the peri-  
6 od July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to  
7 June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or  
8 covering the period July 1, 2017 to June 30, 2018, or covering the peri-  
9 od July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to  
10 June 30, 2020 that has made payment to such provider of excess insurance  
11 coverage or equivalent excess coverage in accordance with paragraph (b)  
12 of this subdivision and of each physician and dentist who has failed,  
13 refused or neglected to make such payment.

14 (e) A provider of excess insurance coverage or equivalent excess  
15 coverage shall refund to the hospital excess liability pool any amount  
16 allocable to the period July 1, 1992 to June 30, 1993, and to the period  
17 July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June  
18 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the  
19 period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to  
20 June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to  
21 the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000  
22 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001,  
23 and to the period April 1, 2002 to June 30, 2002, and to the period July  
24 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30,  
25 2004, and to the period July 1, 2004 to June 30, 2005, and to the period  
26 July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June  
27 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the  
28 period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to

1 June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to  
2 the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012  
3 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and  
4 to the period July 1, 2014 to June 30, 2015, and to the period July 1,  
5 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and  
6 to the period July 1, 2017 to June 30, 2018, and to the period July 1,  
7 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020  
8 received from the hospital excess liability pool for purchase of excess  
9 insurance coverage or equivalent excess coverage covering the period  
10 July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to  
11 June 30, 1994, and covering the period July 1, 1994 to June 30, 1995,  
12 and covering the period July 1, 1995 to June 30, 1996, and covering the  
13 period July 1, 1996 to June 30, 1997, and covering the period July 1,  
14 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30,  
15 1999, and covering the period July 1, 1999 to June 30, 2000, and cover-  
16 ing the period July 1, 2000 to June 30, 2001, and covering the period  
17 July 1, 2001 to October 29, 2001, and covering the period April 1, 2002  
18 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003,  
19 and covering the period July 1, 2003 to June 30, 2004, and covering the  
20 period July 1, 2004 to June 30, 2005, and covering the period July 1,  
21 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30,  
22 2007, and covering the period July 1, 2007 to June 30, 2008, and cover-  
23 ing the period July 1, 2008 to June 30, 2009, and covering the period  
24 July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to  
25 June 30, 2011, and covering the period July 1, 2011 to June 30, 2012,  
26 and covering the period July 1, 2012 to June 30, 2013, and covering the  
27 period July 1, 2013 to June 30, 2014, and covering the period July 1,  
28 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,

1 2016, and covering the period July 1, 2016 to June 30, 2017, and cover-  
2 ing the period July 1, 2017 to June 30, 2018, and covering the period  
3 July 1, 2018 to June 30, 2019, and covering the period July 1, 2019 to  
4 June 30, 2020 for a physician or dentist where such excess insurance  
5 coverage or equivalent excess coverage is cancelled in accordance with  
6 paragraph (c) of this subdivision.

7 § 4. Section 40 of chapter 266 of the laws of 1986, amending the civil  
8 practice law and rules and other laws relating to malpractice and  
9 professional medical conduct, as amended by section 4 of part M of chap-  
10 ter 57 of the laws of 2018, is amended to read as follows:

11 § 40. The superintendent of financial services shall establish rates  
12 for policies providing coverage for physicians and surgeons medical  
13 malpractice for the periods commencing July 1, 1985 and ending June 30,  
14 [2019;] 2020; provided, however, that notwithstanding any other  
15 provision of law, the superintendent shall not establish or approve any  
16 increase in rates for the period commencing July 1, 2009 and ending June  
17 30, 2010. The superintendent shall direct insurers to establish segre-  
18 gated accounts for premiums, payments, reserves and investment income  
19 attributable to such premium periods and shall require periodic reports  
20 by the insurers regarding claims and expenses attributable to such peri-  
21 ods to monitor whether such accounts will be sufficient to meet incurred  
22 claims and expenses. On or after July 1, 1989, the superintendent shall  
23 impose a surcharge on premiums to satisfy a projected deficiency that is  
24 attributable to the premium levels established pursuant to this section  
25 for such periods; provided, however, that such annual surcharge shall  
26 not exceed eight percent of the established rate until July 1, [2019,]  
27 2020, at which time and thereafter such surcharge shall not exceed twen-  
28 ty-five percent of the approved adequate rate, and that such annual

1 surcharges shall continue for such period of time as shall be sufficient  
2 to satisfy such deficiency. The superintendent shall not impose such  
3 surcharge during the period commencing July 1, 2009 and ending June 30,  
4 2010. On and after July 1, 1989, the surcharge prescribed by this  
5 section shall be retained by insurers to the extent that they insured  
6 physicians and surgeons during the July 1, 1985 through June 30, [2019]  
7 2020 policy periods; in the event and to the extent physicians and  
8 surgeons were insured by another insurer during such periods, all or a  
9 pro rata share of the surcharge, as the case may be, shall be remitted  
10 to such other insurer in accordance with rules and regulations to be  
11 promulgated by the superintendent. Surcharges collected from physicians  
12 and surgeons who were not insured during such policy periods shall be  
13 apportioned among all insurers in proportion to the premium written by  
14 each insurer during such policy periods; if a physician or surgeon was  
15 insured by an insurer subject to rates established by the superintendent  
16 during such policy periods, and at any time thereafter a hospital,  
17 health maintenance organization, employer or institution is responsible  
18 for responding in damages for liability arising out of such physician's  
19 or surgeon's practice of medicine, such responsible entity shall also  
20 remit to such prior insurer the equivalent amount that would then be  
21 collected as a surcharge if the physician or surgeon had continued to  
22 remain insured by such prior insurer. In the event any insurer that  
23 provided coverage during such policy periods is in liquidation, the  
24 property/casualty insurance security fund shall receive the portion of  
25 surcharges to which the insurer in liquidation would have been entitled.  
26 The surcharges authorized herein shall be deemed to be income earned for  
27 the purposes of section 2303 of the insurance law. The superintendent,  
28 in establishing adequate rates and in determining any projected defi-

1 ciency pursuant to the requirements of this section and the insurance  
2 law, shall give substantial weight, determined in his discretion and  
3 judgment, to the prospective anticipated effect of any regulations  
4 promulgated and laws enacted and the public benefit of stabilizing  
5 malpractice rates and minimizing rate level fluctuation during the peri-  
6 od of time necessary for the development of more reliable statistical  
7 experience as to the efficacy of such laws and regulations affecting  
8 medical, dental or podiatric malpractice enacted or promulgated in 1985,  
9 1986, by this act and at any other time. Notwithstanding any provision  
10 of the insurance law, rates already established and to be established by  
11 the superintendent pursuant to this section are deemed adequate if such  
12 rates would be adequate when taken together with the maximum authorized  
13 annual surcharges to be imposed for a reasonable period of time whether  
14 or not any such annual surcharge has been actually imposed as of the  
15 establishment of such rates.

16 § 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of  
17 chapter 63 of the laws of 2001, amending chapter 266 of the laws of  
18 1986, amending the civil practice law and rules and other laws relating  
19 to malpractice and professional medical conduct, relating to the effec-  
20 tiveness of certain provisions of such chapter, as amended by section 5  
21 of part M of chapter 57 of the laws of 2018, are amended to read as  
22 follows:

23 § 5. The superintendent of financial services and the commissioner of  
24 health shall determine, no later than June 15, 2002, June 15, 2003, June  
25 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008,  
26 June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15,  
27 2013, June 15, 2014, June 15, 2015, June 15, 2016, June 15, 2017, June  
28 15, 2018, [and] June 15, 2019, and June 15, 2020 the amount of funds

1 available in the hospital excess liability pool, created pursuant to  
2 section 18 of chapter 266 of the laws of 1986, and whether such funds  
3 are sufficient for purposes of purchasing excess insurance coverage for  
4 eligible participating physicians and dentists during the period July 1,  
5 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003  
6 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to  
7 June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June  
8 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30,  
9 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30,  
10 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,  
11 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,  
12 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,  
13 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020  
14 as applicable.

15 (a) This section shall be effective only upon a determination, pursu-  
16 ant to section five of this act, by the superintendent of financial  
17 services and the commissioner of health, and a certification of such  
18 determination to the state director of the budget, the chair of the  
19 senate committee on finance and the chair of the assembly committee on  
20 ways and means, that the amount of funds in the hospital excess liabil-  
21 ity pool, created pursuant to section 18 of chapter 266 of the laws of  
22 1986, is insufficient for purposes of purchasing excess insurance cover-  
23 age for eligible participating physicians and dentists during the period  
24 July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July  
25 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1,  
26 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007  
27 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to  
28 June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June

1 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30,  
2 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30,  
3 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30,  
4 2018, or July 1, 2018 to June 30, 2019, or July 1, 2019 to June 30, 2020  
5 as applicable.

6 (e) The commissioner of health shall transfer for deposit to the  
7 hospital excess liability pool created pursuant to section 18 of chapter  
8 266 of the laws of 1986 such amounts as directed by the superintendent  
9 of financial services for the purchase of excess liability insurance  
10 coverage for eligible participating physicians and dentists for the  
11 policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30,  
12 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30,  
13 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30,  
14 2007, as applicable, and the cost of administering the hospital excess  
15 liability pool for such applicable policy year, pursuant to the program  
16 established in chapter 266 of the laws of 1986, as amended, no later  
17 than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June  
18 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010,  
19 June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15,  
20 2015, June 15, 2016, June 15, 2017, June 15, 2018, [and] June 15, 2019,  
21 and June 15, 2020 as applicable.

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

26 § 20. Notwithstanding any law, rule or regulation to the contrary,  
27 only physicians or dentists who were eligible, and for whom the super-  
28 intendent of financial services and the commissioner of health, or their



1 designee, purchased, with funds available in the hospital excess liabil-  
2 ity pool, a full or partial policy for excess coverage or equivalent  
3 excess coverage for the coverage period ending the thirtieth of June,  
4 two thousand [eighteen,] nineteen, shall be eligible to apply for such  
5 coverage for the coverage period beginning the first of July, two thou-  
6 sand [eighteen,] nineteen; provided, however, if the total number of  
7 physicians or dentists for whom such excess coverage or equivalent  
8 excess coverage was purchased for the policy year ending the thirtieth  
9 of June, two thousand [eighteen] nineteen exceeds the total number of  
10 physicians or dentists certified as eligible for the coverage period  
11 beginning the first of July, two thousand [eighteen,] nineteen, then the  
12 general hospitals may certify additional eligible physicians or dentists  
13 in a number equal to such general hospital's proportional share of the  
14 total number of physicians or dentists for whom excess coverage or  
15 equivalent excess coverage was purchased with funds available in the  
16 hospital excess liability pool as of the thirtieth of June, two thousand  
17 [eighteen,] nineteen, as applied to the difference between the number of  
18 eligible physicians or dentists for whom a policy for excess coverage or  
19 equivalent excess coverage was purchased for the coverage period ending  
20 the thirtieth of June, two thousand [eighteen] nineteen and the number  
21 of such eligible physicians or dentists who have applied for excess  
22 coverage or equivalent excess coverage for the coverage period beginning  
23 the first of July, two thousand [eighteen] nineteen.

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

Section 1. Paragraph (a) of subdivision 3 of section 366 of the social services law is REPEALED and a new paragraph (a) is added to read as follows:

(a) Medical assistance shall be furnished without consideration of the income and resources of an applicant's legally responsible relative if the applicant's eligibility would normally be determined by comparing the amount of available income and/or resources of the applicant, including amounts deemed available to the applicant from legally responsible relatives, to an applicable eligibility standard, and:

(1) (i) the legally responsible relative is a community spouse, as defined in section three hundred sixty-six-c of this title;

(ii) such relative is refusing to make his or her income and/or resources available to meet the cost of necessary medical care, services, and supplies; and

(iii) the applicant executes an assignment of support from the community spouse in favor of the social services district and the department, unless the applicant is unable to execute such assignment due to physical or mental impairment or to deny assistance would create an undue hardship, as defined by the commissioner; or

(2) the legally responsible relative is absent from the applicant's household, and fails or refuses to make his or her income and/or resources available to meet the cost of necessary medical care, services, and supplies.

In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three of this chapter and other applicable provisions of law.

1     § 2. Paragraphs (b), (c), (d), (e), (f), (g), and (h) of subdivision  
2     4-a and subdivisions 4-b and 4-c of section 365-f of the social services  
3     law are REPEALED, and paragraph (i) of subdivision 4-a is relettered  
4     paragraph (b).

5     § 3. Section 365-f of the social services law is REPEALED, and a new  
6     section 365-f is added to read as follows:

7     § 365-f. Consumer directed personal assistance program. 1. Purpose and  
8     intent. The consumer directed personal assistance program is intended to  
9     permit chronically ill and/or physically disabled individuals receiving  
10    home care services under the medical assistance program greater flexi-  
11    bility and freedom of choice in obtaining such services. The department  
12    shall regularly monitor district participation in the program by review-  
13    ing the implementation plans submitted pursuant to this section. The  
14    department shall provide guidance to the districts to improve compliance  
15    with implementation plans and promote consistency among counties  
16    regarding approved service levels based on the assessments required by  
17    this section. In addition, the department shall provide technical  
18    assistance and such other assistance as may be necessary to assist such  
19    districts in assuring access to the program for eligible individuals.

20    2. Eligibility. All eligible individuals receiving home care shall be  
21    provided notice of the availability of the program, and no less  
22    frequently than annually thereafter, and shall have the opportunity to  
23    apply for participation in the program. Each social services district  
24    shall file an implementation plan with the commissioner of the depart-  
25    ment of health, which shall be updated annually. Such updates shall be  
26    submitted no later than November thirtieth of each year. The plans and  
27    updates submitted by districts shall require the approval of the depart-  
28    ment. Implementation plans shall include district enrollment targets,

1 describe methods for the provision of notice and assistance to inter-  
2 ested individuals eligible for enrollment in the program, and shall  
3 contain such other information as, shall be required by the department.

4 An "eligible individual", for purposes of this section is a person who:

5 (a) is eligible for long term care and services provided by a certi-  
6 fied home health agency, long term home health care program or AIDS home  
7 care program authorized pursuant to article thirty-six of the public  
8 health law, or is eligible for personal care services provided pursuant  
9 to this article;

10 (b) is eligible for medical assistance;

11 (c) has been determined by the social services district or an entity  
12 certified under article forty-four of the public health law, pursuant  
13 to an assessment of the person's appropriateness for the program,  
14 conducted with an appropriate long term home health care program, a  
15 certified home health agency, or an AIDS home care program or pursuant  
16 to the personal care program, as being in need of home care services or  
17 private duty nursing and is able and willing or has a designated repre-  
18 sentative, including a legal guardian able and willing to make informed  
19 choices, or a designated relative or other adult who is able and willing  
20 to assist in making informed choices, as to the type and quality of  
21 services, including but not limited to such services as nursing care,  
22 personal care, transportation and respite services; and

23 (d) meets such other criteria, as may be established by the commis-  
24 sioner, which are necessary to effectively implement the objectives of  
25 this section.

26 3. Eligible individuals. Eligible individuals who elect to participate  
27 in the program assume the responsibility for services under such  
28 program as mutually agreed to by the eligible individual and provider

1 and as documented in the eligible individual's record, including, but  
2 not limited to, recruiting, hiring and supervising their personal  
3 assistants. For the purposes of this section, personal assistant shall  
4 mean an adult who provides services under this section to the eligible  
5 individual under the eligible individual's instruction, supervision and  
6 direction or under the instruction, supervision and direction of the  
7 eligible individual's designated representative, provided that a person  
8 legally responsible for an eligible individual's care and support, an  
9 eligible individual's spouse or designated representative may not be the  
10 personal assistant for the eligible individual; however, a personal  
11 assistant may include any other adult relative of the eligible individ-  
12 ual, provided, however, that the program determines that the services  
13 provided by such relative are consistent with an individual's plan of  
14 care and that the aggregate cost for such services does not exceed the  
15 aggregate costs for equivalent services provided by a non-relative  
16 personal assistant. Such individuals shall be assisted as appropriate  
17 with service coverage, supervision, advocacy and management. Providers  
18 shall not be liable for fulfillment of responsibilities agreed to be  
19 undertaken by the eligible individual. This subdivision, however, shall  
20 not diminish the participating provider's liability for failure to exer-  
21 cise reasonable care in properly carrying out its responsibilities  
22 under this program, which shall include monitoring such individual's  
23 continuing ability to fulfill those responsibilities documented in his  
24 or her records. Failure of the individual to carry out his or her  
25 agreed to responsibilities may be considered in determining such indi-  
26 vidual's continued appropriateness for the program.

27 4. Participating providers. All agencies or individuals who meet the  
28 qualifications to provide home health, personal care or nursing services

1 and who elect to provide such services to persons receiving medical  
2 assistance may participate in the program. Any agency or individuals  
3 providing services under a patient managed home care program authorized  
4 under the former section thirty-six hundred twenty-two of the public  
5 health law or the former section three hundred sixty-five-f of this  
6 chapter may continue to provide such services under this section.

7 5. Fiscal intermediaries. (a) For the purposes of this section "fiscal  
8 intermediary" means:

9 (i) an entity that has a contract with the department of health to  
10 provide fiscal intermediary services pursuant to paragraph (e) of this  
11 subdivision; or

12 (ii) an entity authorized by the commissioner upon application with a  
13 history of providing fiscal intermediary services that:

14 (A) is a service center for independent living under section one thou-  
15 sand one hundred twenty-one of the education law; or

16 (B) has experience providing fiscal intermediary services for persons  
17 with disabilities, in accordance with such criteria as the department  
18 may develop, as demonstrated by having a continuous history of arrange-  
19 ments with local departments of social services beginning no later than  
20 January first, two thousand twelve.

21 (b) An application for authorization as a fiscal intermediary under  
22 subparagraph (ii) of paragraph (a) of this subdivision shall be filed  
23 with the commissioner, together with such other forms and information as  
24 shall be prescribed by, or acceptable to the commissioner.

25 (c) Fiscal intermediary services shall include the following services,  
26 performed on behalf of the consumer to facilitate his or her role as the  
27 employer:

1 (i) wage and benefit processing for consumer directed personal assist-  
2 ants;

3 (ii) processing all income tax and other required wage withholdings;

4 (iii) complying with workers' compensation, disability and unemploy-  
5 ment requirements;

6 (iv) maintaining personnel records for each consumer directed personal  
7 assistants including time sheets and other documentation needed for  
8 wages and benefit processing and a copy of the medical documentation  
9 required pursuant to regulations established by the commissioner;

10 (v) ensuring that the health status of each consumer directed personal  
11 assistant is assessed prior to service delivery pursuant to regulations  
12 issued by the commissioner;

13 (vi) maintaining records of service authorizations or reauthori-  
14 zations;

15 (vii) monitoring the consumer's or, if applicable, the designated  
16 representative's continuing ability to fulfill the consumer's responsi-  
17 bilities under the program and promptly notifying the authorizing entity  
18 of any circumstance that may affect the consumer's or, if applicable,  
19 the designated representative's ability to fulfill such responsibil-  
20 ities;

21 (viii) complying with regulations established by the commissioner  
22 specifying the responsibilities of fiscal intermediaries providing  
23 services under this title; and

24 (ix) entering into a department approved memorandum of understanding  
25 with the consumer that describes the parties' responsibilities under  
26 this program.

27 (d) Fiscal intermediaries are not responsible for, and fiscal interme-  
28 diary services shall not include, fulfillment of the responsibilities of

1 the consumer or, if applicable, the consumer's designated representative  
2 as established by the commissioner. A fiscal intermediary's responsibil-  
3 ities shall not include, and a fiscal intermediary shall not engage in:  
4 managing the plan of care including recruiting and hiring a sufficient  
5 number of individuals who meet the definition of consumer directed  
6 personal assistant, as such term is defined by the commissioner, to  
7 provide authorized services that are included on the consumer's plan of  
8 care; training, supervising and scheduling each consumer directed  
9 personal assistant; terminating the consumer directed personal assist-  
10 ant's employment; or assuring that each consumer directed personal  
11 assistant competently and safely performs the personal care services,  
12 home health aide services and skilled nursing tasks that are included  
13 on the consumer's plan of care. A fiscal intermediary shall exercise  
14 reasonable care in properly carrying out its responsibilities under the  
15 program.

16 (e) Notwithstanding any inconsistent provision of sections one hundred  
17 twelve and one hundred sixty-three of the state finance law, or section  
18 one hundred forty-two of the economic development law, or any other law,  
19 the commissioner is authorized to enter into a contract or contracts  
20 under this subdivision with an entity or entities without a competitive  
21 bid or request for proposal process, provided, however, that:

22 (i) the department shall post on its website, for a period of no less  
23 than thirty days:

24 (A) a description of the proposed services to be provided pursuant to  
25 the contract or contracts;

26 (B) the criteria for selection of a contractor or contractors;



1 (C) the period of time during which a prospective contractor may seek  
2 selection, which shall be no less than thirty days after such informa-  
3 tion is first posted on the website; and

4 (D) the manner by which a prospective contractor may seek such  
5 selection, which may include submission by electronic means;

6 (ii) all reasonable and responsive submissions that are received from  
7 prospective contractors in a timely fashion shall be reviewed by the  
8 commissioner; and

9 (iii) the commissioner shall select such contractor or contractors  
10 that, in his or her discretion, are best suited to serve the purposes of  
11 this section.

12 6. Actions involving the authorization of a fiscal intermediary. (a) A  
13 fiscal intermediary's authorization under subparagraph (ii) of paragraph  
14 (a) of subdivision five of this section may be revoked, suspended,  
15 limited or annulled upon thirty days' written notice to the fiscal  
16 intermediary, if the commissioner finds that the fiscal intermediary has  
17 failed to comply with the provisions of this subdivision or regulations  
18 promulgated hereunder. Notwithstanding the foregoing, upon determining  
19 that the public health or safety would be imminently endangered by the  
20 continued authorization of the fiscal intermediary, the commissioner may  
21 revoke, suspend, limit or annul the fiscal intermediary's authorization  
22 immediately.

23 (b) All orders or determinations under this subdivision shall be  
24 subject to review as provided in article seventy-eight of the civil  
25 practice law and rules.

26 7. Waivers, regulations and effectiveness. (a) The commissioner may,  
27 subject to the approval of the director of budget, file for such federal  
28 waivers as may be needed for the implementation of the program.

1 (b) Notwithstanding any other provision of law, the commissioner is  
2 authorized to waive any provision of section three hundred sixty-seven-b  
3 of this title related to payment and may promulgate regulations neces-  
4 sary to carry out the objectives of the program, and which describe the  
5 responsibilities of the eligible individuals in arranging and paying for  
6 services and the protections assured such individuals if they are unable  
7 or no longer desire to continue in the program.

8 8. Notwithstanding any inconsistent provision of this section or any  
9 other contrary provision of law, managed care programs established  
10 pursuant to section three hundred sixty-four-j of this title and managed  
11 long term care plans and other care coordination models established  
12 pursuant to section four thousand four hundred three-f of the public  
13 health law shall offer consumer directed personal assistance programs to  
14 enrollees.

15 9. Notwithstanding any provision of this section or any other law to  
16 the contrary, the provisions pertaining to consumer directed personal  
17 assistance services and fiscal intermediaries pursuant to this section  
18 shall only be available if the commissioner of health determines that  
19 there is adequate Federal Financial Participation to fund such programs  
20 and/or entities.

21 10. Subject to the availability of federal financial participation,  
22 the provisions of this section governing consumer directed personal  
23 assistance services shall also apply to such services when offered under  
24 the home and community-based attendant services and supports state plan  
25 option, community first choice, pursuant to 42 U.S.C. § 1396n(k).

26 § 4. This act shall take effect immediately and shall be deemed to  
27 have been in full force and effect on and after April 1, 2019; provided

1 however, that section three of this act shall take effect January 1,  
2 2020.

3 PART H

4 Section 1. Subparagraph (v) of paragraph (b) of subdivision 5-b of  
5 section 2807-k of the public health law is REPEALED.

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

8 20-a. Notwithstanding any provision of law to the contrary, the  
9 commissioners of the department of health, the office of mental health,  
10 the office of people with developmental disabilities, and the office of  
11 alcoholism and substance abuse services are authorized to waive any  
12 regulatory requirements as are necessary, consistent with applicable  
13 law, to allow providers that are involved in DSRIP projects or repli-  
14 cation and scaling activities, as approved by the authorizing commis-  
15 sioner, to avoid duplication of requirements and to allow the efficient  
16 scaling and replication of DSRIP promising practices, as determined by  
17 the authorizing commissioner; provided however, that regulations  
18 pertaining to patient safety may not be waived, nor shall any regu-  
19 lations be waived if such waiver would risk patient safety.

20 § 3. Subparagraph (i) of paragraph (e-1) of subdivision 4 of section  
21 2807-c of the public health law, as amended by section 29 of part C of  
22 chapter 60 of the laws of 2014, is amended to read as follows:

23 (i) For rate periods on and after April first, two thousand ten, the  
24 commissioner, in consultation with the commissioner of the office of  
25 mental health, shall promulgate regulations, and may promulgate emergen-  
26 cy regulations, establishing methodologies for determining the operating

1 cost components of rates of payments for services described in this  
2 paragraph. Such regulations shall utilize two thousand five operating  
3 costs as submitted to the department prior to July first, two thousand  
4 nine and [shall] may provide for methodologies establishing per diem  
5 inpatient rates that utilize case mix adjustment mechanisms. Such regu-  
6 lations [shall] may contain criteria for adjustments based on length of  
7 stay and may also provide for a base year update, provided, however,  
8 that such base year update shall take effect no earlier than April  
9 first, two thousand fifteen, and provided further, however, that the  
10 commissioner may make such adjustments to such utilization and to the  
11 methodology for computing such rates as is necessary to achieve no  
12 aggregate, net growth in overall Medicaid expenditures related to such  
13 rates, as compared to such aggregate expenditures from the prior year.  
14 In determining the updated base year to be utilized pursuant to this  
15 subparagraph, the commissioner shall take into account the base year  
16 determined in accordance with paragraph (c) of subdivision thirty-five  
17 of this section.

18 § 4. Paragraph (b) of subdivision 35 of section 2807-c of the public  
19 health law is amended by adding a new subparagraph (xiv) to read as  
20 follows:

21 (xiv) Such rates and payment methodologies may incorporate methodol-  
22 ogies to reduce payments to facilities with a higher percentage of  
23 potentially avoidable inpatient services by instituting lower inpatient  
24 payment rates for both fee-for-service and managed care to incentivize  
25 the provision of preventative care to reduce preventable events and  
26 overall inpatient costs. A portion of such savings derived from the  
27 implementation of such payment methodologies shall be reinvested in  
28 initiatives to incentivize the provision of preventative care, maternity

1 services, and other ambulatory care services to reduce preventable  
2 health care costs.

3 § 5. This act shall take effect immediately.

4 PART I

5 Section 1. The insurance law is amended by adding a new article 29 to  
6 read as follows:

7 ARTICLE 29

8 PHARMACY BENEFIT MANAGERS

9 Section 2901. Definitions.

10 2902. Acting without a registration.

11 2903. Registration requirements for pharmacy benefit managers.

12 2904. Reporting requirements for pharmacy benefit managers.

13 2905. Acting without a license.

14 2906. Licensing of a pharmacy benefit manager.

15 2907. Revocation or suspension of a registration or license of a  
16 pharmacy benefit manager.

17 2908. Penalties for violations.

18 2909. Stay or suspension of superintendent's determination.

19 2910. Revoked registration or licenses.

20 2911. Change of address.

21 2912. Applicability of other laws.

22 2913. Assessments.

23 § 2901. Definitions. For purposes of this article:

24 (a) "Controlling person" is any person or other entity who or which  
25 directly or indirectly has the power to direct or cause to be directed  
26 the management, control or activities of a pharmacy benefit manager.

1     (b) "Health insurer" means an insurance company authorized in this  
2     state to write accident and health insurance, a company organized pursu-  
3     ant to article forty-three of this chapter, a municipal cooperative  
4     health benefit plan established pursuant to article forty-seven of this  
5     chapter, an organization certified pursuant to article forty-four of the  
6     public health law, an institution of higher education certified pursuant  
7     to section one thousand one hundred twenty-four of this chapter, or the  
8     New York state health insurance plan established under article eleven of  
9     the civil service law.

10    (c) "Pharmacy benefit management services" means directly or through  
11    an intermediary, managing the prescription drug coverage provided by a  
12    health insurer under a contract or policy delivered or issued for deliv-  
13    ery in this state or a plan subject to section three hundred  
14    sixty-four-j of the social services law, including the processing and  
15    payment of claims for prescription drugs, the performance of drug utili-  
16    zation review, the processing of drug prior authorization requests, the  
17    adjudication of appeals or grievances related to prescription drug  
18    coverage, contracting with network pharmacies, and controlling the cost  
19    of covered prescription drugs.

20    (d) "Pharmacy benefit manager" means a person, firm, association,  
21    corporation or other entity that, pursuant to a contract with a health  
22    insurer provides pharmacy benefit management services, except that term  
23    shall not include:

24    (1) an officer or employee of a registered or licensed pharmacy bene-  
25    fit manager; or

26    (2) a health insurer, or any manager thereof, individual or corporate,  
27    or any officer, director or regular salaried employee thereof, providing

1 pharmacy benefit management services under a policy or contract issued  
2 by the health insurer.

3 § 2902. Acting without a registration. (a) No person, firm, associ-  
4 ation, corporation or other entity may act as a pharmacy benefits manag-  
5 er prior to January first, two thousand twenty without having a valid  
6 registration as a pharmacy benefit manager filed with the superintendent  
7 in accordance with this article and any regulations promulgated there-  
8 under.

9 (b) Prior to January first, two thousand twenty, no health insurer may  
10 pay any fee or other compensation to any person, firm, association,  
11 corporation or other entity for performing pharmacy benefit management  
12 services unless the person, firm, association, corporation or other  
13 entity is registered as a pharmacy benefit manager in accordance with  
14 this article.

15 (c) Any person, firm, association, corporation or other entity that  
16 violates this section shall, in addition to any other penalty provided  
17 by law, be liable for restitution to any insurer or insured harmed by  
18 the violation and shall also be subject to a penalty of the greater of  
19 (1) one thousand dollars for the first violation and two thousand five  
20 hundred dollars for each subsequent violation or (2) the aggregate  
21 economic gross receipts attributable to all violations.

22 § 2903. Registration requirements for pharmacy benefit managers. (a)  
23 Every pharmacy benefit manager that performs pharmacy benefit management  
24 services prior to January first, two thousand twenty-one shall register  
25 with the superintendent in a manner acceptable to the superintendent,  
26 and shall pay a fee of one thousand dollars for each year or fraction of  
27 a year in which the registration shall be valid. The superintendent, in  
28 consultation with the commissioner of health, may establish, by regu-

1 lation, minimum registration standards required for a pharmacy benefit  
2 manager. The superintendent can reject a registration application filed  
3 by a pharmacy benefit manager that fails to comply with the minimum  
4 registration standards.

5 (b) For each business entity, the officer or officers and director or  
6 directors named in the application shall be designated responsible for  
7 the business entity's compliance with the financial services and insur-  
8 ance laws, rules and regulations of this state.

9 (c) Every registration will expire on December thirty-first, two thou-  
10 sand twenty regardless of when registration was first made.

11 (d) Every pharmacy benefit manager that performs pharmacy benefit  
12 management services at any time between January first, two thousand  
13 nineteen and June first, two thousand nineteen, shall make the registra-  
14 tion and fee payment required by subsection (a) of this section on or  
15 before June first, two thousand nineteen. Any other pharmacy benefit  
16 manager shall make the registration and fee payment required by  
17 subsection (a) of this section prior to performing pharmacy benefit  
18 management services.

19 (e) Registrants under this section shall be subject to examination by  
20 the superintendent as often as the superintendent may deem it necessary.  
21 The superintendent may promulgate regulations establishing methods and  
22 procedures for facilitating and verifying compliance with the require-  
23 ments of this article and such other regulations as necessary to enforce  
24 the provisions of this article.

25 § 2904. Reporting requirements for pharmacy benefit managers. (a) (1)  
26 On or before July first of each year, beginning in two thousand twenty,  
27 every pharmacy benefit manager shall report to the superintendent, in a  
28 statement subscribed and affirmed as true under penalties of perjury,



1 the information requested by the superintendent including, without limi-  
2 tation, disclosure of any financial incentive or benefit for promoting  
3 the use of certain drugs and other financial arrangements affecting  
4 health insurers or their policyholders or insureds and any information  
5 relating to the business, financial condition, or market conduct of the  
6 pharmacy benefit manager. The superintendent also may require the filing  
7 of quarterly or other statements, which shall be in such form and shall  
8 contain such matters as the superintendent shall prescribe.

9 (2) The superintendent also may address to any pharmacy benefit manag-  
10 er or its officers any inquiry in relation to its provision of pharmacy  
11 benefit management services or any matter connected therewith. Every  
12 pharmacy benefit manager or person so addressed shall reply in writing  
13 to such inquiry promptly and truthfully, and such reply shall be, if  
14 required by the superintendent, subscribed by such individual, or by  
15 such officer or officers of the pharmacy benefit manager, as the super-  
16 intendent shall designate, and affirmed by them as true under the penal-  
17 ties of perjury.

18 (b) In the event any pharmacy benefit manager or person does not  
19 submit the report required by paragraph one of subsection (a) of this  
20 section or does not provide a good faith response to an inquiry from the  
21 superintendent pursuant to paragraph two of subsection (a) of this  
22 section within a time period specified by the superintendent of not less  
23 than fifteen business days, the superintendent is authorized to levy a  
24 civil penalty, after notice and hearing, against such pharmacy benefit  
25 manager or person not to exceed five hundred dollars per day for each  
26 day beyond the date the report is due or the date specified by the  
27 superintendent for response to the inquiry.

1     (c) All information disclosed by a pharmacy benefit manager shall be  
2     deemed confidential and not subject to disclosure unless the superinten-  
3     dent determines that such disclosure is in the public interest, or is  
4     necessary to carry out this article or to allow the department to  
5     perform examinations or investigations authorized by law.

6     § 2905. Acting without a license. (a) No person, firm, association,  
7     corporation or other entity may act as a pharmacy benefit manager on or  
8     after January first, two thousand twenty-one without having authority to  
9     do so by virtue of a license issued in force pursuant to the provisions  
10    of this article.

11    (b) No health insurer may pay any fee or other compensation to any  
12    person, firm, association, corporation or other entity for performing  
13    pharmacy benefit management services on or after January first, two  
14    thousand twenty-one unless the person, firm, association, corporation or  
15    other entity is licensed as a pharmacy benefit manager in accordance  
16    with this article.

17    (c) Any person, firm, association, corporation or other entity that  
18    violates this section shall, in addition to any other penalty provided  
19    by law, be subject to a penalty of the greater of (1) one thousand  
20    dollars for the first violation and two thousand five hundred dollars  
21    for each subsequent violation or (2) the aggregate gross receipts  
22    attributable to all violations.

23    § 2906. Licensing of a pharmacy benefit manager. (a) The superinten-  
24    dent may issue a pharmacy benefit manager's license to any person, firm,  
25    association or corporation who or that has complied with the require-  
26    ments of this article, including regulations promulgated by the super-  
27    intendent. The superintendent, in consultation with the commissioner of

1 health, may establish, by regulation, minimum standards for the issuance  
2 of a license to a pharmacy benefit manager.

3 (b) The minimum standards established under this subsection may  
4 address, without limitation:

5 (1) conflicts of interest between pharmacy benefit managers and health  
6 insurers;

7 (2) deceptive practices in connection with the performance of pharmacy  
8 benefit management services;

9 (3) anti-competitive practices in connection with the performance of  
10 pharmacy benefit management services;

11 (4) unfair claims practices in connection with the performance of  
12 pharmacy benefit management services; and

13 (5) protection of consumers.

14 (c) (1) Any such license issued to a firm or association shall author-  
15 ize all of the members of the firm or association and any designated  
16 employees to act as pharmacy benefit managers under the license, and all  
17 such persons shall be named in the application and supplements thereto.

18 (2) Any such license issued to a corporation shall authorize all of  
19 the officers and any designated employees and directors thereof to act  
20 as pharmacy benefit managers on behalf of such corporation, and all such  
21 persons shall be named in the application and supplements thereto.

22 (3) For each business entity, the officer or officers and director or  
23 directors named in the application shall be designated responsible for  
24 the business entity's compliance with the insurance laws, rules and  
25 regulations of this state.

26 (d) (1) Before a pharmacy benefit manager's license shall be issued or  
27 renewed, the prospective licensee shall properly file in the office of  
28 the superintendent a written application therefor in such form or forms

1 and supplements thereto as the superintendent prescribes, and pay a fee  
2 of one thousand dollars for each year or fraction of a year in which a  
3 license shall be valid.

4 (2) Every pharmacy benefit manager's license issued to a business  
5 entity pursuant to this section shall expire on the thirtieth day of  
6 November of even-numbered years. Every license issued pursuant to this  
7 section to an individual pharmacy benefit manager who was born in an  
8 odd-numbered year, shall expire on the individual's birthday in each  
9 odd-numbered year. Every license issued pursuant to this section to an  
10 individual pharmacy benefit manager who was born in an even-numbered  
11 year, shall expire on the individual's birthday in each even-numbered  
12 year. Every license issued pursuant to this section may be renewed for  
13 the ensuing period of twenty-four months upon the filing of an applica-  
14 tion in conformity with this subsection.

15 (e)(1) If an application for a renewal license shall have been filed  
16 with the superintendent before October first of the year of expiration,  
17 then the license sought to be renewed shall continue in full force and  
18 effect either until the issuance by the superintendent of the renewal  
19 license applied for or until five days after the superintendent shall  
20 have refused to issue such renewal license and given notice of such  
21 refusal to the applicant.

22 (2) Before refusing to renew any license pursuant to this section for  
23 which a renewal application has been filed pursuant to paragraph one of  
24 this subsection, the superintendent shall notify the applicant of the  
25 superintendent's intention to do so and shall give such applicant a  
26 hearing.

27 (f) The superintendent may refuse to issue a pharmacy benefit manag-  
28 er's license if, in the superintendent's judgment, the applicant or any

1 member, principal, officer or director of the applicant, is not trust-  
2 worthy and competent to act as or in connection with a pharmacy benefit  
3 manager, or that any of the foregoing has given cause for revocation or  
4 suspension of such license, or has failed to comply with any prerequi-  
5 site for the issuance of such license.

6 (g) Licensees and applicants for a license under this section shall be  
7 subject to examination by the superintendent as often as the superinten-  
8 dent may deem it expedient. The superintendent may promulgate regu-  
9 lations establishing methods and procedures for facilitating and verify-  
10 ing compliance with the requirements of this section and such other  
11 regulations as necessary.

12 (h) The superintendent may issue a replacement for a currently  
13 in-force license that has been lost or destroyed. Before the replacement  
14 license shall be issued, there shall be on file in the office of the  
15 superintendent a written application for the replacement license,  
16 affirming under penalty of perjury that the original license has been  
17 lost or destroyed, together with a fee of one hundred dollars.

18 § 2907. Revocation or suspension of a registration or license of a  
19 pharmacy benefit manager. (a) The superintendent may refuse to renew,  
20 may revoke, or may suspend for a period the superintendent determines  
21 the registration or license of any pharmacy benefit manager if, after  
22 notice and hearing, the superintendent determines that the registrant or  
23 licensee or any member, principal, officer, director, or controlling  
24 person of the registrant or licensee, has:

25 (1) violated any insurance laws, or violated any regulation, subpoena  
26 or order of the superintendent or of another state's insurance commis-  
27 sioner, or has violated any law in the course of his or her dealings in  
28 such capacity;

1 (2) provided materially incorrect, materially misleading, materially  
2 incomplete or materially untrue information in the registration or  
3 license application;

4 (3) obtained or attempted to obtain a registration or license through  
5 misrepresentation or fraud;

6 (4) (A) used fraudulent, coercive or dishonest practices;

7 (B) demonstrated incompetence;

8 (C) demonstrated untrustworthiness; or

9 (D) demonstrated financial irresponsibility in the conduct of business  
10 in this state or elsewhere;

11 (5) improperly withheld, misappropriated or converted any monies or  
12 properties received in the course of business in this state or else-  
13 where;

14 (6) intentionally misrepresented the terms of an actual or proposed  
15 insurance contract;

16 (7) been convicted of a felony;

17 (8) admitted or been found to have committed any insurance unfair  
18 trade practice or fraud;

19 (9) had a pharmacy benefit manager registration or license, or its  
20 equivalent, denied, suspended or revoked in any other state, province,  
21 district or territory;

22 (10) failed to pay state income tax or comply with any administrative  
23 or court order directing payment of state income tax; or

24 (11) ceased to meet the requirements for registration or licensure  
25 under this article.

26 (b) Before revoking or suspending the registration or license of any  
27 pharmacy benefit manager pursuant to the provisions of this article, the  
28 superintendent shall give notice to the registrant or licensee and to

1 every sub-licensee and shall hold, or cause to be held, a hearing not  
2 less than ten days after the giving of such notice.

3 (c) If a registration or license pursuant to the provisions of this  
4 article is revoked or suspended by the superintendent, then the super-  
5 intendent shall forthwith give notice to the registrant or licensee.

6 (d) The revocation or suspension of any registration or license pursu-  
7 ant to the provisions of this article shall terminate forthwith such  
8 registration or license and the authority conferred thereby upon all  
9 sub-licensees. For good cause shown, the superintendent may delay the  
10 effective date of a revocation or suspension to permit the registrant or  
11 licensee to satisfy some or all of its contractual obligations to  
12 perform pharmacy benefit management services in the state.

13 (e) (1) No individual, corporation, firm or association whose registra-  
14 tion or license as a pharmacy benefit manager has been revoked pursuant  
15 to subsection (a) of this section, and no firm or association of which  
16 such individual is a member, and no corporation of which such individual  
17 is an officer or director, and no controlling person of the registrant  
18 or licensee shall be entitled to obtain any registration or license  
19 under the provisions of this article for a period of one year after such  
20 revocation, or, if such revocation be judicially reviewed, for one year  
21 after the final determination thereof affirming the action of the super-  
22 intendent in revoking such license.

23 (2) If any such registration or license held by a firm, association or  
24 corporation be revoked, no member of such firm or association and no  
25 officer or director of such corporation or any controlling person of the  
26 registrant or licensee shall be entitled to obtain any registration or  
27 license, or to be named as a sub-licensee in any such license, under  
28 this article for the same period of time, unless the superintendent

1 determines, after notice and hearing, that such member, officer or  
2 director was not personally at fault in the matter on account of which  
3 such registration or license was revoked.

4 (f) If any registered or licensed pharmacy benefit manager or any  
5 person aggrieved shall file with the superintendent a verified complaint  
6 setting forth facts tending to show sufficient ground for the revocation  
7 or suspension of any pharmacy benefit manager's registration or license,  
8 then the superintendent shall, after notice and a hearing, determine  
9 whether such registration or license shall be suspended or revoked.

10 (g) The superintendent shall retain the authority to enforce the  
11 provisions of and impose any penalty or remedy authorized by this chap-  
12 ter against any person or entity who is under investigation for or  
13 charged with a violation of this chapter, even if the person's or enti-  
14 ty's registration or license has been surrendered, or has expired or has  
15 lapsed by operation of law.

16 (h) A registrant or licensee subject to this article shall report to  
17 the superintendent any administrative action taken against the regis-  
18 trant or licensee in another jurisdiction or by another governmental  
19 agency in this state within thirty days of the final disposition of the  
20 matter. This report shall include a copy of the order, consent to order  
21 or other relevant legal documents.

22 (i) Within thirty days of the initial pretrial hearing date, a regis-  
23 trant or licensee subject to this article shall report to the super-  
24 intendent any criminal prosecution of the registrant or licensee taken  
25 in any jurisdiction. The report shall include a copy of the initial  
26 complaint filed, the order resulting from the hearing and any other  
27 relevant legal documents.



1    § 2908. Penalties for violations. (a) The superintendent, in lieu of  
2 revoking or suspending the registration or license of a registrant or  
3 licensee in accordance with the provisions of this article, may in any  
4 one proceeding by order, require the registrant or licensee to pay to  
5 the people of this state a penalty in a sum not exceeding the greater of  
6 (1) one thousand dollars for each offense and two thousand five hundred  
7 dollars for each subsequent violation or (2) the aggregate gross  
8 receipts attributable to all offenses.

9    (b) Upon the failure of such a registrant or licensee to pay the  
10 penalty ordered pursuant to subsection (a) of this section within twenty  
11 days after the mailing of the order, postage prepaid, registered, and  
12 addressed to the last known place of business of the licensee, unless  
13 the order is stayed by an order of a court of competent jurisdiction,  
14 the superintendent may revoke the registration or license of the regis-  
15 trant or licensee or may suspend the same for such period as the super-  
16 intendent determines.

17   § 2909. Stay or suspension of superintendent's determination. The  
18 commencement of a proceeding under article seventy-eight of the civil  
19 practice law and rules, to review the action of the superintendent in  
20 suspending or revoking or refusing to renew any certificate under this  
21 article, shall stay such action of the superintendent for a period of  
22 thirty days. Such stay shall not be extended for a longer period unless  
23 the court shall determine, after a preliminary hearing of which the  
24 superintendent is notified forty-eight hours in advance, that a stay of  
25 the superintendent's action pending the final determination or further  
26 order of the court will not unduly injure the interests of the people of  
27 the state.

1    § 2910. Revoked registrations or licenses. (a)(1) No person, firm,  
2 association, corporation or other entity subject to the provisions of  
3 this article whose registration or license under this article has been  
4 revoked, or whose registration or license to engage in the business of  
5 pharmacy benefit management in any capacity has been revoked by any  
6 other state or territory of the United States shall become employed or  
7 appointed by a pharmacy benefit manager as an officer, director, manag-  
8 er, controlling person or for other services, without the prior written  
9 approval of the superintendent, unless such services are for maintenance  
10 or are clerical or ministerial in nature.

11    (2) No person, firm, association, corporation or other entity subject  
12 to the provisions of this article shall knowingly employ or appoint any  
13 person or entity whose registration or license issued under this article  
14 has been revoked, or whose registration or license to engage in the  
15 business of pharmacy benefit management in any capacity has been revoked  
16 by any other state or territory of the United States, as an officer,  
17 director, manager, controlling person or for other services, without the  
18 prior written approval of the superintendent, unless such services are  
19 for maintenance or are clerical or ministerial in nature.

20    (3) No corporation or partnership subject to the provisions of this  
21 article shall knowingly permit any person whose registration or license  
22 issued under this article has been revoked, or whose registration or  
23 license to engage in the business of pharmacy benefit management in any  
24 capacity has been revoked by any other state, or territory of the United  
25 States, to be a shareholder or have an interest in such corporation or  
26 partnership, nor shall any such person become a shareholder or partner  
27 in such corporation or partnership, without the prior written approval  
28 of the superintendent.

1     (b) The superintendent may approve the employment, appointment or  
2 participation of any such person whose registration or license has been  
3 revoked:

4     (1) if the superintendent determines that the duties and responsibil-  
5 ities of such person are subject to appropriate supervision and that  
6 such duties and responsibilities will not have an adverse effect upon  
7 the public, other registrants or licensees, or the registrant or licen-  
8 see proposing employment or appointment of such person; or

9     (2) if such person has filed an application for reregistration or  
10 relicensing pursuant to this article and the application for reregistra-  
11 tion or relicensing has not been approved or denied within one hundred  
12 twenty days following the filing thereof, unless the superintendent  
13 determines within the said time that employment or appointment of such  
14 person by a registrant or licensee in the conduct of a pharmacy benefit  
15 management business would not be in the public interest.

16     (c) The provisions of this section shall not apply to the ownership of  
17 shares of any corporation registered or licensed pursuant to this arti-  
18 cle if the shares of such corporation are publicly held and traded in  
19 the over-the-counter market or upon any national or regional securities  
20 exchange.

21     § 2911. Change of address. A registrant or licensee under this article  
22 shall inform the superintendent by a means acceptable to the superinten-  
23 dent of a change of address within thirty days of the change.

24     § 2912. Applicability of other laws. Nothing in this article shall be  
25 construed to exempt a pharmacy benefit manager from complying with the  
26 provisions of articles twenty-one and forty-nine of this chapter and  
27 article forty-nine of the public health law or any other provision of  
28 this chapter or the financial services law.

1     § 2913. Assessments. Pharmacy benefit managers that file a registra-  
2     tion with the department or are licensed by the department shall be  
3     assessed by the superintendent for the operating expenses of the depart-  
4     ment that are solely attributable to regulating such pharmacy benefit  
5     managers in such proportions as the superintendent shall deem just and  
6     reasonable.

7     § 2. Subsection (b) of section 2402 of the insurance law, as amended  
8     by section 71 of part A of chapter 62 of the laws of 2011, is amended to  
9     read as follows:

10    (b) "Defined violation" means the commission by a person of an act  
11    prohibited by: subsection (a) of section one thousand one hundred two,  
12    section one thousand two hundred fourteen, one thousand two hundred  
13    seventeen, one thousand two hundred twenty, one thousand three hundred  
14    thirteen, subparagraph (B) of paragraph two of subsection (i) of section  
15    one thousand three hundred twenty-two, subparagraph (B) of paragraph two  
16    of subsection (i) of section one thousand three hundred twenty-four, two  
17    thousand one hundred two, two thousand one hundred seventeen, two thou-  
18    sand one hundred twenty-two, two thousand one hundred twenty-three,  
19    subsection (p) of section two thousand three hundred thirteen, section  
20    two thousand three hundred twenty-four, two thousand five hundred two,  
21    two thousand five hundred three, two thousand five hundred four, two  
22    thousand six hundred one, two thousand six hundred two, two thousand six  
23    hundred three, two thousand six hundred four, two thousand six hundred  
24    six, two thousand seven hundred three, two thousand nine hundred two,  
25    two thousand nine hundred five, three thousand one hundred nine, three  
26    thousand two hundred twenty-four-a, three thousand four hundred twenty-  
27    nine, three thousand four hundred thirty-three, paragraph seven of  
28    subsection (e) of section three thousand four hundred twenty-six, four

1 thousand two hundred twenty-four, four thousand two hundred twenty-five,  
2 four thousand two hundred twenty-six, seven thousand eight hundred nine,  
3 seven thousand eight hundred ten, seven thousand eight hundred eleven,  
4 seven thousand eight hundred thirteen, seven thousand eight hundred  
5 fourteen and seven thousand eight hundred fifteen of this chapter; or  
6 section 135.60, 135.65, 175.05, 175.45, or 190.20, or article one  
7 hundred five of the penal law.

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

10 PART J

11 Section 1. This Part enacts into law major components of legislation  
12 which are necessary to protect health care consumers; increase access to  
13 more affordable quality health insurance coverage; and preserve and  
14 foster New York's health insurance markets. Each component is wholly  
15 contained within a Subpart identified as Subparts A through F. The  
16 effective date for each particular provision contained within such  
17 Subpart is set forth in the last section of such Subpart. Any provision  
18 in any section contained within a Subpart, including the effective date  
19 of the Subpart, which makes a reference to a section "of this act," when  
20 used in connection with that particular component, shall be deemed to  
21 mean and refer to the corresponding section of the Subpart in which it  
22 is found. Section five of this Part sets forth the general effective  
23 date of this Part.

24 SUBPART A

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

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

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

12 § 2. Paragraph 1 of subsection (g) of section 3231 of the insurance  
13 law, as amended by section 70 of part D of chapter 56 of the laws of  
14 2013, is amended to read as follows:

15 (1) This section shall also apply to policies issued to a group  
16 defined in subsection (c) of section four thousand two hundred thirty-  
17 five, including but not limited to an association or trust of employers,  
18 if the group includes one or more member employers or other member  
19 groups which have [fifty] one hundred or fewer employees or members  
20 exclusive of spouses and dependents. For policies issued or renewed on  
21 or after January first, two thousand fourteen, if the group includes one  
22 or more member small group employers eligible for coverage subject to  
23 this section, then such member employers shall be classified as small  
24 groups for rating purposes and the remaining members shall be rated  
25 consistent with the rating rules applicable to such remaining members  
26 pursuant to paragraph two of this subsection.

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

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

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

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

19     § 5. Subparagraph (A) of paragraph 1 of subsection (c) of section 4235  
20 of the insurance law, as amended by chapter 515 of the laws of 2010, is  
21 amended to read as follows:

22     (A) A policy issued to an employer or to a trustee or trustees of a  
23 fund established by an employer, which employer or trustee or trustees  
24 shall be deemed the policyholder, insuring with or without evidence of  
25 insurability satisfactory to the insurer, employees of such employer,  
26 and insuring, except as hereinafter provided, all of such employees or  
27 all of any class or classes thereof determined by conditions pertaining  
28 to the employment or a combination of such conditions and conditions

1 pertaining to the family status of the employee, for insurance coverage  
2 on each person insured based upon some plan [which] that will preclude  
3 individual selection. However, such a plan may permit a limited number  
4 of selections by employees if the selections offered utilize consistent  
5 plans of coverage for individual group members so that the resulting  
6 plans of coverage are reasonable. The premium for the policy shall be  
7 paid by the policyholder, either from the employer's funds, or from  
8 funds contributed by the insured employees, or from funds contributed  
9 jointly by the employer and employees. If all or part of the premium is  
10 to be derived from funds contributed by the insured employees, then  
11 [such] the insurer issuing the policy [must insure not less than fifty  
12 percent of such eligible employees or, if less, fifty or more] shall not  
13 require a minimum number or minimum percentage of such employees be  
14 insured when [such] the policy is providing coverage for group hospital,  
15 medical, major medical or similar comprehensive types of expense reim-  
16 bursed insurance and, for all other types of group accident and health  
17 insurance, [must] the policy shall insure a minimum of fifty percent or  
18 five of such eligible employees, whichever is fewer.

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

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

27 (2) The requirements of paragraph one of this subsection shall apply  
28 with respect to an employer that applies for coverage either directly



1 from the corporation or through an association or trust to which the  
2 corporation has issued coverage and in which the employer participates.

3 § 7. Paragraph 1 of subsection (d) of section 4317 of the insurance  
4 law, as amended by section 72 of part D of chapter 56 of the laws of  
5 2013, is amended to read as follows:

6 (1) This section shall also apply to a contract issued to a group  
7 defined in subsection (c) of section four thousand two hundred thirty-  
8 five of this chapter, including but not limited to an association or  
9 trust of employers, if the group includes one or more member employers  
10 or other member groups which have [fifty] one hundred or fewer employees  
11 or members exclusive of spouses and dependents. For contracts issued or  
12 renewed on or after January first, two thousand fourteen, if the group  
13 includes one or more member small group employers eligible for coverage  
14 subject to this section, then such member employers shall be classified  
15 as small groups for rating purposes and the remaining members shall be  
16 rated consistent with the rating rules applicable to such remaining  
17 members pursuant to paragraph two of this subsection.

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

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

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

1 under age nineteen covered under an individual contract of hospital,  
2 medical, surgical or prescription drug expense insurance that is a  
3 grandfathered health plan.

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

10 § 10. Section 4413 of the insurance law is amended by adding a new  
11 subsection (h) to read as follows:

12 (h) (1) On or after June first, two thousand nineteen, an employee  
13 welfare fund registered with the superintendent shall not provide  
14 medical, surgical or hospital care or benefits in the event of sickness  
15 or injury for employees or their families or dependents, or for both,  
16 unless provided under a group comprehensive-type health insurance policy  
17 or contract in accordance with the requirements of this chapter and  
18 delivered or issued for delivery in this state by an authorized insurer  
19 or a health maintenance organization issued a certificate of authority  
20 under article forty-four of the public health law.

21 (2) Notwithstanding paragraph one of this subsection, an employee  
22 welfare fund registered with the superintendent prior to June first, two  
23 thousand nineteen, which, as of February first, two thousand nineteen  
24 directly provided medical, surgical or hospital care or benefits in the  
25 event of sickness or injury for employees or their families or depen-  
26 dents, or for both, may continue to provide those benefits directly  
27 rather than under a group comprehensive-type health insurance policy or  
28 contract delivered or issued for delivery in this state by an authorized

1 insurer or a health maintenance organization issued a certificate of  
2 authority under article forty-four of the public health law; provided,  
3 however, that, if the employee welfare fund ceases offering the benefits  
4 directly, it may not resume providing the benefits directly.

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

8 1. The contract between a health maintenance organization and an  
9 enrollee shall be subject to regulation by the superintendent as if it  
10 were a health insurance subscriber contract, and shall include, but not  
11 be limited to, all mandated benefits required by article forty-three of  
12 the insurance law. Such contract shall fully and clearly state the bene-  
13 fits and limitations therein provided or imposed, so as to facilitate  
14 understanding and comparisons, and to exclude provisions which may be  
15 misleading or unreasonably confusing. Such contract shall be issued to  
16 any individual and dependents of such individual and any group of  
17 [fifty] one hundred or fewer employees or members, exclusive of spouses  
18 and dependents, or to any employee or member of the group, including  
19 dependents, applying for such contract at any time throughout the year[,  
20 and may include a pre-existing condition provision as provided for in  
21 section four thousand three hundred eighteen of the insurance law,  
22 provided, however, that, the]. An individual direct payment contract  
23 shall be issued only in accordance with section four thousand three  
24 hundred twenty-eight of the insurance law. The superintendent may, after  
25 giving consideration to the public interest, exempt a health maintenance  
26 organization from the requirements of this section provided that another  
27 health insurer or health maintenance organization within the health  
28 maintenance organization's same holding company system, as defined in

1 article fifteen of the insurance law, including a health maintenance  
2 organization operated as a line of business of a health service corpo-  
3 ration licensed under article forty-three of the insurance law, offers  
4 coverage that, at a minimum, complies with this section and provides all  
5 of the consumer protections required to be provided by a health mainte-  
6 nance organization pursuant to this chapter and regulations, including  
7 those consumer protections contained in sections four thousand four  
8 hundred three and four thousand four hundred eight-a of this chapter.  
9 The requirements shall not apply to a health maintenance organization  
10 exclusively serving individuals enrolled pursuant to title eleven of  
11 article five of the social services law, title eleven-D of article five  
12 of the social services law, title one-A of article twenty-five of [the  
13 public health law] this chapter or title eighteen of the federal Social  
14 Security Act, and, further provided, that such health maintenance organ-  
15 ization shall not discontinue a contract for an individual receiving  
16 comprehensive-type coverage in effect prior to January first, two thou-  
17 sand four who is ineligible to purchase policies offered after such date  
18 pursuant to this section or section four thousand three hundred [twen-  
19 ty-two of this article] twenty-eight of the insurance law due to the  
20 provision of 42 U.S.C. 1395ss in effect prior to January first, two  
21 thousand four. [Subject to the creditable coverage requirements of  
22 subsection (a) of section four thousand three hundred eighteen of the  
23 insurance law, the organization may, as an alternative to the use of a  
24 pre-existing condition provision, elect to offer contracts without a  
25 pre-existing condition provision to such groups but may require that  
26 coverage shall not become effective until after a specified affiliation  
27 period of not more than sixty days after the application for coverage is  
28 submitted. The organization is not required to provide health care

1 services or benefits during such period and no premium shall be charged  
2 for any coverage during the period. After January first, nineteen  
3 hundred ninety-six, all individual direct payment contracts shall be  
4 issued only pursuant to sections four thousand three hundred twenty-one  
5 and four thousand three hundred twenty-two of the insurance law. Such  
6 contracts may not, with respect to an eligible individual (as defined in  
7 section 2741(b) of the federal Public Health Service Act, 42 U.S.C. §  
8 300gg-41(b), impose any pre-existing condition exclusion.]

9 § 12. This act shall take effect immediately, provided that:

10 (1) sections one, three, four, five, six, eight and nine of this act  
11 shall apply to all policies and contracts issued, renewed, modified,  
12 altered or amended on or after January 1, 2020; and

13 (2) sections two and seven of this act shall take effect on the same  
14 date as the reversion of paragraph 1 of subsection (g) of section 3231  
15 and paragraph 1 of subsection (d) of section 4317 of the insurance law,  
16 as provided in section 5 of chapter 588 of the laws of 2015, as amended.

17 SUBPART B

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

21 (A) Any family policy providing hospital or surgical expense insurance  
22 (but not including such insurance against accidental injury only) shall  
23 provide that, in the event such insurance on any person, other than the  
24 policyholder, is terminated because the person is no longer within the  
25 definition of the family as set forth in the policy but before such  
26 person has attained the limiting age, if any, for coverage of adults

1 specified in the policy, such person shall be entitled to have issued to  
2 that person by the insurer, without evidence of insurability, upon  
3 application therefor and payment of the first premium, within sixty days  
4 after such insurance shall have terminated, an individual conversion  
5 policy that contains the essential health benefits package described in  
6 paragraph [one] three of subsection [(b)] (f) of section [four thousand  
7 three hundred twenty-eight of this chapter. The insurer shall offer one  
8 policy at each level of coverage as defined in section 1302(d) of the  
9 affordable care act, 42 U.S.C. § 18022(d).] three thousand two hundred  
10 seventeen-i of this article. The insurer shall offer one policy at each  
11 level of coverage as defined in subsection (c) of section three thousand  
12 two hundred seventeen-i of this article. The individual may choose any  
13 such policy offered by the insurer. Provided, however, the superinten-  
14 dent may, after giving due consideration to the public interest, approve  
15 a request made by an insurer for the insurer to satisfy the requirements  
16 of this subparagraph through the offering of policies that comply with  
17 this subparagraph by another insurer, corporation or health maintenance  
18 organization within the insurer's holding company system, as defined in  
19 article fifteen of this chapter. The conversion privilege afforded here-  
20 in shall also be available upon the divorce or annulment of the marriage  
21 of the policyholder to the former spouse of such policyholder.

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

25 (E) The superintendent may, after giving due consideration to the  
26 public interest, approve a request made by an insurer for the insurer to  
27 satisfy the requirements of subparagraph (C) of this paragraph through  
28 the offering of policies at each level of coverage as defined in

1 subsection (c) of section [1302(d) of the affordable care act, 42 U.S.C.  
2 § 18022(d)] three thousand two hundred seventeen-i of this article that  
3 contains the essential health benefits package described in paragraph  
4 [one] three of subsection [(b)] (f) of section [four thousand three  
5 hundred twenty-eight of this chapter] three thousand two hundred seven-  
6 teen-i of this article by another insurer, corporation or health mainte-  
7 nance organization within the insurer's same holding company system, as  
8 defined in article fifteen of this chapter.

9 § 3. Items (i) and (ii) of subparagraph (D) of paragraph 11 of  
10 subsection (i) of section 3216 of the insurance law, as added by chapter  
11 219 of the laws of 2011, are amended, and a new item (iii) is added to  
12 read as follows:

13 (i) evidence-based items or services for mammography that have in  
14 effect a rating of 'A' or 'B' in the current recommendations of the  
15 United States preventive services task force; [and]

16 (ii) with respect to women, such additional preventive care and  
17 screenings for mammography not described in item (i) of this subpara-  
18 graph and as provided for in comprehensive guidelines supported by the  
19 health resources and services administration[.]; and

20 (iii) any other preventive care and screenings designated by the  
21 superintendent in a regulation that are consistent with current or  
22 previous recommendations or guidelines identified in items (i) and (ii)  
23 of this subparagraph.

24 § 4. Items (i) and (ii) of subparagraph (D) of paragraph 15 of  
25 subsection (i) of section 3216 of the insurance law, as added by chapter  
26 219 of the laws of 2011, are amended, and a new item (iii) is added to  
27 read as follows:

1 (i) evidence-based items or services for cervical cytology that have  
2 in effect a rating of 'A' or 'B' in the current recommendations of the  
3 United States preventive services task force; [and]

4 (ii) with respect to women, such additional preventive care and  
5 screenings for cervical cytology not described in item (i) of this  
6 subparagraph and as provided for in comprehensive guidelines supported  
7 by the health resources and services administration[.]; and

8 (iii) any other preventive care and screenings designated by the  
9 superintendent in a regulation that are consistent with current or  
10 previous recommendations or guidelines identified in items (i) and (ii)  
11 of this subparagraph.

12 § 5. Items (iii) and (iv) of subparagraph (E) of paragraph 17 of  
13 subsection (i) of section 3216 of the insurance law, as added by chapter  
14 219 of the laws of 2011, are amended and a new item (v) is added to read  
15 as follows:

16 (iii) with respect to children, including infants and adolescents,  
17 evidence-informed preventive care and screenings provided for in compre-  
18 hensive guidelines supported by the health resources and services admin-  
19 istration; [and]

20 (iv) with respect to women, such additional preventive care and  
21 screenings not described in item (i) of this subparagraph and as  
22 provided for in comprehensive guidelines supported by the health  
23 resources and services administration[.]; and

24 (v) any other preventive care and screenings designated by the super-  
25 intendent in a regulation that are consistent with current or previous  
26 recommendations or guidelines identified in items (i) through (iv) of  
27 this subparagraph.



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

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

1 products for any calendar year or for any continuous period of twelve  
2 months for any insured individual shall not exceed two thousand five  
3 hundred dollars].

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

7 (30) Every policy [which] that provides medical coverage that includes  
8 coverage for physician services in a physician's office and every policy  
9 [which] that provides major medical or similar comprehensive-type cover-  
10 age shall include coverage for equipment and supplies used for the  
11 treatment of ostomies, if prescribed by a physician or other licensed  
12 health care provider legally authorized to prescribe under title eight  
13 of the education law. Such coverage shall be subject to annual deduct-  
14 ibles and coinsurance as deemed appropriate by the superintendent. The  
15 coverage required by this paragraph shall be identical to, and shall not  
16 enhance or increase the coverage required as part of essential health  
17 benefits as [required pursuant to] defined in subsection (a) of section  
18 [2707 (a) of the public health services act 42 U.S.C. 300 gg-6(a)] three  
19 thousand two hundred seventeen-i of this article.

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

23 (1) [On and after October first, two thousand thirteen, an] An insurer  
24 shall not offer individual hospital, medical or surgical expense insur-  
25 ance policies unless the policies meet the requirements of subsection  
26 (b) of section four thousand three hundred twenty-eight of this chapter.  
27 Such policies that are offered within the health benefit exchange estab-  
28 lished [pursuant to section 1311 of the affordable care act, 42 U.S.C. §

1 18031, or any regulations promulgated thereunder,] by this state also  
2 shall meet any requirements established by the health benefit exchange.

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

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

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

19 § 3217-i. Essential health benefits package and limit on cost-sharing.

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

22 (1) ambulatory patient services;

23 (2) emergency services;

24 (3) hospitalization;

25 (4) maternity and newborn care;

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

28 (6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

and

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

(b) The superintendent, in consultation with the commissioner of health, may select as a benchmark, a plan or combination of plans that together contain essential health benefits, in accordance with this section and any applicable federal regulation.

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

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

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

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

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

1 equivalent to ninety percent of the full actuarial value of the benefits  
2 provided under the plan.

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

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

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

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

24 (f) For purposes of this section:

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

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

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

4     (A) provides for essential health benefits;

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

7     (C) provides one of the levels of coverage described in subsection (c)  
8     of this section;

9     (4) "grandfathered health plan" means coverage provided by an insurer  
10    in which an individual was enrolled on March twenty-third, two thousand  
11    ten for as long as the coverage maintains grandfathered status in  
12    accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. §  
13    18011(e);

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

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

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

21    (g) For conversion purposes, an insurer shall offer to the employee or  
22    member a policy at each level of coverage as defined in subsection (c)  
23    of section [1302(d) of the affordable care act, 42 U.S.C. § 18022(d)]  
24    three thousand two hundred seventeen-i of this article that contains the  
25    essential health benefits package described in paragraph [one] three of  
26    subsection [(b)] (f) of section [four thousand three hundred twenty-  
27    eight of this chapter] three thousand two hundred seventeen-i of this  
28    article. Provided, however, the superintendent may, after giving due

1 consideration to the public interest, approve a request made by an  
2 insurer for the insurer to satisfy the requirements of this subsection  
3 and subsections (e) and (f) of this section through the offering of  
4 policies that comply with this subsection by another insurer, corpo-  
5 ration or health maintenance organization within the insurer's holding  
6 company system, as defined in article fifteen of this chapter.

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

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

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

20 (2) "grandfathered health plan" means coverage provided by an insurer  
21 in which an individual was enrolled on March twenty-third, two thousand  
22 ten for as long as the coverage maintains grandfathered status in  
23 accordance with section 1251(e) of the affordable care act, 42 U.S.C. §  
24 18011(e);

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

1 group of] one hundred or fewer employees or members exclusive of spouses  
2 and dependents; and

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

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

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

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

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

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

22 (11) Every policy [which] that provides coverage for prescription  
23 drugs shall include coverage for the cost of enteral formulas for home  
24 use, whether administered orally or via tube feeding, for which a physi-  
25 cian or other licensed health care provider legally authorized to  
26 prescribe under title eight of the education law has issued a written  
27 order. Such written order shall state that the enteral formula is clear-  
28 ly medically necessary and has been proven effective as a disease-spe-



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

22 § 15. Items (i) and (ii) of subparagraph (D) of paragraph 13 of  
23 subsection (k) of section 3221 of the insurance law, as added by chapter  
24 219 of the laws of 2011, are amended and a new item (iii) is added to  
25 read as follows:

26 (i) evidence-based items or services for bone mineral density that  
27 have in effect a rating of 'A' or 'B' in the current recommendations of  
28 the United States preventive services task force; [and]

(ii) with respect to women, such additional preventive care and screenings for bone mineral density not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration[.]; and

(iii) any other preventive care and screenings designated by the superintendent in a regulation that are consistent with current or previous recommendations or guidelines identified in items (i) and (ii) of this subparagraph.

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

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

§ 17. Items (iii) and (iv) of subparagraph (E) of paragraph 8 of subsection (1) of section 3221 of the insurance law, as added by chapter

1 219 of the laws of 2011, are amended and a new item (v) is added to read  
2 as follows:

3 (iii) with respect to children, including infants and adolescents,  
4 evidence-informed preventive care and screenings provided for in compre-  
5 hensive guidelines supported by the health resources and services admin-  
6 istration; [and]

7 (iv) with respect to women, such additional preventive care and  
8 screenings not described in item (i) of this subparagraph and as  
9 provided for in comprehensive guidelines supported by the health  
10 resources and services administration[.]; and

11 (v) any other preventive care and screenings designated by the super-  
12 intendent in a regulation that are consistent with current or previous  
13 recommendations or guidelines identified in items (i) through (iv) of  
14 this subparagraph.

15 § 18. Items (i) and (ii) of subparagraph (D) of paragraph 11 of  
16 subsection (1) of section 3221 of the insurance law, as added by chapter  
17 219 of the laws of 2011, are amended and a new item (iii) is added to  
18 read as follows:

19 (i) evidence-based items or services for mammography that have in  
20 effect a rating of 'A' or 'B' in the current recommendations of the  
21 United States preventive services task force; [and]

22 (ii) with respect to women, such additional preventive care and  
23 screenings for mammography not described in item (i) of this subpara-  
24 graph and as provided for in comprehensive guidelines supported by the  
25 health resources and services administration[.]; and

26 (iii) any other preventive care and screenings designated by the  
27 superintendent in a regulation that are consistent with current or

1 previous recommendations or guidelines identified in items (i) and (ii)  
2 of this subparagraph.

3 § 19. Items (i) and (ii) of subparagraph (D) of paragraph 14 of  
4 subsection (1) of section 3221 of the insurance law, as added by chapter  
5 219 of the laws of 2011, are amended and a new item (iii) is added to  
6 read as follows:

7 (i) evidence-based items or services for cervical cytology that have  
8 in effect a rating of 'A' or 'B' in the current recommendations of the  
9 United States preventive services task force; [and]

10 (ii) with respect to women, such additional preventive care and  
11 screenings for cervical cytology not described in item (i) of this  
12 subparagraph and as provided for in comprehensive guidelines supported  
13 by the health resources and services administration[.]; and

14 (iii) any other preventive care and screenings designated by the  
15 superintendent in a regulation that are consistent with current or  
16 previous recommendations or guidelines identified in items (i) and (ii)  
17 of this subparagraph.

18 § 20. Paragraph 4 of subsection (a) of section 3231 of the insurance  
19 law, as amended by section 69 of part D of chapter 56 of the laws of  
20 2013, is amended to read as follows:

21 (4) For the purposes of this section, "community rated" means a rating  
22 methodology in which the premium for all persons covered by a policy  
23 form is the same based on the experience of the entire pool of risks of  
24 all individuals or small groups covered by the insurer without regard to  
25 age, sex, health status, tobacco usage or occupation, excluding those  
26 individuals or small groups covered by medicare supplemental insurance.  
27 For medicare supplemental insurance coverage, "community rated" means a  
28 rating methodology in which the premiums for all persons covered by a

1 policy or contract form is the same based on the experience of the  
2 entire pool of risks covered by that policy or contract form without  
3 regard to age, sex, health status, tobacco usage or occupation.  
4 [Catastrophic health insurance policies issued pursuant to section  
5 1302(e) of the affordable care act, 42 U.S.C. § 18022(e), shall be clas-  
6 sified in a distinct community rating pool.]

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

10 (d) A student accident and health insurance policy or contract shall  
11 provide coverage for essential health benefits as defined in subsection  
12 (a) of section [1302(b) of the affordable care act, 42 U.S.C. §  
13 18022(b)] three thousand two hundred seventeen-i or subsection (a) of  
14 section four thousand three hundred six-h of this chapter, as  
15 applicable.

16 § 22. Subparagraph (A) of paragraph 3 of subsection (d) of section  
17 4235 of the insurance law, as added by section 60 of part D of chapter  
18 56 of the laws of 2013, is amended to read as follows:

19 (A) "employee" shall have the meaning set forth in [section 2791 of  
20 the public health service act, 42 U.S.C. § 300gg-91(d)(5) or any regu-  
21 lations promulgated thereunder] the Employee Retirement Income Security  
22 Act of 1974, 29 U.S.C. § 1002(6); and

23 § 23. Subparagraphs (C) and (D) of paragraph 3 of subsection (j) of  
24 section 4303 of the insurance law, as added by chapter 219 of the laws  
25 of 2011, are amended and a new subparagraph (E) is added to read as  
26 follows:

27 (C) with respect to children, including infants and adolescents,  
28 evidence-informed preventive care and screenings provided for in compre-

1 hensive guidelines supported by the health resources and services admin-  
2 istration; [and]

3 (D) with respect to women, such additional preventive care and screen-  
4 ings not described in subparagraph (A) of this paragraph and as provided  
5 for in comprehensive guidelines supported by the health resources and  
6 services administration[.]; and

7 (E) any other preventive care and screenings designated by the super-  
8 intendent in a regulation that are consistent with current or previous  
9 recommendations or guidelines identified in subparagraphs (A) through  
10 (D) of this paragraph.

11 § 24. Subparagraphs (A) and (B) of paragraph 3 of subsection (p) of  
12 section 4303 of the insurance law, as added by chapter 219 of the laws  
13 of 2011, are amended and a new subparagraph (C) is added to read as  
14 follows:

15 (A) evidence-based items or services for mammography that have in  
16 effect a rating of 'A' or 'B' in the current recommendations of the  
17 United States preventive services task force; [and]

18 (B) with respect to women, such additional preventive care and screen-  
19 ings for mammography not described in subparagraph (A) of this paragraph  
20 and as provided for in comprehensive guidelines supported by the health  
21 resources and services administration[.]; and

22 (C) any other preventive care and screenings designated by the super-  
23 intendent in a regulation that are consistent with current or previous  
24 recommendations or guidelines identified in subparagraphs (A) and (B) of  
25 this paragraph.

26 § 25. Subparagraphs (A) and (B) of paragraph 3 of subsection (t) of  
27 section 4303 of the insurance law, as added by chapter 219 of the laws

1 of 2011, are amended and a new subparagraph (C) is added to read as  
2 follows:

3 (A) evidence-based items or services for cervical cytology that have  
4 in effect a rating of 'A' or 'B' in the current recommendations of the  
5 United States preventive services task force; [and]

6 (B) with respect to women, such additional preventive care and screen-  
7 ings for cervical cytology not described in subparagraph (A) of this  
8 paragraph and as provided for in comprehensive guidelines supported by  
9 the health resources and services administration[.]; and

10 (C) any other preventive care and screenings designated by the super-  
11 intendent in a regulation that are consistent with current or previous  
12 recommendations or guidelines identified in subparagraphs (A) and (B) of  
13 this paragraph.

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

17 (u-1) A medical expense indemnity corporation or a health service  
18 corporation which provides medical coverage that includes coverage for  
19 physician services in a physician's office and every policy which  
20 provides major medical or similar comprehensive-type coverage shall  
21 include coverage for equipment and supplies used for the treatment of  
22 ostomies, if prescribed by a physician or other licensed health care  
23 provider legally authorized to prescribe under title eight of the educa-  
24 tion law. Such coverage shall be subject to annual deductibles and coin-  
25 surance as deemed appropriate by the superintendent. The coverage  
26 required by this subsection shall be identical to, and shall not enhance  
27 or increase the coverage required as part of essential health benefits  
28 as [required pursuant to] defined in subsection (a) of section [2707(a)]

1 of the public health services act 42 U.S.C. 300 gg-6(a)] four thousand  
2 three hundred six-h of this article.

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

5 (y) Every contract [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



1 medically necessary[, and such coverage for such modified solid food  
2 products for any calendar year or for any continuous period of twelve  
3 months for any insured individual shall not exceed two thousand five  
4 hundred dollars].

5 § 28. Subparagraphs (A) and (B) of paragraph 4 of subsection (bb) of  
6 section 4303 of the insurance law, as added by chapter 219 of the laws  
7 of 2011, are amended and a new subparagraph (C) is added to read as  
8 follows:

9 (A) evidence-based items or services for bone mineral density that  
10 have in effect a rating of 'A' or 'B' in the current recommendations of  
11 the United States preventive services task force; [and]

12 (B) with respect to women, such additional preventive care and screen-  
13 ings for bone mineral density not described in subparagraph (A) of this  
14 paragraph and as provided for in comprehensive guidelines supported by  
15 the health resources and services administration[.]; and

16 (C) any other preventive care and screenings designated by the super-  
17 intendent in a regulation that are consistent with current or previous  
18 recommendations or guidelines identified in subparagraphs (A) and (B) of  
19 this paragraph.

20 § 29. Subsection (11) of section 4303 of the insurance law, as added  
21 by section 55 of part D of chapter 56 of the laws of 2013, is amended to  
22 read as follows:

23 (11) Every small group contract or association group contract [deliv-  
24 ered or issued for delivery in this state] issued by a corporation  
25 subject to the provisions of this article that provides coverage for  
26 hospital, medical or surgical expense insurance and is not a grandfa-  
27 thered health plan shall provide coverage for the essential health  
28 [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 (f) 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  
13 members exclusive of spouses and dependents. Beginning January first,  
14 two thousand sixteen, "small group" means a group of] one hundred or  
15 fewer 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

1 established [pursuant to section 1311 of the affordable care act, 42  
2 U.S.C. § 18031] by this state, a corporation shall not be required to  
3 offer the contract holder any benefits that must be made available  
4 pursuant to this section.

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

8 (i) Discontinuance of a class of contract upon not less than ninety  
9 days' prior written notice. In exercising the option to discontinue  
10 coverage pursuant to this item, the corporation must act uniformly with-  
11 out regard to any health status-related factor of enrolled individuals  
12 or individuals who may become eligible for such coverage and must offer  
13 to subscribers or group remitting agents, as may be appropriate, the  
14 option to purchase all other individual health insurance coverage  
15 currently being offered by the corporation to applicants in that market.  
16 Provided, however, the superintendent may, after giving due consider-  
17 ation to the public interest, approve a request made by a corporation  
18 for the corporation to satisfy the requirements of this item through the  
19 offering of contracts at each level of coverage as defined in subsection  
20 (c) of section [1302(d) of the affordable care act, 42 U.S.C. §  
21 18022(d)] four thousand three hundred six-h of this article that  
22 contains the essential health benefits package described in paragraph  
23 [one] three of subsection [(b)] (f) of section four thousand three  
24 hundred [twenty-eight] six-h of this [chapter] article by another corpo-  
25 ration, insurer or health maintenance organization within the corpo-  
26 ration's same holding company system, as defined in article fifteen of  
27 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)] (f) 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 (c) of section [1302(d)] of the affordable care

1 act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this  
2 article. The individual may choose any such contract offered by the  
3 corporation. Provided, however, the superintendent may, after giving due  
4 consideration to the public interest, approve a request made by a corpo-  
5 ration for the corporation to satisfy the requirements of this paragraph  
6 through the offering of contracts that comply with this paragraph by  
7 another corporation, insurer or health maintenance organization within  
8 the corporation's same holding company system, as defined in article  
9 fifteen of this chapter.

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

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

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

1 through the offering of contracts that comply with this subparagraph by  
2 another corporation, insurer or health maintenance organization within  
3 the corporation's same holding company system, as defined in article  
4 fifteen of this chapter.

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

7 § 4306-h. Essential health benefits package and limit on cost-sharing.

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

10 (1) ambulatory patient services;

11 (2) emergency services;

12 (3) hospitalization;

13 (4) maternity and newborn care;

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

16 (6) prescription drugs;

17 (7) rehabilitative and habilitative services and devices;

18 (8) laboratory services;

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

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

22 (b) The superintendent, in consultation with the commissioner of  
23 health, may select as a benchmark, a plan or combination of plans that  
24 together contain essential health benefits, in accordance with this  
25 section and any applicable federal regulation.

26 (c) (1) Every individual and small group contract that provides hospi-  
27 tal, surgical, or medical expense coverage and is not a grandfathered

1 health plan shall provide coverage that meets the actuarial requirements  
2 of one of the following levels of coverage:

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

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

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

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

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

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

27 (d) Every individual or group contract that provides hospital, surgi-  
28 cal, or medical expense coverage and is not a grandfathered health plan,



1 and every student accident and health insurance contract shall limit the  
2 insured's cost-sharing for in-network services in a contract year to not  
3 more than the maximum out-of-pocket amount determined by the superinten-  
4 dent for all contracts subject to this section. Such amount shall not  
5 exceed any annual out-of-pocket limit on cost-sharing set by the United  
6 States secretary of health and human services, if available.

7 (e) The superintendent may require the use of model language describ-  
8 ing the coverage requirements for any form that is subject to the  
9 approval of the superintendent pursuant to section four thousand three  
10 hundred eight of this article.

11 (f) For purposes of this section:

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

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

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

19 (A) provides for essential health benefits;

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

22 (C) provides one of the levels of coverage described in subsection (c)  
23 of this section;

24 (4) "grandfathered health plan" means coverage provided by a corpo-  
25 ration in which an individual was enrolled on March twenty-third, two  
26 thousand ten for as long as the coverage maintains grandfathered status  
27 in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C.  
28 § 18011(e);

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

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

6     § 36. Paragraph 4 of subsection (a) of section 4317 of the insurance  
7 law, as amended by section 72 of part D of chapter 56 of the laws of  
8 2013, is amended to read as follows:

9     (4) For the purposes of this section, "community rated" means a rating  
10 methodology in which the premium for all persons covered by a policy or  
11 contract form is the same, based on the experience of the entire pool of  
12 risks of all individuals or small groups covered by the corporation  
13 without regard to age, sex, health status, tobacco usage or occupation  
14 excluding those individuals of small groups covered by Medicare supple-  
15 mental insurance. For medicare supplemental insurance coverage, "commu-  
16 nity rated" means a rating methodology in which the premiums for all  
17 persons covered by a policy or contract form is the same based on the  
18 experience of the entire pool of risks covered by that policy or  
19 contract form without regard to age, sex, health status, tobacco usage  
20 or occupation. [Catastrophic health insurance contracts issued pursuant  
21 to section 1302(e) of the affordable care act, 42 U.S.C. § 18022(e),  
22 shall be classified in a distinct community rating pool.]

23     § 37. Subsections (d), (e) and (j) of section 4326 of the insurance  
24 law, as amended by section 56 of part D of chapter 56 of the laws of  
25 2013, are amended to read as follows:

26     (d) A qualifying group health insurance contract shall provide cover-  
27 age for the essential health [benefit] benefits package as [required in]  
28 defined in paragraph three of subsection (f) of section [2707(a) of the

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

5 (e) A qualifying group health insurance contract [issued to a qualify-  
6 ing small employer prior to January first, two thousand fourteen that  
7 does not include all essential health benefits required pursuant to  
8 section 2707(a) of the public health service act, 42 U.S.C. §  
9 300gg-6(a), shall be discontinued, including grandfathered health plans.  
10 For the purposes of this paragraph, "grandfathered health plans" means  
11 coverage provided by a corporation to individuals who were enrolled on  
12 March twenty-third, two thousand ten for as long as the coverage main-  
13 tains grandfathered status in accordance with section 1251(e) of the  
14 affordable care act, 42 U.S.C. § 18011(e). A qualifying small employer  
15 shall be transitioned to a plan that provides: (1)] shall provide a  
16 level of coverage that is designed to provide benefits that are actuari-  
17 ally equivalent to eighty percent of the full actuarial value of the  
18 benefits provided under the plan[; and (2) coverage for the essential  
19 health benefit package as required in section 2707(a) of the public  
20 health service act, 42 U.S.C. § 300gg-6(a)]. The superintendent shall  
21 standardize the benefit package and cost sharing requirements of quali-  
22 fied group health insurance contracts consistent with coverage offered  
23 through the health benefit exchange established [pursuant to section  
24 1311 of the affordable care act, 42 U.S.C. § 18031] by this state.

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

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

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

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

15     (1) The individual enrollee direct payment contract offered pursuant  
16 to this section shall provide coverage for the essential health [bene-  
17 fit] benefits package as [required in] defined in paragraph three of  
18 subsection (f) of section [2707(a) of the public health service act, 42  
19 U.S.C. § 300gg-6(a). For purposes of this paragraph, "essential health  
20 benefits package" shall have the meaning set forth in section 1302(a) of  
21 the affordable care act, 42 U.S.C. § 18022(a)] four thousand three  
22 hundred six-h of this article.

23     (2) A health maintenance organization shall offer at least one indi-  
24 vidual enrollee direct payment contract at each level of coverage as  
25 defined in subsection (c) of section [1302(d) of the affordable care  
26 act, 42 U.S.C. § 18022(d)] four thousand three hundred six-h of this  
27 article. A health maintenance organization also shall offer one child-  
28 only plan, as required by section 1302(f) of the affordable care act, 42

1 U.S.C. § 18022(f), at each level of coverage [as required in section  
2 2707(c) of the public health service act, 42 U.S.C. § 300gg-6(c)].

3 (3) Within the health benefit exchange established [pursuant to  
4 section 1311 of the affordable care act, 42 U.S.C. § 18031] by this  
5 state, a health maintenance organization may offer an individual enrol-  
6 lee direct payment contract that is a catastrophic health plan as  
7 defined in section 1302(e) of the affordable care act, 42 U.S.C. §  
8 18022(e), or any regulations promulgated thereunder.

9 § 40. Subparagraph (A) of paragraph 4 of subsection (b) of section  
10 4328 of the insurance law, as added by chapter 11 of the laws of 2016,  
11 is amended to read as follows:

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

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

21 (c) In addition to or in lieu of the individual enrollee direct  
22 payment contracts required under this section, all health maintenance  
23 organizations issued a certificate of authority under article forty-four  
24 of the public health law or licensed under this article may offer indi-  
25 vidual enrollee direct payment contracts within the health benefit  
26 exchange established [pursuant to section 1311 of the affordable care  
27 act, 42 U.S.C. § 18031, or any regulations promulgated thereunder] by  
28 this state, subject to any requirements established by the health bene-

1 fit exchange. If a health maintenance organization satisfies the  
2 requirements of subsection (a) of this section by offering individual  
3 enrollee direct payment contracts, only within the health benefit  
4 exchange, the health maintenance organization, not including a holder of  
5 a special purpose certificate of authority issued pursuant to section  
6 four thousand four hundred three-a of the public health law, shall also  
7 offer at least one individual enrollee direct payment contract at each  
8 level of coverage as defined in subsection (c) section [1302 (d) of the  
9 affordable care act, 42 U.S.C. § 18022 (d)] four thousand three hundred  
10 six-h of this article, outside the health benefit exchange.

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

15 SUBPART C

16 Section 1. Subsection (i) of section 3216 of the insurance law is  
17 amended by adding a new paragraph 35 to read as follows:

18 (35) No policy delivered or issued for delivery in this state that  
19 provides hospital, surgical, or medical expense coverage shall limit or  
20 exclude coverage for abortions that are medically necessary. Coverage  
21 for abortions that are medically necessary shall not be subject to annu-  
22 al deductibles or coinsurance, including co-payments, unless the policy  
23 is a high deductible health plan as defined in section 223(c)(2) of the  
24 internal revenue code of 1986; in which case coverage for medically  
25 necessary abortions may be subject to the plan's annual deductible.

1     § 2. Subsection (1) of section 3221 of the insurance law is amended by  
2 adding a new paragraph 21 to read as follows:

3     (21) (A) No policy delivered or issued for delivery in this state that  
4 provides hospital, surgical, or medical expense coverage shall limit or  
5 exclude coverage for abortions that are medically necessary. Coverage  
6 for abortions that are medically necessary shall not be subject to annu-  
7 al deductibles or coinsurance, including co-payments, unless the policy  
8 is a high deductible health plan as defined in section 223(c)(2) of the  
9 internal revenue code of 1986; in which case coverage for medically  
10 necessary abortions may be subject to the plan's annual deductible.

11     (B) Notwithstanding any other provision, a group policy that provides  
12 hospital, surgical, or medical expense coverage delivered or issued for  
13 delivery in this state to a religious employer, as defined in paragraph  
14 sixteen of this subsection, may exclude coverage for medically necessary  
15 abortions only if the insurer:

16     (i) obtains an annual certification from the group policyholder that  
17 the policyholder is a religious employer and that the religious employer  
18 requests a policy without coverage for medically necessary abortions;

19     (ii) issues a rider to each certificateholder at no premium to be  
20 charged to the certificateholder or religious employer for the rider,  
21 that provides coverage for medically necessary abortions subject to the  
22 same rules as would have been applied to the same category of treatment  
23 in the policy issued to the religious employer. The rider shall clearly  
24 and conspicuously specify that the religious employer does not adminis-  
25 ter medically necessary abortion benefits, but that the insurer is issu-  
26 ing a rider for coverage of medically necessary abortions, and shall  
27 provide the insurer's contact information for questions; and

1 (iii) provides notice of the issuance of the policy and rider to the  
2 superintendent in a form and manner acceptable to the superintendent.

3 § 3. Section 4303 of the insurance law is amended by adding a new  
4 subsection (ss) to read as follows:

5 (ss) (1) No contract issued by a corporation subject to the provisions  
6 of this article that provides hospital, surgical, or medical expense  
7 coverage shall limit or exclude coverage for abortions that are  
8 medically necessary. Coverage for abortions that are medically necessary  
9 shall not be subject to annual deductibles or coinsurance, including  
10 co-payments, unless the contract is a high deductible health plan as  
11 defined in section 223(c)(2) of the internal revenue code of 1986 in  
12 which case coverage for medically necessary abortions may be subject to  
13 the contract's annual deductible.

14 (2) Notwithstanding any other provision, a group contract that  
15 provides hospital, surgical, or medical expense coverage delivered or  
16 issued for delivery in this state to a religious employer as defined in  
17 subsection (cc) of this section may exclude coverage for medically  
18 necessary abortions only if the corporation:

19 (A) obtains an annual certification from the group contractholder that  
20 the contractholder is a religious employer and that the religious  
21 employer requests a contract without coverage for medically necessary  
22 abortions;

23 (B) issues a rider to each certificateholder at no premium to be  
24 charged to the certificateholder or religious employer for the rider,  
25 that provides coverage for medically necessary abortions subject to the  
26 same rules as would have been applied to the same category of treatment  
27 in the contract issued to the religious employer. The rider must clearly  
28 and conspicuously specify that the religious employer does not adminis-



1 ter medically necessary abortion benefits, but that the corporation is  
2 issuing a rider for coverage of medically necessary abortions, and shall  
3 provide the corporation's contact information for questions; and

4 (C) provides notice of the issuance of the contract and rider to the  
5 superintendent in a form and manner acceptable to the superintendent.

6 § 4. This act shall take effect on the first of January next succeed-  
7 ing the date on which it shall have become a law and shall apply to all  
8 policies and contracts issued, renewed, modified, altered or amended on  
9 or after such date.

10 SUBPART D

11 Section 1. The insurance law is amended by adding a new section 3242  
12 to read as follows:

13 § 3242. Prescription drug coverage. (a) Every insurer that delivers  
14 or issues for delivery in this state a policy that provides coverage for  
15 prescription drugs shall, with respect to the prescription drug cover-  
16 age, publish an up-to-date, accurate, and complete list of all covered  
17 prescription drugs on its formulary drug list, including any tiering  
18 structure that it has adopted and any restrictions on the manner in  
19 which a prescription drug may be obtained, in a manner that is easily  
20 accessible to insureds and prospective insureds. The formulary drug list  
21 shall clearly identify the preventive prescription drugs that are avail-  
22 able without annual deductibles or coinsurance, including co-payments.

23 (b) (1) Every policy delivered or issued for delivery in this state  
24 that provides coverage for prescription drugs shall include in the poli-  
25 cy a process that allows an insured, the insured's designee, or the  
26 insured's prescribing health care provider to request a formulary excep-

tion. With respect to the process for such a formulary exception, an insurer shall follow the process and procedures specified in article forty-nine of this chapter and article forty-nine of the public health law, except as otherwise provided in paragraphs two, three, four and five of this subsection.

(2) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request a standard review that is not based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

(B) An insurer shall make a determination on a standard exception request that is not based on exigent circumstances and notify the insured or the insured's designee and the insured's prescribing health care provider by telephone of its coverage determination no later than seventy-two hours following receipt of the request.

(C) An insurer that grants a standard exception request that is not based on exigent circumstances shall provide coverage of the non-formulary prescription drug for the duration of the prescription, including refills.

(D) For the purpose of this subsection, "exigent circumstances" means when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a non-formulary prescription drug.

(3) (A) An insurer shall have a process for an insured, the insured's designee, or the insured's prescribing health care provider to request an expedited review based on exigent circumstances of a formulary exception for a prescription drug that is not covered by the policy.

1     (B) An insurer shall make a determination on an expedited review  
2     request based on exigent circumstances and notify the insured or the  
3     insured's designee and the insured's prescribing health care provider by  
4     telephone of its coverage determination no later than twenty-four hours  
5     following receipt of the request.

6     (C) An insurer that grants an exception based on exigent circumstances  
7     shall provide coverage of the non-formulary prescription drug for the  
8     duration of the exigent circumstances.

9     (4) An insurer that denies an exception request under paragraph two or  
10    three of this subsection shall provide written notice of its determi-  
11    nation to the insured or the insured's designee and the insured's  
12    prescribing health care provider within three business days of receipt  
13    of the exception request. The written notice shall be considered a final  
14    adverse determination under section four thousand nine hundred four of  
15    this chapter or section four thousand nine hundred four of the public  
16    health law. Written notice shall also include the name or names of clin-  
17    ically appropriate prescription drugs covered by the insurer to treat  
18    the insured.

19    (5) (A) If an insurer denies a request for an exception under para-  
20    graph two or three of this subsection, the insured, the insured's desig-  
21    nee, or the insured's prescribing health care provider shall have the  
22    right to request that such denial be reviewed by an external appeal  
23    agent certified by the superintendent pursuant to section four thousand  
24    nine hundred eleven of this chapter in accordance with article forty-  
25    nine of this chapter or article forty-nine of the public health law.

26    (B) An external appeal agent shall make a determination on the  
27    external appeal and notify the insurer, the insured or the insured's  
28    designee, and the insured's prescribing health care provider by tele-

1 phone of its determination no later than seventy-two hours following the  
2 external appeal agent's receipt of the request, if the original request  
3 was a standard exception request under paragraph two of this subsection.  
4 The external appeal agent shall notify the insurer, the insured or the  
5 insured's designee, and the insured's prescribing health care provider  
6 in writing of the external appeal determination within two business days  
7 of rendering such determination.

8 (C) An external appeal agent shall make a determination on the  
9 external appeal and notify the insurer, the insured or the insured's  
10 designee, and the insured's prescribing health care provider by tele-  
11 phone of its determination no later than twenty-four hours following the  
12 external appeal agent's receipt of the request, if the original request  
13 was an expedited exception request under paragraph three of this  
14 subsection and the insured's prescribing health care provider attests  
15 that exigent circumstances exist. The external appeal agent shall notify  
16 the insurer, the insured or the insured's designee, and the insured's  
17 prescribing health care provider in writing of the external appeal  
18 determination within seventy-two hours of the external appeal agent's  
19 receipt of the external appeal.

20 (D) An external appeal agent shall make a determination in accordance  
21 with subparagraph (A) of paragraph four of subsection (b) of section  
22 four thousand nine hundred fourteen of this chapter or subparagraph (A)  
23 of paragraph (d) of subdivision two of section four thousand nine  
24 hundred fourteen of the public health law. When making a determination,  
25 the external appeal agent shall consider whether the formulary  
26 prescription drug covered by the insurer will be or has been ineffec-  
27 tive, would not be as effective as the non-formulary prescription drug,  
28 or would have adverse effects.

1 (E) If an external appeal agent overturns the insurer's denial of a  
2 standard exception request under paragraph two of this subsection, then  
3 the insurer shall provide coverage of the non-formulary prescription  
4 drug for the duration of the prescription, including refills. If an  
5 external appeal agent overturns the insurer's denial of an expedited  
6 exception request under paragraph three of this subsection, then the  
7 insurer shall provide coverage of the non-formulary prescription drug  
8 for the duration of the exigent circumstances.

9 § 2. The insurance law is amended by adding a new section 4329 to read  
10 as follows:

11 § 4329. Prescription drug coverage. (a) Every corporation subject to  
12 the provisions of this article that issues a contract that provides  
13 coverage for prescription drugs shall, with respect to the prescription  
14 drug coverage, publish an up-to-date, accurate, and complete list of all  
15 covered prescription drugs on its formulary drug list, including any  
16 tiering structure that it has adopted and any restrictions on the manner  
17 in which a prescription drug may be obtained, in a manner that is easily  
18 accessible to insureds and prospective insureds. The formulary drug list  
19 shall clearly identify the preventive prescription drugs that are avail-  
20 able without annual deductibles or coinsurance, including co-payments.

21 (b) (1) Every contract issued by a corporation subject to the  
22 provisions of this article that provides coverage for prescription drugs  
23 shall include in the contract a process that allows an insured, the  
24 insured's designee, or the insured's prescribing health care provider to  
25 request a formulary exception. With respect to the process for such a  
26 formulary exception, a corporation shall follow the process and proce-  
27 dures specified in article forty-nine of this chapter and article

1 forty-nine of the public health law, except as otherwise provided in  
2 paragraphs two, three, four and five of this subsection.

3 (2) (A) A corporation shall have a process for an insured, the  
4 insured's designee, or the insured's prescribing health care provider to  
5 request a standard review that is not based on exigent circumstances of  
6 a formulary exception for a prescription drug that is not covered by the  
7 contract.

8 (B) A corporation shall make a determination on a standard exception  
9 request that is not based on exigent circumstances and notify the  
10 insured or the insured's designee and the insured's prescribing health  
11 care provider by telephone of its coverage determination no later than  
12 seventy-two hours following receipt of the request.

13 (C) A corporation that grants a standard exception request that is not  
14 based on exigent circumstances shall provide coverage of the non-formu-  
15 lary prescription drug for the duration of the prescription, including  
16 refills.

17 (D) For the purpose of this subsection, "exigent circumstances" means  
18 when an insured is suffering from a health condition that may seriously  
19 jeopardize the insured's life, health, or ability to regain maximum  
20 function or when an insured is undergoing a current course of treatment  
21 using a non-formulary prescription drug.

22 (3) (A) A corporation shall have a process for an insured, the  
23 insured's designee, or the insured's prescribing health care provider to  
24 request an expedited review based on exigent circumstances of a formu-  
25 lary exception for a prescription drug is not covered by the contract.

26 (B) A corporation shall make a determination on an expedited review  
27 request based on exigent circumstances and notify the insured or the  
28 insured's designee and the insured's prescribing health care provider by

1 telephone of its coverage determination no later than twenty-four hours  
2 following receipt of the request.

3 (C) A corporation that grants an exception based on exigent circum-  
4 stances shall provide coverage of the non-formulary prescription drug  
5 for the duration of the exigent circumstances.

6 (4) A corporation that denies an exception request under paragraph two  
7 or three of this subsection shall provide written notice of its determi-  
8 nation to the insured or the insured's designee and the insured's  
9 prescribing health care provider within three business days of receipt  
10 of the exception request. The written notice shall be considered a final  
11 adverse determination under section four thousand nine hundred four of  
12 this chapter or section four thousand nine hundred four of the public  
13 health law. Written notice shall also include the name or names of clin-  
14 ically appropriate prescription drugs covered by the corporation to  
15 treat the insured.

16 (5) (A) If a corporation denies a request for an exception under para-  
17 graph two or three of this subsection, the insured, the insured's desig-  
18 nee, or the insured's prescribing health care provider shall have the  
19 right to request that such denial be reviewed by an external appeal  
20 agent certified by the superintendent pursuant to section four thousand  
21 nine hundred eleven of this chapter in accordance with article forty-  
22 nine of this chapter and article forty-nine of the public health law.

23 (B) An external appeal agent shall make a determination on the  
24 external appeal and notify the corporation, the insured or the insured's  
25 designee, and the insured's prescribing health care provider by tele-  
26 phone of its determination no later than seventy-two hours following the  
27 external appeal agent's receipt of the request, if the original request  
28 was a standard exception request under paragraph two of this subsection.

1 The external appeal agent shall notify the corporation, the insured or  
2 the insured's designee and the insured's prescribing health care provid-  
3 er in writing of the external appeal determination within two business  
4 days of rendering such determination.

5 (C) An external appeal agent shall make a determination on the  
6 external appeal and notify the corporation, the insured or the insured's  
7 designee, and the insured's prescribing health care provider by tele-  
8 phone of its determination no later than twenty-four hours following the  
9 external appeal agent's receipt of the request, if the original request  
10 was an expedited exception request under paragraph three of this  
11 subsection and the insured's prescribing health care provider attests  
12 that exigent circumstances exist. The external appeal agent shall notify  
13 the corporation, the insured or the insured's designee and the insured's  
14 prescribing health care provider in writing of the external appeal  
15 determination within seventy-two hours of the external appeal agent's  
16 receipt of the external appeal.

17 (D) An external appeal agent shall make a determination in accordance  
18 with subparagraph (A) of paragraph four of subsection (b) of section  
19 four thousand nine hundred fourteen of this chapter and subparagraph (A)  
20 of paragraph (d) of subdivision two of section four thousand nine  
21 hundred fourteen of the public health law. When making a determination,  
22 the external appeal agent shall consider whether the formulary  
23 prescription drug covered by the corporation will be or has been inef-  
24 fective, would not be as effective as the non-formulary prescription  
25 drug, or would have adverse effects.

26 (E) If an external appeal agent overturns the corporation's denial of  
27 a standard exception request under paragraph two of this subsection,  
28 then the corporation shall provide coverage of the non-formulary



1 prescription drug for the duration of the prescription, including  
2 refills. If an external appeal agent overturns the corporation's denial  
3 of an expedited exception request under paragraph three of this  
4 subsection, then the corporation shall provide coverage of the non-for-  
5 mulary prescription drug for the duration of the exigent circumstances.

6 § 3. This act shall take effect on the first of January next succeed-  
7 ing the date on which it shall have become a law and shall apply to all  
8 policies and contracts issued, renewed, modified, altered or amended on  
9 or after such date.

10 SUBPART E

11 Section 1. Section 2607 of the insurance law is amended to read as  
12 follows:

13 § 2607. Discrimination because of sex or marital status. (a) No indi-  
14 vidual or entity shall refuse to issue any policy of insurance, or  
15 cancel or decline to renew [such] the policy because of the sex or mari-  
16 tal status of the applicant or policyholder or engage in sexual stere-  
17 otyping.

18 (b) For the purposes of this section, "sex" shall include sexual  
19 orientation, gender identity or expression, and transgender status.

20 § 2. The insurance law is amended by adding a new section 3243 to read  
21 as follows:

22 § 3243. Discrimination because of sex or marital status in hospital,  
23 surgical or medical expense insurance. (a) With regard to an accident  
24 and health insurance policy that provides hospital, surgical, or medical  
25 expense coverage or a policy of student accident and health insurance,  
26 as defined in subsection (a) of section three thousand two hundred forty

1 of this article, delivered or issued for delivery in this state, no  
2 insurer shall because of sex, marital status or based on pregnancy,  
3 false pregnancy, termination of pregnancy, or recovery therefrom, child-  
4 birth or related medical conditions:

5 (1) make any distinction or discrimination between persons as to the  
6 premiums or rates charged for the policy or in any other manner whatev-  
7 er;

8 (2) demand or require a greater premium from any person than it  
9 requires at that time from others in similar cases;

10 (3) make or require any rebate, discrimination or discount upon the  
11 amount to be paid or the service to be rendered on any policy;

12 (4) insert in the policy any condition, or make any stipulation,  
13 whereby the insured binds his or herself, or his or her heirs, execu-  
14 tors, administrators or assigns, to accept any sum or service less than  
15 the full value or amount of such policy in case of a claim thereon  
16 except such conditions and stipulations as are imposed upon others in  
17 similar cases; and any such stipulation or condition so made or inserted  
18 shall be void;

19 (5) reject any application for a policy issued or sold by it;

20 (6) cancel or refuse to issue, renew or sell such policy after appro-  
21 priate application therefor;

22 (7) fix any lower rate or discriminate in the fees or commissions of  
23 insurance agents or insurance brokers for writing or renewing such a  
24 policy; or

25 (8) engage in sexual stereotyping.

26 (b) For the purposes of this section, "sex" shall include sexual  
27 orientation, gender identity or expression, and transgender status.

1     § 3. The insurance law is amended by adding a new section 4330 to read  
2 as follows:

3     § 4330. Discrimination because of sex or marital status in hospital,  
4 surgical or medical expense insurance. (a) With regard to a contract  
5 issued by a corporation subject to the provisions of this article that  
6 provides hospital, surgical, or medical expense coverage or a contract  
7 of student accident and health insurance, as defined in subsection (a)  
8 of section three thousand two hundred forty of this chapter, no corpo-  
9 ration shall because of sex, marital status or based on pregnancy, false  
10 pregnancy, termination of pregnancy, or recovery therefrom, childbirth  
11 or related medical conditions:

12     (1) make any distinction or discrimination between persons as to the  
13 premiums or rates charged for the contract or in any other manner what-  
14 ever;

15     (2) demand or require a greater premium from any person than it  
16 requires at that time from others in similar cases;

17     (3) make or require any rebate, discrimination or discount upon the  
18 amount to be paid or the service to be rendered on any contract;

19     (4) insert in the contract any condition, or make any stipulation,  
20 whereby the insured binds his or herself, or his or her heirs, execu-  
21 tors, administrators or assigns, to accept any sum or service less than  
22 the full value or amount of such contract in case of a claim thereon  
23 except such conditions and stipulations as are imposed upon others in  
24 similar cases; and any such stipulation or condition so made or inserted  
25 shall be void;

26     (5) reject any application for a contract issued or sold by it;

27     (6) cancel or refuse to issue, renew or sell such contract after  
28 appropriate application therefor;

1     (7) fix any lower rate or discriminate in the fees or commissions of  
2     insurance agents or insurance brokers for writing or renewing such a  
3     contract; or

4 (8) engage in sexual stereotyping.

5     (b) For purposes of this section, "sex" shall include sexual orien-  
6     tation, gender identity or expression, and transgender status.

7     § 4. This act shall take effect on the first of January next succeed-  
8     ing the date on which it shall have become a law and shall apply to all  
9     policies and contracts issued, renewed, modified, altered or amended on  
10    or after such date.

11 SUBPART F

12 Section 1. Subparagraph (B) of paragraph 2 of subsection (b) of  
13 section 1101 of the insurance law, as amended by chapter 369 of the laws  
14 of 1985, is amended to read as follows:

15 (B) transactions with respect to group life, group annuity, group  
16 accident and health or blanket accident and health insurance (other than  
17 any transaction with respect to a group annuity contract funding indi-  
18 vidual retirement accounts or individual retirement annuities, as  
19 defined in section four hundred eight of the Internal Revenue Code,  
20 funding annuities in accordance with subdivision (b) of section four  
21 hundred three of such code or providing a plan of retirement annuities  
22 under which the payments are derived wholly from funds contributed by  
23 the persons covered):

24 (i) where such groups conform to the definitions of eligibility  
25 contained in[;]:

1 (I) the following paragraphs of subsection (b) of section four thou-  
2 sand two hundred sixteen of this chapter:

3 (aa) paragraph (1) or (2);

4 (bb) paragraph (3), if, with respect to those credit transactions  
5 entered into in this state, the policy fully conforms with the require-  
6 ments of sections three thousand two hundred one, three thousand two  
7 hundred twenty and four thousand two hundred sixteen of this chapter; or

8 (cc) paragraphs (4), (5), (6), (7), (8), (9) [and] or (10) [.] ;

9 (II) the following subparagraphs of paragraph (1) of subsection (c) of  
10 section four thousand two hundred thirty-five of this chapter:

11 (aa) subparagraph (A), (B), (C) or (D), (except that with regard to  
12 subparagraphs (A), (B), and (D), transactions with respect to an employ-  
13 er that has established or participates in a fund to insure employees of  
14 an employer or an employer to whom the policy is issued, where: (aaa)  
15 the employer has its principal place of business in this state; or (bbb)  
16 the lesser of twenty-five percent of employees work in this state or  
17 twenty-five or more employers work in this state);

18 (bb) subparagraph (E), if, with respect to those credit transactions  
19 entered into in this state, the policy fully conforms with the require-  
20 ments of sections three thousand two hundred one, three thousand two  
21 hundred twenty-one and four thousand two hundred thirty-five of this  
22 chapter;

23 (cc) subparagraphs (F) [,] and (G) [and (H).] ;

24 (III) section four thousand two hundred thirty-seven (except subpara-  
25 graph (B) for transactions with respect to an employer to whom the poli-  
26 cy is issued where the employer has its principal place of business in  
27 this state or the lesser of twenty-five percent of employees work in  
28 this state or twenty-five or more employees work in this state, (C),

1 (E), or (F) of paragraph three of subsection (a) thereof) or four thou-  
2 sand two hundred thirty-eight (except paragraphs six and seven of  
3 subsection (b) thereof) of this chapter; and

4 (ii) where the master policies or contracts were lawfully issued with-  
5 out this state in a jurisdiction where the insurer was authorized to do  
6 an insurance business;

7 § 2. Items (ii) and (iii) of subparagraph (A) of paragraph 8 of  
8 subsection (b) of section 1101 of the insurance law, as added by chapter  
9 449 of the laws of 2014, are amended to read as follows:

10 (ii) subparagraph (A), (B), (C), or (D) [(with respect to a policy  
11 issued to a trustee or trustees of a fund established or participated in  
12 by two or more employers, one or more labor unions, or by one or more  
13 employers or labor unions, provided that all such employers or labor  
14 unions are in the same industry)] of paragraph one of subsection (c) of  
15 section four thousand two hundred thirty-five of this chapter (except  
16 that with regard to subparagraphs (A), (B), and (D), transactions with  
17 respect to an employer that has established or participates in a fund to  
18 insure employees of an employer or an employer to whom the policy is  
19 issued, where: (I) the employer has its principal place of business in  
20 this state; or (II) the lesser of twenty-five percent of employees work  
21 in this state or twenty-five or more employees work in this state); or

22 (iii) paragraphs one, two, three or four of subsection (b) of section  
23 four thousand two hundred thirty-eight of this chapter, but not includ-  
24 ing a group annuity contract: (I) funding individual retirement accounts  
25 or individual retirement annuities, as defined in section four hundred  
26 eight of the Internal Revenue Code; (II) funding annuities in accordance  
27 with subdivision (b) of section four hundred three of such code; or

1 (III) providing a plan of retirement annuities under which the payments  
2 are derived wholly from funds contributed by the persons covered[.];

3 § 3. Subsection (b) of section 1101 of the insurance law is amended by  
4 adding a new paragraph 9 to read as follows:

5 (9) For purposes of this subsection, "principal place of business"  
6 shall mean the place where an employer maintains its headquarters or  
7 where the employer's high-level officers direct, control, and coordinate  
8 the business activities.

9 § 4. Paragraph 1 of subsection (b) of section 3201 of the insurance  
10 law, as amended by chapter 369 of the laws of 1985, is amended to read  
11 as follows:

12 (1) (A) No policy form shall be delivered or issued for delivery in  
13 this state unless it has been filed with and approved by the superinten-  
14 dent as conforming to the requirements of this chapter and not incon-  
15 sistent with law.

16 (B) A group life, group accident, group health, group accident and  
17 health, blanket accident, blanket health, or blanket accident and health  
18 insurance certificate evidencing insurance coverage on a resident of  
19 this state shall be deemed to have been delivered in this state, regard-  
20 less of the place of actual delivery[, unless the insured group] or the  
21 type of group to which the group or blanket policy or contract is  
22 issued.

23 (C) Notwithstanding subparagraph (B) of this paragraph, a certificate  
24 shall not be deemed to have been delivered in this state when: (i) the  
25 certificate is not actually delivered in this state; (ii) the insured  
26 group is of the type described in[: (A)] section four thousand two  
27 hundred sixteen of this chapter, except paragraph four where the group  
28 policy is issued to a trustee or trustees of a fund established or

1 participated in by two or more employers not in the same industry with  
2 respect to an employer principally located within the state, paragraph  
3 twelve, thirteen or fourteen of subsection (b) thereof; and (iii) the  
4 master policy or contract is lawfully issued without this state in a  
5 jurisdiction where the insurer is authorized to do an insurance busi-  
6 ness.

7 (D) Notwithstanding subparagraph (B) of this paragraph, where the  
8 master policy or contract is lawfully issued without this state in a  
9 jurisdiction where the insurer is authorized to do an insurance busi-  
10 ness, a certificate shall not be deemed to have been delivered in this  
11 state even if it is actually delivered in this state when the insured  
12 group is of the type described in:

13 [(B)] (i) section four thousand two hundred thirty-five of this chap-  
14 ter, except [subparagraph]: (I) subparagraphs (A), (B) and (D) [where  
15 the group policy is issued to a trustee or trustees of a fund estab-  
16 lished or participated in by two or more employers not in the same  
17 industry with respect to an employer principally located within the  
18 state, subparagraph] of paragraph one of subsection (c) thereof, with  
19 respect to an employer that has established or participates in a fund to  
20 insure employees of an employer or an employer to whom the policy is  
21 issued, where the employer has its principal place of business in this  
22 state or the lesser of twenty-five percent of employees work in this  
23 state or twenty-five or more employees work in this state; or (II)  
24 subparagraphs (H), (K), (L) or (M) of paragraph one of subsection (c)  
25 thereof; or

26 [(C)] (ii) section four thousand two hundred thirty-seven [(] of this  
27 chapter, except subparagraph (B) with respect to an employer to whom the  
28 policy is issued where the employer has its principal place of business



1 in this state or the lesser of twenty-five percent of employees work in  
2 this state or twenty-five or more employees work in this state, (C), (E)  
3 or (F) of paragraph three of subsection (a) thereof[; of this chapter;  
4 and where the master policies or contracts were lawfully issued without  
5 this state in a jurisdiction where the insurer was authorized to do an  
6 insurance business].

7 (E)(i) With regard to any group life insurance certificate deemed to  
8 have been delivered in this state by virtue of subparagraph (B) or (C)  
9 of this paragraph, the superintendent shall [(i)]: (I) require that the  
10 premiums charged be reasonable in relation to the benefits provided,  
11 except in cases where the policyholder pays the entire premium; [(ii)]  
12 (II) have power to issue regulations prescribing the required, optional  
13 and prohibited provisions in such certificates; [(iii)] and (III) estab-  
14 lish an accelerated certificate form approval procedure available to an  
15 insurer [which] that includes a statement in its policy form submission  
16 letter that it is the company's opinion that the certificate form or  
17 forms comply with applicable New York law and regulations. The super-  
18 intendent, upon receipt of such a filing letter, shall grant conditional  
19 approval of such certificate form or forms in reliance on the aforemen-  
20 tioned statement by the company upon the condition that the company will  
21 retroactively modify such certificate form or forms, to the extent  
22 necessary, if it is found by the superintendent that the certificate  
23 form fails to comply with applicable New York laws and regulations[.];

24 (ii) The superintendent may, with regard to the approval of any group  
25 life insurance certificate deemed to have been delivered in this state  
26 by virtue of subparagraph (B) or (C) of this paragraph, approve such  
27 certificate if the superintendent finds that the certificate affords

1 insureds protections substantially similar to those [which] that have  
2 been provided by certificates delivered in this state[.]; and

3 (iii) Any regulations issued by the superintendent pursuant to this  
4 [paragraph] subparagraph may not impose stricter requirements than those  
5 applicable to similar policies and certificates actually delivered in  
6 this state.

7 (F)(i) A group accident, group health, group accident and health,  
8 blanket accident, blanket health, or blanket accident and health insur-  
9 ance certificate deemed to have been delivered in this state pursuant to  
10 subparagraph (B) or (D) of this paragraph, shall be subject to the same  
11 provisions of this chapter as a certificate actually delivered or issued  
12 for delivery in this state.

13 (ii) An insurer shall issue to the group or person in whose name the  
14 policy or contract is issued, for delivery to each member of the insured  
15 group, a certificate setting forth in summary form a statement of the  
16 essential features of the insurance coverage.

17 (G) For purposes of this paragraph:

18 (i) "institution of higher education" shall have the meaning set forth  
19 in paragraph two of subsection (a) of section three thousand two hundred  
20 forty of this article;

21 (ii) "principal place of business" shall mean the place where an  
22 employer maintains its headquarters or where the employer's high-level  
23 officers direct, control, and coordinate the business activities; and

24 (iii) "resident of this state" shall include a student who is enrolled  
25 in an institution of higher education in this state that offers coverage  
26 to the student through a group or blanket policy or contract.

27 § 5. Subparagraph (E) of paragraph 3 of subsection (a) of section 4237  
28 of the insurance law is amended to read as follows:

(E) Under a policy or contract issued to [and in the name of] an [incorporated or unincorporated] association [of persons having a common interest or calling, which association shall be deemed the policyholder, having not less than fifty members, covering all the members of such association or if part or all of] or the trustee or trustees of a trust established, or participated in, by one or more associations, to insure association members, subject to the following:

(i) Each association shall have:

(I) a minimum of two hundred insured individuals at the policy or contract's date of issue;

(II) been organized and maintained in good faith for purposes principally other than that of obtaining insurance;

(III) been in active existence for at least two years; and

(IV) a constitution and by-laws that provide that:

(aa) the association hold regular meetings not less than annually to further the purposes of the association;

(bb) the association collect dues or solicit contributions from members; and

(cc) the members have voting privileges and representation on the governing board and committees;

(ii) the premium [is to be derived] for the policy or contract shall be paid by the association or the trustees either wholly from funds contributed by the association or by the insured [members and if the opportunity to take such insurance is offered to all eligible] individuals, or from funds contributed jointly by the association and insured [members, then such] individuals. A policy [must cover not less than seventy-five percent of any class or classes of members determined by conditions pertaining to membership in the association] or contract on

1 which no part of the premium is to be derived from funds contributed by  
2 the insured individuals specifically for their insurance shall insure  
3 all eligible individuals, excluding any as to whom evidence of individ-  
4 ual insurability is not satisfactory to the insurer to the extent  
5 permitted by law;

6 (iii) The amount of insurance under the policy or contract shall be  
7 based upon some plan precluding individual selection either by the  
8 insured individuals or by the association. However, with respect to an  
9 association, such a plan may permit a number of selections by the asso-  
10 ciation if the selections offered utilize consistent plans of insurance  
11 so that the resulting plans of coverage are reasonable. Furthermore,  
12 such a plan may permit a limited number of selections by insured indi-  
13 viduals if the selections offered utilize consistent plans of insurance  
14 for insured individuals so that the resulting plans of coverage are  
15 reasonable.

16 (iv) Except as provided in subsection (b) of this section, such policy  
17 or contract shall provide for the payment of benefits to the person  
18 insured or to some beneficiary or beneficiaries other than the associ-  
19 ation or any officials, representatives, trustees or agents thereof and  
20 shall provide for the issuance of a certificate to the association for  
21 delivery to the insured individual or such beneficiary, as evidence of  
22 such insurance.

23 (v) The premiums charged shall be reasonable in relation to the bene-  
24 fits provided.

25 § 6. Subsection (d) of section 4237-a of the insurance law, as amended  
26 by chapter 599 of the laws of 2003, is amended to read as follows:

(d) No stop-loss insurance contract shall be delivered or issued [or renewed] for delivery in or outside this state by an insurer or health service corporation:

(1) to a New York employer with one hundred or fewer employees, provided that "New York employer" shall mean an employer who has at least one employee that works in this state; or

(2) if issuance of the policy would be prohibited by section two thousand six hundred thirteen, three thousand two hundred thirty-one, four thousand three hundred seventeen or four thousand three hundred twenty of this chapter.

§ 7. This act shall take effect on the one hundred eightieth day after it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date. Effective immediately:

(1) the superintendent of financial services may promulgate any rules or regulations necessary for the implementation of the provisions of this act on its effective date; and

(2) insurers may submit to the superintendent and the superintendent may approve filings necessary to comply with the provisions of this act on its effective date.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or subpart of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or subpart thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the

1 intent of the legislature that this act would have been enacted even if  
2 such invalid provisions had not been included herein.

3 § 3. Interpretations by the superintendent. The superintendent of  
4 financial services has special expertise and experience in the regu-  
5 lation of insurance in this state. As such his or her interpretations of  
6 the insurance law shall be afforded the highest level of deference.

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. In addition  
12 to any other power conferred by law, the superintendent of financial  
13 services is hereby specifically empowered to promulgate regulations  
14 under, and issue interpretations of, this act as necessary to ensure  
15 that the intent of the legislature as expressed in this section is real-  
16 ized.

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

20 PART K

21 Section 1. Subdivisions 4 and 5 of section 2999-h of the public health  
22 law, as added by section 52 of part H of chapter 59 of the laws of 2011,  
23 are amended to read as follows:

24 4. "Qualified plaintiff" means every plaintiff or claimant who (i) has  
25 been found by a jury or court to have sustained a birth-related neuro-  
26 logical injury as the result of medical malpractice, or (ii) has

1 sustained a birth-related neurological injury as the result of alleged  
2 medical malpractice, and has settled his or her lawsuit or claim there-  
3 for; and (iii) has been ordered to be enrolled in the fund by a court in  
4 New York state.

5 [5. Any reference to the "department of financial services" and the  
6 "superintendent of financial services" in this title shall mean, prior  
7 to October third, two thousand eleven, respectively, the "department of  
8 insurance" and "superintendent of insurance."]

9 § 2. Section 2999-i of the public health law, as added by section 52  
10 of part H of chapter 59 of the laws of 2011, subdivision 1 as amended by  
11 section 29 of part D of chapter 56 of the laws of 2012, is amended to  
12 read as follows:

13 § 2999-i. Custody and administration of the fund. 1. (a) The commis-  
14 sioner of taxation and finance shall be the custodian of the fund and  
15 the special account established pursuant to section ninety-nine-t of the  
16 state finance law. All payments from the fund shall be made by the  
17 commissioner of taxation and finance upon certificates signed by the  
18 [superintendent of financial services] commissioner, or his or her  
19 designee, as hereinafter provided. The fund shall be separate and apart  
20 from any other fund and from all other state monies; provided, however,  
21 that monies of the fund may be invested as set forth in paragraph (b) of  
22 this subdivision. No monies from the fund shall be transferred to any  
23 other fund, nor shall any such monies be applied to the making of any  
24 payment for any purpose other than the purpose set forth in this title.

25 (b) Any monies of the fund not required for immediate use may, at the  
26 discretion of the commissioner [of financial services] in consultation  
27 with [the commissioner of health and] the director of the budget, be  
28 invested by the commissioner of taxation and finance in obligations of

1 the United States or the state or obligations the principal and interest  
2 of which are guaranteed by the United States or the state. The proceeds  
3 of any such investment shall be retained by the fund as assets to be  
4 used for the purposes of the fund.

5 2. (a) The fund shall be administered by the [superintendent of finan-  
6 cial services] commissioner or his or her designee in accordance with  
7 the provisions of this article.

8 (b) The [superintendent of financial services] commissioner shall have  
9 all powers necessary and proper to carry out the purposes of the fund.

10 (c) Notwithstanding any contrary provision of this section, sections  
11 one hundred twelve and one hundred sixty-three of the state finance law  
12 or any other contrary provision of law, the superintendent of financial  
13 services is authorized to [enter into a contract or contracts without a  
14 competitive bid or request for proposal process for purposes of adminis-  
15 tering the fund for the first year of its operation and in preparation  
16 therefor] assign and the commissioner is authorized to receive assign-  
17 ment of any and all contracts entered into by the superintendent of  
18 financial services to administer the fund for periods prior to October  
19 first, two thousand nineteen.

20 (d) The department [of financial services and the department] shall  
21 post on [their websites] its website information about the fund[, eligi-  
22 bility for enrollment in the fund,] and the process for enrollment in  
23 the fund.

24 3. The expense of administering the fund[, including the expenses  
25 incurred by the department,] shall be paid from the fund.

26 4. Monies for the fund will be provided pursuant to this chapter.

27 5. For the state fiscal year beginning April first, two thousand elev-  
28 en and ending March thirty-first, two thousand twelve, the state fiscal



1 year beginning April first, two thousand twelve and ending March thirty-first, two thousand thirteen, and the state fiscal year beginning April first, two thousand thirteen and ending March thirty-first, two thousand fourteen, the superintendent of financial services shall cause to be deposited into the fund for each such fiscal year the amount appropriated for such purpose. Beginning April first, two thousand fourteen and annually thereafter, the superintendent of financial services or the commissioner, whoever is administering the fund for the applicable period shall cause to be deposited into the fund, subject to available appropriations, an amount equal to the difference between the amount appropriated to the fund in the preceding fiscal year, as increased by the adjustment factor defined in subdivision seven of this section, and the assets of the fund at the conclusion of that fiscal year.

15 6. (a) Following the deposit referenced in subdivision five of this section, the [superintendent of financial services] commissioner shall conduct an actuarial calculation of the estimated liabilities of the fund for the coming year resulting from the qualified plaintiffs enrolled in the fund. The administrator shall from time to time adjust such calculation in accordance with subdivision seven of this section. If the total of all estimates of current liabilities equals or exceeds eighty percent of the fund's assets, then the fund shall not accept any new enrollments until a new deposit has been made pursuant to subdivision five of this section. When, as a result of such new deposit, the fund's liabilities no longer exceed eighty percent of the fund's assets, the fund administrator shall enroll new qualified plaintiffs in the order that an application for enrollment has been submitted in accord-

1   ance with subdivision seven of section twenty-nine hundred ninety-nine-j  
2   of this title.

3       (b) Whenever enrollment is suspended pursuant to paragraph (a) of this  
4   subdivision and until such time as enrollment resumes pursuant to such  
5   paragraph: (i) notice of such suspension shall be promptly posted on the  
6   department's website [and on the website of the department of financial  
7   services]; (ii) the fund administrator shall deny each application for  
8   enrollment that had been received but not accepted prior to the date of  
9   suspension and each application for enrollment received after the date  
10   of such suspension; and (iii) notification of each such denial shall be  
11   made to the plaintiff or claimant or persons authorized to act on behalf  
12   of such plaintiff or claimant and all defendants in regard to such  
13   plaintiff or claimant, to the extent they are known to the fund adminis-  
14   trator. Judgments and settlements for plaintiffs or claimants for whom  
15   applications are denied under this paragraph or who are not eligible for  
16   enrollment due to suspension pursuant to paragraph (a) of this subdivi-  
17   sion shall be satisfied as if this title had not been enacted.

18       (c) Following a suspension, whenever enrollment resumes pursuant to  
19   paragraph (a) of this subdivision, notice that enrollment has resumed  
20   shall be promptly posted on the department's website [and on the website  
21   of the department of financial services].

22       (d) The suspension of enrollment pursuant to paragraph (a) of this  
23   subdivision shall not impact payment under the fund for any qualified  
24   plaintiffs already enrolled in the fund.

25       7. For purposes of this section, the adjustment factor referenced in  
26   this section shall be the ten year rolling average medical component of  
27   the consumer price index as published by the United States department of  
28   labor, bureau of labor statistics, for the preceding ten years.

1 § 3. Subdivisions 2, 5, 6, 7, 9, 11, 12, 15 and 16 of section 2999-j  
2 of the public health law, subdivision 2 as amended by chapter 517 of the  
3 laws of 2016, paragraph (c) of subdivision 2 as amended by chapter 4 of  
4 the laws of 2017, and subdivisions 5, 6, 7, 9, 11, 12, 15 and 16 as  
5 added by section 52 of part H of chapter 59 of the laws of 2011, are  
6 amended to read as follows:

7 2. The provision of qualifying health care costs to qualified plain-  
8 tiffs shall not be subject to prior authorization, except as described  
9 by the commissioner in regulation; provided, however:

10 (a) such regulation shall not prevent qualified plaintiffs from  
11 receiving care or assistance that would, at a minimum, be authorized  
12 under the medicaid program;

13 (b) if any prior authorization is required by such regulation, the  
14 regulation shall require that requests for prior authorization be proc-  
15 essed within a reasonably prompt period of time and[, subject to the  
16 provisions of subdivision two-a of this section,] shall identify a proc-  
17 ess for prompt administrative review of any denial of a request for  
18 prior authorization; and

19 (c) such regulations shall not prohibit qualifying health care costs  
20 on the grounds that the qualifying health care cost may incidentally  
21 benefit other members of the household, provided that whether the quali-  
22 fying health care cost primarily benefits the patient may be considered.

23 5. Claims for the payment or reimbursement from the fund of qualifying  
24 health care costs shall be made upon forms prescribed and furnished by  
25 the fund administrator [in consultation with the commissioner and] in  
26 conjunction with regulations establishing a mechanism for submission of  
27 claims by health care providers directly to the fund, where practicable.

1     6. (a) Every settlement agreement for claims arising out of a  
2 plaintiff's or claimant's birth related neurological injury subject to  
3 this title, and that provides for the payment of future medical expenses  
4 for the plaintiff or claimant, shall provide that [in the event the  
5 administrator of the fund determines that the plaintiff or claimant is a  
6 qualified plaintiff,] all payments for future medical expenses shall be  
7 paid in accordance with this title[,] in lieu of that portion of the  
8 settlement agreement that provides for payment of such expenses. The  
9 plaintiff's or claimant's future medical expenses shall be paid in  
10 accordance with this title. When such a settlement agreement does not so  
11 provide, the court shall direct the modification of the agreement to  
12 include such term as a condition of court approval.

13     (b) In any case where the jury or court has made an award for future  
14 medical expenses arising out of a birth related neurological injury, any  
15 party to such action or person authorized to act on behalf of such party  
16 may make application to the court that the judgment reflect that, in  
17 lieu of that portion of the award that provides for payment of such  
18 expenses, [and upon a determination by the fund administrator that the  
19 plaintiff is a qualified plaintiff,] the future medical expenses of the  
20 plaintiff shall be paid out of the fund in accordance with this title.  
21 Upon a finding by the court that the applicant has made a prima facie  
22 showing that the plaintiff is a qualified plaintiff, the court shall  
23 ensure that the judgment so provides.

24     7. A qualified plaintiff shall be enrolled when (a) such plaintiff or  
25 person authorized to act on behalf of such person, upon notice to all  
26 defendants, or any of the defendants in regard to the plaintiff's claim,  
27 upon notice to such plaintiff, makes an application for enrollment by  
28 providing the fund administrator with a certified copy of the judgment

1 or of the court approved settlement agreement; and (b) the fund adminis-  
2 trator determines [upon the basis of such judgment or settlement agree-  
3 ment and any additional information the fund administrator shall  
4 request] that the relevant provisions of subdivision six of this section  
5 have been met [and that the plaintiff is a qualified plaintiff];  
6 provided that no enrollment shall occur when the fund is closed to  
7 enrollment pursuant to subdivision six of section twenty-nine hundred  
8 ninety-nine-i of this title.

9 9. Payments from the fund shall be made by the commissioner of taxa-  
10 tion and finance on the said certificate of the [superintendent of  
11 financial services] commissioner. No payment shall be made by the  
12 commissioner of taxation and finance in excess of the amount certified.  
13 Promptly upon receipt of the said certificate of the [superintendent of  
14 financial services] commissioner, the commissioner of taxation and  
15 finance shall pay the qualified plaintiff's health care provider or  
16 reimburse the qualified plaintiff the amount so certified for payment.

17 11. All health care providers shall accept from qualified plaintiff's  
18 or persons authorized to act on behalf of such plaintiff's assignments  
19 of the right to receive payments from the fund for qualifying health  
20 care costs. Such payments shall constitute payment in full for any  
21 services provided to a qualified plaintiff in accordance with this arti-  
22 cle.

23 12. Health insurers (other than medicare and Medicaid) shall be the  
24 primary payers of qualifying health care costs of qualified plaintiffs.  
25 Such costs shall be paid from the fund only to the extent that health  
26 insurers or other collateral sources or other persons are not otherwise  
27 obligated to make payments therefor. Health insurers that make payments  
28 for qualifying health care costs to or on behalf of qualified plaintiffs

1 shall have no right of recovery against and shall have no lien upon the  
2 fund or any person or entity nor shall the fund constitute an additional  
3 payment source to offset the payments otherwise contractually required  
4 to be made by such health insurers. The superintendent of financial  
5 services shall have the authority to enforce the provisions of this  
6 subdivision upon the referral of the commissioner.

7 15. The commissioner[, in consultation with the superintendent of  
8 financial services,] shall promulgate, amend and enforce all rules and  
9 regulations necessary for the proper administration of the fund in  
10 accordance with the provisions of this section, including, but not  
11 limited to, those concerning the payment of claims and concerning the  
12 actuarial calculations necessary to determine, annually, the total  
13 amount to be paid into the fund as provided herein, and as otherwise  
14 needed to implement this title.

15 [16. The commissioner shall convene a consumer advisory committee for  
16 the purpose of providing information, as requested by the commissioner,  
17 in the development of the regulations authorized by subdivision fifteen  
18 of this section.]

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.

1     § 5. Section 99-t of the state finance law, as added by section 52-e  
2 of part H of chapter 59 of the laws of 2011, is amended to read as  
3 follows:

4     § 99-t. New York state medical indemnity fund account. 1. There is  
5 hereby established in the custody of the commissioner of taxation and  
6 finance a special account to be known as the "New York state medical  
7 indemnity fund account".

8     2. All moneys received by the New York state medical indemnity fund  
9 pursuant to title four of article twenty-nine-D of the public health law  
10 from whatever source derived shall be deposited to the exclusive credit  
11 of such fund account. Said moneys shall be kept separate and shall not  
12 be commingled with any other moneys in the custody of the commissioner  
13 of taxation and finance.

14     3. The moneys in said account shall be retained by the fund and shall  
15 be released by the commissioner of taxation and finance only upon  
16 certificates signed by the [superintendent of financial services or the  
17 head of any successor agency to the department of insurance] commission-  
18 er of health or his or her designee and only for the purposes set forth  
19 in title four of article twenty-nine-D of the public health law.

20     § 6. This act shall take effect October 1, 2019; provided however, on  
21 and after April 1, 2019, the commissioner of health may take any steps  
22 necessary to implement this act on its effective date; and notwithstand-  
23 ing any inconsistent provision of the state administrative procedure act  
24 or any other provision of law, rule or regulation, the commissioner of  
25 health is authorized to adopt or amend or promulgate on an emergency  
26 basis any regulation he or she determines necessary to implement any  
27 provision of this act on its effective date.

1

## PART L

2 Section 1. Subparagraph (C) of paragraph 6 of subsection (k) of  
3 section 3221 of the insurance law, as amended by section 1 of part K of  
4 chapter 82 of the laws of 2002, is amended to read as follows:

5 (C) Coverage of diagnostic and treatment procedures, including  
6 prescription drugs, used in the diagnosis and treatment of infertility  
7 as required by subparagraphs (A) and (B) of this paragraph shall be  
8 provided in accordance with the provisions of this subparagraph.

9 (i) [Coverage] Except as provided in items (vi) and (vii) of this  
10 subparagraph, coverage shall be provided for persons whose ages range  
11 from twenty-one through forty-four years, provided that nothing herein  
12 shall preclude the provision of coverage to persons whose age is below  
13 or above such range.

14 (ii) Diagnosis and treatment of infertility shall be prescribed as  
15 part of a physician's overall plan of care and consistent with the  
16 guidelines for coverage as referenced in this subparagraph.

17 (iii) Coverage may be subject to co-payments, coinsurance and deduct-  
18 ibles as may be deemed appropriate by the superintendent and as are  
19 consistent with those established for other benefits within a given  
20 policy.

21 (iv) [Coverage shall be limited to those individuals who have been  
22 previously covered under the policy for a period of not less than twelve  
23 months, provided that for the purposes of this subparagraph "period of  
24 not less than twelve months" shall be determined by calculating such  
25 time from either the date the insured was first covered under the exist-  
26 ing policy or from the date the insured was first covered by a previous-  
27 ly in-force converted policy, whichever is earlier.



1 (v) Coverage] Except as provided in items (vi) and (vii) of this  
2 subparagraph, coverage shall not be required to include the diagnosis  
3 and treatment of infertility in connection with: (I) in vitro fertiliza-  
4 tion, gamete intrafallopian tube transfers or zygote intrafallopian tube  
5 transfers; (II) the reversal of elective sterilizations; (III) sex  
6 change procedures; (IV) cloning; or (V) medical or surgical services or  
7 procedures that are deemed to be experimental in accordance with clin-  
8 ical guidelines referenced in [clause (vi)] item (v) of this subpara-  
9 graph.

10 [(vi)] (v) The superintendent, in consultation with the commissioner  
11 of health, shall promulgate regulations which shall stipulate the guide-  
12 lines and standards which shall be used in carrying out the provisions  
13 of this subparagraph, which shall include:

14 (I) The determination of "infertility" in accordance with the stand-  
15 ards and guidelines established and adopted by the American College of  
16 Obstetricians and Gynecologists and the American Society for Reproduc-  
17 tive Medicine including "iatrogenic infertility", which means an impair-  
18 ment of fertility by surgery, radiation, chemotherapy or other medical  
19 treatment affecting reproductive organs or processes;

20 (II) The identification of experimental procedures and treatments not  
21 covered for the diagnosis and treatment of infertility determined in  
22 accordance with the standards and guidelines established and adopted by  
23 the American College of Obstetricians and Gynecologists and the American  
24 Society for Reproductive Medicine;

25 (III) The identification of the required training, experience and  
26 other standards for health care providers for the provision of proce-  
27 dures and treatments for the diagnosis and treatment of infertility  
28 determined in accordance with the standards and guidelines established

1 and adopted by the American College of Obstetricians and Gynecologists  
2 and the American Society for Reproductive Medicine; and

3 (IV) The determination of appropriate medical candidates by the treat-  
4 ing physician in accordance with the standards and guidelines estab-  
5 lished and adopted by the American College of Obstetricians and Gynecol-  
6 ogists and/or the American Society for Reproductive Medicine.

7 (vi) Coverage shall also include standard fertility preservation  
8 services when a medical treatment may directly or indirectly cause  
9 iatrogenic infertility to an insured. Coverage may be subject to annual  
10 deductibles and coinsurance, including copayments, as may be deemed  
11 appropriate by the superintendent and as are consistent with those  
12 established for other benefits within a given policy.

13 (vii) Every large group policy delivered or issued for delivery in  
14 this state that provides medical, major medical or similar comprehen-  
15 sive-type coverage shall provide coverage for three cycles of in-vitro  
16 fertilization used in the treatment of infertility as defined in clause  
17 (I) of item (v) of this subparagraph. Coverage may be subject to annual  
18 deductibles and coinsurance, including copayments, as may be deemed  
19 appropriate by the superintendent and as are consistent with those  
20 established for other benefits within a given policy. For purposes of  
21 this item, a "cycle" is defined as either all treatment that starts  
22 when: preparatory medications are administered for ovarian stimulation  
23 for oocyte retrieval with the intent of undergoing in-vitro fertiliza-  
24 tion using a fresh embryo transfer; or medications are administered for  
25 endometrial preparation with the intent of undergoing in-vitro fertili-  
26 zation using a frozen embryo transfer. No insurer providing coverage  
27 under this item or item (vi) of this subparagraph shall discriminate  
28 based on an insured's expected length of life, present or predicted

1 disability, degree of medical dependency, perceived quality of life, or  
2 other health conditions, nor based on personal characteristics, includ-  
3 ing age, sex, sexual orientation, marital status or gender identity.

4 § 2. Paragraph 3 of subsection (s) of section 4303 of the insurance  
5 law, as amended by section 2 of part K of chapter 82 of the laws of  
6 2002, is amended to read as follows:

7 (3) Coverage of diagnostic and treatment procedures, including  
8 prescription drugs used in the diagnosis and treatment of infertility as  
9 required by paragraphs one and two of this subsection shall be provided  
10 in accordance with this paragraph.

11 (A) [Coverage] Except as provided in subparagraphs (F) and (G) of this  
12 paragraph, coverage shall be provided for persons whose ages range from  
13 twenty-one through forty-four years, provided that nothing herein shall  
14 preclude the provision of coverage to persons whose age is below or  
15 above such range.

16 (B) Diagnosis and treatment of infertility shall be prescribed as part  
17 of a physician's overall plan of care and consistent with the guidelines  
18 for coverage as referenced in this paragraph.

19 (C) Coverage may be subject to co-payments, coinsurance and deduct-  
20 ibles as may be deemed appropriate by the superintendent and as are  
21 consistent with those established for other benefits within a given  
22 policy.

23 (D) [Coverage shall be limited to those individuals who have been  
24 previously covered under the policy for a period of not less than twelve  
25 months, provided that for the purposes of this paragraph "period of not  
26 less than twelve months" shall be determined by calculating such time  
27 from either the date the insured was first covered under the existing

1 policy or from the date the insured was first covered by a previously  
2 in-force converted policy, whichever is earlier.

3 (E) Coverage] Except as provided in subparagraphs (F) and (G) of this  
4 paragraph, coverage shall not be required to include the diagnosis and  
5 treatment of infertility in connection with: (i) in vitro fertilization,  
6 gamete intrafallopian tube transfers or zygote intrafallopian tube  
7 transfers; (ii) the reversal of elective sterilizations; (iii) sex  
8 change procedures; (iv) cloning; or (v) medical or surgical services or  
9 procedures that are deemed to be experimental in accordance with clin-  
10 ical guidelines referenced in subparagraph [(F)] (E) of this paragraph.

11 [(F)] (E) The superintendent, in consultation with the commissioner of  
12 health, shall promulgate regulations which shall stipulate the guide-  
13 lines and standards which shall be used in carrying out the provisions  
14 of this paragraph, which shall include:

15 (i) The determination of "infertility" in accordance with the stand-  
16 ards and guidelines established and adopted by the American College of  
17 Obstetricians and Gynecologists and the American Society for Reproduc-  
18 tive Medicine;

19 (ii) The identification of experimental procedures and treatments not  
20 covered for the diagnosis and treatment of infertility determined in  
21 accordance with the standards and guidelines established and adopted by  
22 the American College of Obstetricians and Gynecologists and the American  
23 Society for Reproductive Medicine including "iatrogenic infertility",  
24 which means an impairment of fertility by surgery, radiation, chemother-  
25 apy or other medical treatment affecting reproductive organs or proc-  
26 esses;

27 (iii) The identification of the required training, experience and  
28 other standards for health care providers for the provision of proce-

dures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine; and

(iv) The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.

(F) Coverage shall also include standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility to an insured. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract.

(G) Every large group contract that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for three cycles of in-vitro fertilization used in the treatment of infertility as defined in item (i) of subparagraph (E) of this paragraph. Coverage may be subject to annual deductibles and coinsurance, including copayments, as may be deemed appropriate by the superintendent and as are consistent with those established for other benefits within a given contract. For purposes of this subparagraph, a "cycle" is defined as either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer. No corporation providing coverage under subparagraphs (F) or (G) of this paragraph

1 shall discriminate based on an insured's expected length of life, pres-  
2 ent or predicted disability, degree of medical dependency, perceived  
3 quality of life, or other health conditions, nor based on personal char-  
4 acteristics, including age, sex, sexual orientation, marital status or  
5 gender identity.

6 § 3. Paragraph 13 of subsection (i) of section 3216 of the insurance  
7 law is amended by adding a new subparagraph (C) to read as follows:

8 (C) Every policy that provides medical, major medical or similar  
9 comprehensive-type coverage shall provide coverage for standard fertili-  
10 ty preservation services when a medical treatment may directly or indi-  
11 rectly cause iatrogenic infertility to an insured. Coverage may be  
12 subject to annual deductibles and coinsurance, including copayments, as  
13 may be deemed appropriate by the superintendent and as are consistent  
14 with those established for other benefits within a given policy.

15 (i) For purposes of this subparagraph, "iatrogenic infertility" means  
16 an impairment of fertility by surgery, radiation, chemotherapy or other  
17 medical treatment affecting reproductive organs or processes.

18 (ii) No insurer providing coverage under this paragraph shall discrim-  
19 inate based on an insured's expected length of life, present or  
20 predicted disability, degree of medical dependency, perceived quality of  
21 life, or other health conditions, nor based on personal characteristics,  
22 including age, sex, sexual orientation, marital status or gender identi-  
23 ty.

24 § 4. This act shall take effect January 1, 2020 and shall apply to  
25 policies and contracts issued, renewed, modified, altered or amended on  
26 or after such date.

1 Section 1. This act shall be known and may be cited as the "comprehen-  
2 sive contraception coverage act".

3 § 2. Paragraph 16 of subsection (1) of section 3221 of the insurance  
4 law, as added by chapter 554 of the laws of 2002, is amended to read as  
5 follows:

6 (16) (A) Every group or blanket policy which [provides coverage for  
7 prescription drugs shall include coverage for the cost of contraceptive  
8 drugs or devices approved by the federal food and drug administration or  
9 generic equivalents approved as substitutes by such food and drug admin-  
10 istration under the prescription of a health care provider legally  
11 authorized to prescribe under title eight of the education law. The  
12 coverage required by this section shall be included in policies and  
13 certificates only through the addition of a rider.

14 (A)] provides medical, major medical or similar comprehensive-type  
15 coverage shall provide coverage for all of the following services and  
16 contraceptive methods:

17 (i) All FDA-approved contraceptive drugs, devices, and other products.  
18 This includes all FDA-approved over-the-counter contraceptive drugs,  
19 devices, and products as prescribed or as otherwise authorized under  
20 state or federal law. Notwithstanding this paragraph, an insurer shall  
21 not be required to provide coverage of male condoms. The following  
22 applies to this coverage:

23 (I) where the FDA has approved one or more therapeutic and pharmaceu-  
24 tical equivalent, as defined by the FDA, versions of a contraceptive  
25 drug, device, or product, an insurer is not required to include all such  
26 therapeutic and pharmaceutical equivalent versions in its formulary, so  
27 long as at least one is included and covered without cost-sharing and in  
28 accordance with this paragraph;

1 (II) if the covered therapeutic and pharmaceutical equivalent versions  
2 of a drug, device, or product are not available or are deemed medically  
3 inadvisable, the insurer shall provide coverage for an alternate thera-  
4 peutic and pharmaceutical equivalent version of the contraceptive drug,  
5 device, or product without cost-sharing upon the recommendation of the  
6 insured's attending health care provider. An insurer shall defer to the  
7 attending health care provider's determination of medical necessity.  
8 The superintendent may develop a standard exception form with  
9 instructions that an attending health care provider may use to recommend  
10 a particular contraceptive drug, device, or product based upon a deter-  
11 mination of medical necessity for an insured. The insurer shall accept  
12 the standard exception form submitted by the insured's attending health  
13 care provider;

14 (III) this coverage shall include emergency contraception without  
15 cost-sharing when provided pursuant to prescription, order under section  
16 sixty-eight hundred thirty-one of the education law, over-the-counter,  
17 or when otherwise lawfully provided other than pursuant to a  
18 prescription; and

19 (IV) this coverage shall allow for the dispensing of twelve months-  
20 worth of a contraceptive at one time;

21 (ii) Voluntary sterilization procedures for women;

22 (iii) Patient education and counseling on contraception; and

23 (iv) Follow-up services related to the drugs, devices, products, and  
24 procedures covered under this paragraph, including, but not limited to,  
25 management of side effects, counseling for continued adherence, and  
26 device insertion and removal.



1     (B) An insurer subject to this paragraph shall not impose a deduct-  
2     ible, coinsurance, copayment or any other cost-sharing requirement on  
3     the coverage provided pursuant to this paragraph.

4     (C) Except as otherwise authorized under this paragraph, an insurer  
5     shall not impose any restrictions or delays on the coverage required  
6     under this paragraph.

7     (D) Notwithstanding any other provision of this subsection, a reli-  
8     gious employer may request a contract without coverage for federal food  
9     and drug administration approved contraceptive methods that are contrary  
10    to the religious employer's religious tenets. If so requested, such  
11    contract shall be provided without coverage for contraceptive methods.  
12    This paragraph shall not be construed to deny an enrollee coverage of,  
13    and timely access to, contraceptive methods.

14    (1) For purposes of this subsection, a "religious employer" is an  
15    entity for which each of the following is true:

16    (a) The inculcation of religious values is the purpose of the entity.

17    (b) The entity primarily employs persons who share the religious  
18    tenets of the entity.

19    (c) The entity serves primarily persons who share the religious tenets  
20    of the entity.

21    (d) The entity is a nonprofit organization as described in Section  
22    6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

23    (2) Every religious employer that invokes the exemption provided under  
24    this paragraph shall provide written notice to prospective enrollees  
25    prior to enrollment with the plan, listing the contraceptive health care  
26    services the employer refuses to cover for religious reasons.

27    [(B) (i)] (E) (1) Where a group policyholder makes an election not to  
28    purchase coverage for contraceptive drugs or devices in accordance with

1 subparagraph [(A)] (D) of this paragraph each certificateholder covered  
2 under the policy issued to that group policyholder shall have the right  
3 to directly purchase the rider required by this paragraph from the  
4 insurer which issued the group policy at the prevailing small group  
5 community rate for such rider whether or not the employee is part of a  
6 small group.

7 [(ii)] (2) Where a group policyholder makes an election not to  
8 purchase coverage for contraceptive drugs or devices in accordance with  
9 subparagraph [(A)] (D) of this paragraph, the insurer that provides such  
10 coverage shall provide written notice to certificateholders upon enroll-  
11 ment with the insurer of their right to directly purchase a rider for  
12 coverage for the cost of contraceptive drugs or devices. The notice  
13 shall also advise the certificateholders of the additional premium for  
14 such coverage.

15 [(C)] (F) Nothing in this paragraph shall be construed as authorizing  
16 a group or blanket policy which provides coverage for prescription drugs  
17 to exclude coverage for prescription drugs prescribed for reasons other  
18 than contraceptive purposes.

19 [(D) Such coverage may be subject to reasonable annual deductibles and  
20 coinsurance as may be deemed appropriate by the superintendent and as  
21 are consistent with those established for other drugs or devices covered  
22 under the policy.]

23 § 3. Subsection (cc) of section 4303 of the insurance law, as added by  
24 chapter 554 of the laws of 2002, is amended to read as follows:

25 (cc) (1) Every contract [which provides coverage for prescription  
26 drugs shall include coverage for the cost of contraceptive drugs or  
27 devices approved by the federal food and drug administration or generic  
28 equivalents approved as substitutes by such food and drug administration

1 under the prescription of a health care provider legally authorized to  
2 prescribe under title eight of the education law. The coverage required  
3 by this section shall be included in contracts and certificates only  
4 through the addition of a rider.

5 (1)] which provides medical, major medical, or similar comprehensive-  
6 type coverage shall provide coverage for all of the following services  
7 and contraceptive methods:

8 (A) All FDA-approved contraceptive drugs, devices, and other products.  
9 This includes all FDA-approved over-the-counter contraceptive drugs,  
10 devices, and products as prescribed or as otherwise authorized under  
11 state or federal law. Notwithstanding this paragraph, a corporation  
12 shall not be required to provide coverage of male condoms. The follow-  
13 ing applies to this coverage:

14 (i) where the FDA has approved one or more therapeutic and pharmaceu-  
15 tical equivalent, as defined by the FDA, versions of a contraceptive  
16 drug, device, or product, a corporation is not required to include all  
17 such therapeutic and pharmaceutical equivalent versions in its formu-  
18 lary, so long as at least one is included and covered without cost-shar-  
19 ing and in accordance with this subsection;

20 (ii) if the covered therapeutic and pharmaceutical equivalent versions  
21 of a drug, device, or product are not available or are deemed medically  
22 inadvisable, a corporation shall provide coverage for an alternate ther-  
23 apeutic and pharmaceutical equivalent version of the contraceptive drug,  
24 device, or product without cost-sharing upon the recommendation of the  
25 insured's attending health care provider. A corporation shall defer to  
26 the attending health care provider's determination of medical necessity.  
27 The superintendent may develop a standard exception form with  
28 instructions that an attending health care provider may use to recommend

1 a particular contraceptive drug, device, or product based upon a deter-  
2 mination of medical necessity for an insured. The insurer shall accept  
3 the standard exception form submitted by the insured's attending health  
4 care provider;

5 (iii) this coverage shall include emergency contraception without  
6 cost-sharing when provided pursuant to a prescription, order under  
7 section sixty-eight hundred thirty-one of the education law, over-the-  
8 counter, or when otherwise lawfully provided other than through a  
9 prescription; and

10 (iv) this coverage shall allow for the dispensing of twelve months  
11 worth of a contraceptive at one time;

12 (B) Voluntary sterilization procedures for women;

13 (C) Patient education and counseling on contraception; and

14 (D) Follow-up services related to the drugs, devices, products, and  
15 procedures covered under this subsection, including, but not limited to,  
16 management of side effects, counseling for continued adherence, and  
17 device insertion and removal.

18 (2) A corporation subject to this paragraph shall not impose a deduct-  
19 ible, coinsurance, copayment or any other cost-sharing requirement on  
20 the coverage provided pursuant to this subsection.

21 (3) Except as otherwise authorized under this subsection, a corpo-  
22 ration shall not impose any restrictions or delays on the coverage  
23 required under this subsection.

24 (4) Notwithstanding any other provision of this subsection, a reli-  
25 gious employer may request a contract without coverage for federal food  
26 and drug administration approved contraceptive methods that are contrary  
27 to the religious employer's religious tenets. If so requested, such  
28 contract shall be provided without coverage for contraceptive methods.

1 This paragraph shall not be construed to deny an enrollee coverage of,  
2 and timely access to, contraceptive methods.

3 (A) For purposes of this subsection, a "religious employer" is an  
4 entity for which each of the following is true:

5 (i) The inculcation of religious values is the purpose of the entity.

6 (ii) The entity primarily employs persons who share the religious  
7 tenets of the entity.

8 (iii) The entity serves primarily persons who share the religious  
9 tenets of the entity.

10 (iv) The entity is a nonprofit organization as described in Section  
11 6033(a)(2)(A)i or iii, of the Internal Revenue Code of 1986, as amended.

12 (B) Every religious employer that invokes the exemption provided under  
13 this paragraph shall provide written notice to prospective enrollees  
14 prior to enrollment with the plan, listing the contraceptive health care  
15 services the employer refuses to cover for religious reasons.

16 [(2)][5] (A) Where a group contractholder makes an election not to  
17 purchase coverage for contraceptive drugs or devices in accordance with  
18 paragraph [one] four of this subsection, each enrollee covered under the  
19 contract issued to that group contractholder shall have the right to  
20 directly purchase the rider required by this subsection from the insurer  
21 or health maintenance organization which issued the group contract at  
22 the prevailing small group community rate for such rider whether or not  
23 the employee is part of a small group.

24 (B) Where a group contractholder makes an election not to purchase  
25 coverage for contraceptive drugs or devices in accordance with paragraph  
26 [one] four of this subsection, the insurer or health maintenance organ-  
27 ization that provides such coverage shall provide written notice to  
28 enrollees upon enrollment with the insurer or health maintenance organ-

ization of their right to directly purchase a rider for coverage for the cost of contraceptive drugs or devices. The notice shall also advise the enrollees of the additional premium for such coverage.

[(3)](6) Nothing in this subsection shall be construed as authorizing a contract which provides coverage for prescription drugs to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes.

[(4) Such coverage may be subject to reasonable annual deductibles and coinsurance as may be deemed appropriate by the superintendent and as are consistent with those established for other drugs or devices covered under the policy.]

§ 4. Paragraph 17 of subsection (i) of section 3216 of the insurance law is amended by adding a new subparagraph (G) to read as follows:

(G)(i) In addition to subparagraphs (A), (B), (C), (D), or (E) of this paragraph, every policy that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for all of the following services and contraceptive methods:

(I) All FDA-approved contraceptive drugs, devices, and other products. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products as prescribed or as otherwise authorized under state or federal law. Notwithstanding this subparagraph, an insurer shall not be required to provide coverage of male condoms. The following applies to this coverage:

(aa) where the FDA has approved one or more therapeutic and pharmaceutical equivalent, as defined by the FDA, versions of a contraceptive drug, device, or product, an insurer is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so

1 long as at least one is included and covered without cost-sharing in  
2 accordance with this subparagraph;

3 (bb) if the covered therapeutic and pharmaceutical equivalent versions  
4 of a drug, device, or product are not available or are deemed medically  
5 inadvisable, the insurer shall provide coverage for an alternate thera-  
6 peutic and pharmaceutical equivalent version of the contraceptive drug,  
7 device, or product without cost-sharing. An insurer shall defer to the  
8 attending health care provider's determination of medical necessity.  
9 The superintendent may develop a standard exception form with  
10 instructions that an attending health care provider may use to recommend  
11 a particular contraceptive drug, device, procedure, service, or product  
12 based upon a determination of medical necessity for an insured. The  
13 insurer shall accept the standard exception form submitted by the  
14 insured's attending health care provider;

15 (cc) this coverage shall include emergency contraception without cost-  
16 sharing when provided pursuant to a prescription, order under section  
17 sixty-eight hundred thirty-one of the education law, over-the-counter,  
18 or when otherwise lawfully provided other than pursuant to a  
19 prescription; and

20 (dd) this coverage shall allow for the dispensing of twelve months-  
21 worth of a contraceptive at one time;

22 (II) Voluntary sterilization procedures for women;

23 (III) Patient education and counseling on contraception; and

24 (IV) Follow-up services related to the drugs, devices, products, and  
25 procedures covered under this subparagraph, including management of side  
26 effects, counseling for continued adherence, and device insertion and  
27 removal.

1 (ii) An insurer subject to this subparagraph shall not impose a deduc-  
2 tible, coinsurance, copayment or any other cost-sharing requirement on  
3 the coverage provided pursuant to this subparagraph.

4 (iii) Except as otherwise authorized under this subparagraph, an  
5 insurer shall not impose any restrictions or delays on the coverage  
6 required under this subparagraph.

7 § 5. Paragraph (d) of subdivision 3 of section 365-a of the social  
8 services law, as amended by chapter 909 of the laws of 1974 and as  
9 relettered by chapter 82 of the laws of 1995, is amended to read as  
10 follows:

11 (d) family planning services and supplies for eligible persons of  
12 childbearing age, including children under twenty-one years of age who  
13 can be considered sexually active, who desire such services and  
14 supplies, in accordance with the requirements of federal law and regu-  
15 lations and the regulations of the department. Prescription contracep-  
16 tives, when prescribed based on generally accepted medical practice, may  
17 be dispensed at one time or up to twelve times within one year from the  
18 date of the prescription. No person shall be compelled or coerced to  
19 accept such services or supplies.

20 § 6. This act shall take effect January 1, 2020; provided that  
21 sections two, three and four of this act shall apply to policies and  
22 contracts issued, renewed, modified, altered or amended on and after  
23 such date.

24 PART N

25 Section 1. Universal access commission. 1. There is hereby created a  
26 universal access commission, which shall consider and advise the commis-



1 sioner of health and the superintendent of financial services on options  
2 for achieving universal access to health care in New York State.

3 2. The universal access commission shall consist of independent health  
4 policy and insurance experts appointed by the commissioner and super-  
5 intendent. The commission shall consult with the legislature and stake-  
6 holder groups and convene at least one meeting for members of the public  
7 to review and discuss options for achieving universal access to care.

8 3. The commissioner and superintendent shall select the chair of the  
9 commission from among the members of such commission and shall designate  
10 at least one employee from each department to assist the commission in  
11 the performance of its duties under this section. The commissioner and  
12 superintendent shall adopt rules for the governance of the commission,  
13 which shall meet as frequently as its business may require and at such  
14 other times as determined by the commissioner and superintendent to be  
15 necessary.

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

20 5. The commission shall provide a report to the Governor on the  
21 options for achieving universal access to health care in New York State  
22 by December 1, 2019.

23 § 2. This act shall take effect immediately.

1 Section 1. Subdivision 2 of section 605 of the public health law, as  
2 amended by section 20 of part E of chapter 56 of the laws of 2013, is  
3 amended to read as follows:

4 2. State aid reimbursement for public health services provided by a  
5 municipality under this title, shall be made if the municipality is  
6 providing some or all of the core public health services identified in  
7 section six hundred two of this title, pursuant to an approved applica-  
8 tion for state aid, at a rate of no less than thirty-six per centum,  
9 except for the city of New York which shall receive no less than twenty  
10 per centum, of the difference between the amount of moneys expended by  
11 the municipality for public health services required by section six  
12 hundred two of this title during the fiscal year and the base grant  
13 provided pursuant to subdivision one of this section. No such reimburse-  
14 ment shall be provided for services that are not eligible for state aid  
15 pursuant to this article.

16 § 2. Subdivision 1 of section 616 of the public health law, as amended  
17 by section 27 of part E of chapter 56 of the laws of 2013, is amended to  
18 read as follows:

19 1. The total amount of state aid provided pursuant to this article  
20 shall be limited to the amount of the annual appropriation made by the  
21 legislature. In no event, however, shall such state aid be less than an  
22 amount to provide the full base grant and, as otherwise provided by  
23 [paragraph (a) of] subdivision two of section six hundred five of this  
24 article, [at least] no less than thirty-six per centum, except for the  
25 city of New York which shall receive no less than twenty per centum, of  
26 the difference between the amount of moneys expended by the municipality  
27 for eligible public health services pursuant to an approved application

1 for state aid during the fiscal year and the base grant provided pursu-  
2 ant to subdivision one of section six hundred five of this article.

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

4 PART P

5 Section 1. Subdivision 6 of section 1370 of the public health law, as  
6 amended by chapter 485 of the laws of 1992, is amended as follows:

7 6. "Elevated lead levels" means a blood lead level greater than or  
8 equal to [ten] five micrograms of lead per deciliter of whole blood or  
9 such lower blood lead level as may be established by the department  
10 pursuant to rule or regulation.

11 § 2. The public health law is amended by adding a new section 1370-f  
12 to read as follows:

13 § 1370-f. Lead safe residential rental properties. 1. Definitions.  
14 For the purposes of this section:

15 (a) "residential rental property" shall mean a dwelling which is  
16 either rented, leased, let or hired out, to be occupied, or is occupied  
17 as the home, residence or sleeping place of one or more persons other  
18 than the owner's family. Residential rental property shall not include  
19 short term rental properties during which guests do not stay in excess  
20 of twenty-eight days.

21 (b) "lead safe" shall mean any residential rental property that:

22 (i) has been determined through a lead-based paint inspection  
23 conducted in accordance with appropriate federal regulations not to  
24 contain lead-based paint; or

25 (ii) meets the minimum standards set forth in regulations promulgated  
26 by the commissioner pursuant to this section.

1     2. The commissioner shall promulgate rules and regulations establish-  
2 ing minimum standards for the maintenance of lead safe residential  
3 rental properties. Such rules and regulations shall include:

4     (a) Minimum standards for maintaining internal and external painted  
5 surfaces that contain lead-based paint; and

6     (b) A schedule by which owners of residential rental property must  
7 implement and comply with such minimum standards.

8     3. It shall be the responsibility of an owner of any residential  
9 rental property to maintain such property in a lead safe condition in  
10 accordance with rules and regulations promulgated by the commissioner  
11 pursuant to this section.

12     4. All paint on any residential rental property on which the original  
13 construction was completed prior to January first, nineteen hundred  
14 seventy-eight, shall be presumed to be lead-based paint. This presump-  
15 tion may be overcome by a certification issued by a federally certified  
16 lead-based paint inspector or risk assessor that the property has been  
17 determined not to contain lead-based paint, or by such other means as  
18 may be prescribed by the rules and regulations adopted by the commis-  
19 sioner pursuant to this section.

20     5. The commissioner, local health officer of a county and, in the City  
21 of New York, the commissioner of the New York City department of health  
22 and mental hygiene, may enter into an agreement or contract with a  
23 municipal government regarding inspection of the lead conditions in  
24 residential rental properties and such health department may designate  
25 the local housing maintenance code enforcement agency in which the  
26 residential rental property is located as an agency authorized to  
27 administer and ensure compliance with the provisions of this section

1 and subsequent regulations pursuant to subdivision one of section thir-  
2 teen hundred seventy-five of this title.

3 6. If the commissioner, or other officer having jurisdiction, deter-  
4 mines that an owner of residential rental property is in violation of  
5 this section or any rules or regulations promulgated pursuant to this  
6 section, the commissioner or other officer having jurisdiction shall  
7 have the authority to order the abatement of any lead condition present  
8 at the residential rental property and assess fines not to exceed two  
9 thousand dollars for each violation.

10 § 3. This act shall take effect immediately.

11 PART Q

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

14 4-a. Notwithstanding subdivision two of this section or any inconsist-  
15 ent provision of law to the contrary, and upon approval of the director  
16 of the budget, the commissioner may, subject to the availability of  
17 lawful appropriation, award up to three hundred million dollars of the  
18 funds made available pursuant to this section for unfunded project  
19 applications submitted in response to the request for applications  
20 number 17648 issued by the department on January eighth, two thousand  
21 eighteen pursuant to section twenty-eight hundred twenty-five-e of this  
22 article, provided however that the provisions of subdivisions three and  
23 four of this section shall apply.

24 4-b. Authorized amounts to be awarded pursuant to applications submit-  
25 ted in response to the request for application number 17648 shall be  
26 awarded no later than May first, two thousand nineteen.

1     § 2. This act shall take effect immediately.

2 PART R

3       Section 1. Legislative findings and intent. The legislature finds that  
4       maternal mortality and morbidity is a serious public health concern and  
5       has a serious family and societal impact. New York state has among the  
6       highest maternal mortality rates in the country and racial disparities  
7       remain significant. The U.S. Centers for Disease Control and Prevention  
8       has determined that a regular process for professional, multi-discipli-  
9       nary, confidential review of all maternal deaths can help identify the  
10      causes of maternal mortality, and those findings can lead to clinical  
11      and social change that can help prevent maternal mortality. The same is  
12      true for severe maternal morbidity. Confidentiality is important to  
13      ensure that full information is made available in the review process to  
14      maximize protection of maternal health.

15 Section 3 of article 17 of the state constitution states: "The  
16 protection and promotion of the health of the inhabitants of the state  
17 are matters of public concern and provision therefor shall be made by  
18 the state and by such of its subdivisions and in such manner, and by  
19 such means as the legislature shall from time to time determine." The  
20 legislature finds that the creation of a state maternal mortality review  
21 board, and recognition and protection of any maternal mortality review  
22 board, including a New York city maternal mortality review board, are a  
23 matter of state concern and an important exercise of the legislature's  
24 constitutional mandate to protect the public health.

25     § 2. The public health law is amended by adding a new section 2509 to  
26 read as follows:

1     § 2509. Maternal mortality review board. 1. (a) There is hereby estab-  
2 lished in the department the maternal mortality review board for the  
3 purpose of reviewing maternal deaths and severe maternal morbidity and  
4 developing findings, recommendations, and best practices to the commis-  
5 sioner to contribute to the prevention of maternal mortality and severe  
6 maternal morbidity. The board shall assess the cause of death, factors  
7 leading to death and preventability for each maternal death reviewed  
8 and, at the discretion of the board, cases of severe maternal morbidity,  
9 and shall develop strategies for reducing the risk of maternal mortality  
10 and severe maternal morbidity, where cases of severe maternal morbidity  
11 were reviewed, taking into account factors such as racial, economic, or  
12 other disparities. The boards' findings, recommendations and best prac-  
13 tices shall be given to the commissioner for dissemination.

14     (b) Any maternal mortality review board, including a New York city  
15 maternal mortality review board, shall provide to the commissioner the  
16 results and the findings of its reviews, including recommendations and  
17 best practices and upon request information and data, including case  
18 summaries, to support statewide surveillance and enforcement.

19     2. As used in this section:

20     (a) "Advisory council" and "council" mean the advisory council on  
21 maternal mortality and severe maternal morbidity, established under this  
22 section.

23     (b) "Board" means a maternal mortality review board established by  
24 this section, referred to in this section as the "state board", or any  
25 board operating, including a New York city maternal mortality review  
26 board, under this section.

27     (c) "Maternal death" means the death of a woman during pregnancy or  
28 within a year from the end of pregnancy.

1 (d) "Severe maternal morbidity" means unexpected outcomes of pregnan-  
2 cy, labor, or delivery that result in significant short- or long-term  
3 consequences to a woman's health.

4 3. (a) The members of the state board shall be comprised of multidis-  
5 ciplinary experts in the field of maternal mortality, women's health and  
6 public health, and shall include health care professionals and other  
7 experts who serve and are representative of the racial and ethnic diver-  
8 sity of the women and mothers of the state.

9 (b) The state board shall be composed of at least fifteen members, all  
10 of whom shall be appointed by the commissioner.

11 (c) The terms of the state board members shall be three years. The  
12 commissioner may choose to reappoint state board members to additional  
13 three year terms.

14 (d) A majority of the appointed membership of the state board, no less  
15 than three, shall constitute a quorum.

16 (e) When any member of the state board fails to attend three consec-  
17 utive regular meetings, unless such absence is for good cause, that  
18 membership may be deemed vacant for purposes of the appointment of a  
19 successor.

20 (f) Meetings of the state board shall be held at least twice a year  
21 but may be held more frequently as deemed necessary, subject to request  
22 of the department.

23 (g) Members of the state board shall be indemnified under section  
24 seventeen of the public officers law.

25 (h) Members of the state board shall not be compensated for their  
26 participation on the board but may receive reimbursement for their ordi-  
27 nary and necessary expenses of participation.



1     (i) Membership on a board shall not disqualify any person from holding  
2     any public office or employment.

3     (j) The board is not subject to the open meetings law.

4     4.    (a) The commissioner shall receive upon request from any depart-  
5     ment, division, board, bureau, commission, local health departments or  
6     other agency of the state or political subdivision thereof or any public  
7     authority, as well as hospitals established pursuant to article twenty-  
8     eight of this chapter, birthing facilities, medical examiners, coroners  
9     and coroner physicians and any other facility providing services associ-  
10    ated with maternal mortality, such information, including, but not  
11    limited to, death records, medical records, autopsy reports, toxicology  
12    reports, hospital discharge records, birth records and any other infor-  
13    mation.

14    (b) The commissioner shall receive information, including oral or  
15    written statements, relating to any maternal death and case of severe  
16    maternal morbidity, from any family member or other interested party  
17    (including the patient in a case of severe maternal morbidity) relating  
18    to any case that may come before the board. Oral statements received  
19    under this paragraph shall be transcribed or summarized in writing. The  
20    commissioner and the city commissioner shall transmit that information  
21    to the board considering the case.

22    (c) Before transmitting any information to the board, the commission-  
23    er, or the city commissioner, shall remove all personal identifying  
24    information of the woman, health care practitioner or practitioners or  
25    anyone else individually named in such information, as well as the  
26    hospital or facility that treated the woman, and any other information  
27    such as geographic location that may inadvertently identify the woman,  
28    practitioner or facility. This paragraph shall not preclude the trans-

1 mitting of information to the board that is reasonably necessary to  
2 enable the board to perform an appropriate review under this section.

3 5. Each board:

4 (a) shall make and report findings, recommendations and best practices  
5 to the commissioner regarding the cause of death, factors leading to  
6 death, and preventability of each maternal death case, and each case of  
7 severe maternal morbidity reviewed by the board, by reviewing relevant  
8 information for each case and consulting with experts as needed to eval-  
9 uate the information for each death; and shall provide such de-identi-  
10 fied findings and recommendations, including best practices and strate-  
11 gies for reducing the risk of maternal mortality and severe maternal  
12 morbidity, to the advisory council; provided that material provided to  
13 the advisory council shall not include any information that would be  
14 confidential under this section;

15 (b) shall develop recommendations to the commissioner for areas of  
16 focus, including issues of severe maternal morbidity and issues of  
17 racial, economic or other disparities in maternal outcomes;

18 (c) may, in addition to the findings, recommendations, and best prac-  
19 tices made under this subdivision, and consistent with all applicable  
20 confidentiality protections, bring any particular matter to the atten-  
21 tion of the commissioner;

22 (d) the state board shall issue a report every other year to the  
23 commissioner on its findings, recommendations, and best practices, and  
24 it shall be a public document.

25 6. The commissioner and boards shall each keep confidential any infor-  
26 mation collected or received under this section that includes personal  
27 identifying information of the woman, health care practitioner or prac-  
28 titioners or anyone else individually named in such information, as well

1 as the hospital or facility that treated the woman, and any other infor-  
2 mation such as geographic location that may inadvertently identify the  
3 woman, practitioner or facility, and shall use the information provided  
4 or received under this section solely for the purposes of improvement of  
5 the quality of health care of women and to prevent maternal mortality  
6 and severe maternal morbidity. This subdivision shall not preclude the  
7 transmitting of information to the board that is reasonably necessary to  
8 enable the board to perform an appropriate review under this section.  
9 All information and records received, meetings conducted, reports and  
10 records made and maintained and all books and papers obtained by the  
11 commissioner as well as the board shall be confidential and shall not be  
12 made open or available, including under article six of the public offi-  
13 cers law, and shall be limited to board members as well as those author-  
14 ized by the commissioner. Such information shall not be discoverable or  
15 admissible as evidence in any action in any court or before any other  
16 tribunal, board, agency or person.

17 7. (a) There is hereby established in the department an advisory coun-  
18 cil on maternal mortality and severe maternal morbidity.

19 (b) The advisory council:

20 (i) may review the findings, recommendations and best practices of the  
21 boards;

22 (ii) may use the boards findings, recommendations and best practices  
23 to develop recommendations on policies, best practices, and strategies  
24 to prevent maternal mortality and severe maternal morbidity;

25 (iii) may hold public hearings on those matters; and

26 (iv) may make findings and issue reports, including an annual report,  
27 on such matters;

1 (c) The advisory council shall consist of at least twenty members,  
2 representative of the racial and ethnic diversity of the women and moth-  
3 ers of the state to be determined by the commissioner. Ten of the  
4 members of the council shall be representative of the population and  
5 health care system of the city of New York. The commissioner shall  
6 appoint the chair of the council.

7 (d) The members of the council shall be comprised of multidisciplinary  
8 experts and lay persons knowledgeable in the field of maternal mortal-  
9 ity, women's health and public health and shall include members who  
10 serve and are representative of the diversity of the women and mothers  
11 in medically underserved areas of the state or areas of the state with  
12 disproportionately high occurrences of maternal mortality or severe  
13 maternal morbidity.

14 (e) The terms of the council members shall be three years. The commis-  
15 sioner may choose to reappoint council members to additional three-year  
16 terms. Vacancies on the council shall be filled by appointment by the  
17 commissioner. A majority of the appointed membership of the council  
18 shall constitute a quorum. When any member of the council fails to  
19 attend three consecutive regular meetings, unless such absence is for  
20 good cause, that membership may be deemed vacant for purposes of the  
21 appointment of a successor.

22 (f) Meetings of the council shall be held at least twice a year.

23 (g) Members of the council shall be indemnified under section seven-  
24 teen of the public officers law. Members of the council shall not be  
25 compensated for their participation on the council but shall receive  
26 reimbursement for their ordinary and necessary expenses of partic-  
27 ipation. Membership on the council shall not disqualify any person from  
28 holding any public office or employment.



1     § 2. The public health law is amended by adding a new article 25-A to  
2 read as follows:

3                             ARTICLE 25-A

4                             REPRODUCTIVE HEALTH ACT

5     Section 2599-aa. Policy and purpose.

6             2599-bb. Abortion.

7     § 2599-aa. Policy and purpose. The legislature finds that comprehen-  
8 sive reproductive health care is a fundamental component of every indi-  
9 vidual's health, privacy and equality. Therefore, it is the policy of  
10 the state that:

11     1. Every individual has the fundamental right to choose or refuse  
12 contraception or sterilization.

13     2. Every individual who becomes pregnant has the fundamental right to  
14 choose to carry the pregnancy to term, to give birth to a child, or to  
15 have an abortion, pursuant to this article.

16     3. The state shall not discriminate against, deny, or interfere with  
17 the exercise of the rights set forth in this section in the regulation  
18 or provision of benefits, facilities, services or information.

19     § 2599-bb. Abortion. 1. A health care practitioner licensed, certi-  
20 fied, or authorized under title eight of the education law, acting with-  
21 in his or her lawful scope of practice, may perform an abortion when,  
22 according to the practitioner's reasonable and good faith professional  
23 judgment based on the facts of the patient's case: the patient is within  
24 twenty-four weeks from the commencement of pregnancy, or there is an  
25 absence of fetal viability, or the abortion is necessary to protect the  
26 patient's life or health.

1     2. This article shall be construed and applied consistent with and  
2     subject to applicable laws and applicable and authorized regulations  
3     governing health care procedures.

4     § 3. Section 4164 of the public health law is REPEALED.

5     § 4. Subdivision 8 of section 6811 of the education law is REPEALED.

6     § 5. Sections 125.40, 125.45, 125.50, 125.55 and 125.60 of the penal  
7     law are REPEALED, and the article heading of article 125 of the penal  
8     law is amended to read as follows:

9                     HOMICIDE[, ABORTION] AND RELATED OFFENSES

10    § 6. Section 125.00 of the penal law is amended to read as follows:

11    § 125.00 Homicide defined.

12    Homicide means conduct which causes the death of a person [or an  
13    unborn child with which a female has been pregnant for more than twen-  
14    ty-four weeks] under circumstances constituting murder, manslaughter in  
15    the first degree, manslaughter in the second degree, or criminally  
16    negligent homicide[, abortion in the first degree or self-abortion in  
17    the first degree].

18    § 7. The section heading, opening paragraph and subdivision 1 of  
19    section 125.05 of the penal law are amended to read as follows:

20    Homicide[, abortion] and related offenses; [definitions of terms]  
21    definition.

22    The following [definitions are] definition is applicable to this arti-  
23    cle:

24    [1.] "Person," when referring to the victim of a homicide, means a  
25    human being who has been born and is alive.

26    § 7-a. Subdivisions 2 and 3 of section 125.05 of the penal law are  
27    REPEALED.

28    § 8. Subdivision 2 of section 125.15 of the penal law is REPEALED.

1     § 9. Subdivision 3 of section 125.20 of the penal law is REPEALED.

2     § 10. Paragraph (b) of subdivision 8 of section 700.05 of the criminal  
3 procedure law, as amended by chapter 189 of the laws of 2018, is amended  
4 to read as follows:

5     (b) Any of the following felonies: assault in the second degree as  
6 defined in section 120.05 of the penal law, assault in the first degree  
7 as defined in section 120.10 of the penal law, reckless endangerment in  
8 the first degree as defined in section 120.25 of the penal law, promot-  
9 ing a suicide attempt as defined in section 120.30 of the penal law,  
10 strangulation in the second degree as defined in section 121.12 of the  
11 penal law, strangulation in the first degree as defined in section  
12 121.13 of the penal law, criminally negligent homicide as defined in  
13 section 125.10 of the penal law, manslaughter in the second degree as  
14 defined in section 125.15 of the penal law, manslaughter in the first  
15 degree as defined in section 125.20 of the penal law, murder in the  
16 second degree as defined in section 125.25 of the penal law, murder in  
17 the first degree as defined in section 125.27 of the penal law,  
18 [abortion in the second degree as defined in section 125.40 of the penal  
19 law, abortion in the first degree as defined in section 125.45 of the  
20 penal law,] rape in the third degree as defined in section 130.25 of the  
21 penal law, rape in the second degree as defined in section 130.30 of the  
22 penal law, rape in the first degree as defined in section 130.35 of the  
23 penal law, criminal sexual act in the third degree as defined in section  
24 130.40 of the penal law, criminal sexual act in the second degree as  
25 defined in section 130.45 of the penal law, criminal sexual act in the  
26 first degree as defined in section 130.50 of the penal law, sexual abuse  
27 in the first degree as defined in section 130.65 of the penal law,  
28 unlawful imprisonment in the first degree as defined in section 135.10



1 of the penal law, kidnapping in the second degree as defined in section  
2 135.20 of the penal law, kidnapping in the first degree as defined in  
3 section 135.25 of the penal law, labor trafficking as defined in section  
4 135.35 of the penal law, aggravated labor trafficking as defined in  
5 section 135.37 of the penal law, custodial interference in the first  
6 degree as defined in section 135.50 of the penal law, coercion in the  
7 first degree as defined in section 135.65 of the penal law, criminal  
8 trespass in the first degree as defined in section 140.17 of the penal  
9 law, burglary in the third degree as defined in section 140.20 of the  
10 penal law, burglary in the second degree as defined in section 140.25 of  
11 the penal law, burglary in the first degree as defined in section 140.30  
12 of the penal law, criminal mischief in the third degree as defined in  
13 section 145.05 of the penal law, criminal mischief in the second degree  
14 as defined in section 145.10 of the penal law, criminal mischief in the  
15 first degree as defined in section 145.12 of the penal law, criminal  
16 tampering in the first degree as defined in section 145.20 of the penal  
17 law, arson in the fourth degree as defined in section 150.05 of the  
18 penal law, arson in the third degree as defined in section 150.10 of the  
19 penal law, arson in the second degree as defined in section 150.15 of  
20 the penal law, arson in the first degree as defined in section 150.20 of  
21 the penal law, grand larceny in the fourth degree as defined in section  
22 155.30 of the penal law, grand larceny in the third degree as defined in  
23 section 155.35 of the penal law, grand larceny in the second degree as  
24 defined in section 155.40 of the penal law, grand larceny in the first  
25 degree as defined in section 155.42 of the penal law, health care fraud  
26 in the fourth degree as defined in section 177.10 of the penal law,  
27 health care fraud in the third degree as defined in section 177.15 of  
28 the penal law, health care fraud in the second degree as defined in

1 section 177.20 of the penal law, health care fraud in the first degree  
2 as defined in section 177.25 of the penal law, robbery in the third  
3 degree as defined in section 160.05 of the penal law, robbery in the  
4 second degree as defined in section 160.10 of the penal law, robbery in  
5 the first degree as defined in section 160.15 of the penal law, unlawful  
6 use of secret scientific material as defined in section 165.07 of the  
7 penal law, criminal possession of stolen property in the fourth degree  
8 as defined in section 165.45 of the penal law, criminal possession of  
9 stolen property in the third degree as defined in section 165.50 of the  
10 penal law, criminal possession of stolen property in the second degree  
11 as defined by section 165.52 of the penal law, criminal possession of  
12 stolen property in the first degree as defined by section 165.54 of the  
13 penal law, trademark counterfeiting in the second degree as defined in  
14 section 165.72 of the penal law, trademark counterfeiting in the first  
15 degree as defined in section 165.73 of the penal law, forgery in the  
16 second degree as defined in section 170.10 of the penal law, forgery in  
17 the first degree as defined in section 170.15 of the penal law, criminal  
18 possession of a forged instrument in the second degree as defined in  
19 section 170.25 of the penal law, criminal possession of a forged instru-  
20 ment in the first degree as defined in section 170.30 of the penal law,  
21 criminal possession of forgery devices as defined in section 170.40 of  
22 the penal law, falsifying business records in the first degree as  
23 defined in section 175.10 of the penal law, tampering with public  
24 records in the first degree as defined in section 175.25 of the penal  
25 law, offering a false instrument for filing in the first degree as  
26 defined in section 175.35 of the penal law, issuing a false certificate  
27 as defined in section 175.40 of the penal law, criminal diversion of  
28 prescription medications and prescriptions in the second degree as

1 defined in section 178.20 of the penal law, criminal diversion of  
2 prescription medications and prescriptions in the first degree as  
3 defined in section 178.25 of the penal law, residential mortgage fraud  
4 in the fourth degree as defined in section 187.10 of the penal law,  
5 residential mortgage fraud in the third degree as defined in section  
6 187.15 of the penal law, residential mortgage fraud in the second degree  
7 as defined in section 187.20 of the penal law, residential mortgage  
8 fraud in the first degree as defined in section 187.25 of the penal law,  
9 escape in the second degree as defined in section 205.10 of the penal  
10 law, escape in the first degree as defined in section 205.15 of the  
11 penal law, absconding from temporary release in the first degree as  
12 defined in section 205.17 of the penal law, promoting prison contraband  
13 in the first degree as defined in section 205.25 of the penal law,  
14 hindering prosecution in the second degree as defined in section 205.60  
15 of the penal law, hindering prosecution in the first degree as defined  
16 in section 205.65 of the penal law, sex trafficking as defined in  
17 section 230.34 of the penal law, sex trafficking of a child as defined  
18 in section 230.34-a of the penal law, criminal possession of a weapon in  
19 the third degree as defined in subdivisions two, three and five of  
20 section 265.02 of the penal law, criminal possession of a weapon in the  
21 second degree as defined in section 265.03 of the penal law, criminal  
22 possession of a weapon in the first degree as defined in section 265.04  
23 of the penal law, manufacture, transport, disposition and defacement of  
24 weapons and dangerous instruments and appliances defined as felonies in  
25 subdivisions one, two, and three of section 265.10 of the penal law,  
26 sections 265.11, 265.12 and 265.13 of the penal law, or prohibited use  
27 of weapons as defined in subdivision two of section 265.35 of the penal  
28 law, relating to firearms and other dangerous weapons, or failure to

1 disclose the origin of a recording in the first degree as defined in  
2 section 275.40 of the penal law;

3 § 11. Subdivision 1 of section 673 of the county law, as added by  
4 chapter 545 of the laws of 1965, is amended to read as follows:

5 1. A coroner or medical examiner has jurisdiction and authority to  
6 investigate the death of every person dying within his county, or whose  
7 body is found within the county, which is or appears to be:

8 (a) A violent death, whether by criminal violence, suicide or casual-  
9 ty;

10 (b) A death caused by unlawful act or criminal neglect;

11 (c) A death occurring in a suspicious, unusual or unexplained manner;

12 (d) [A death caused by suspected criminal abortion;

13 (e)] A death while unattended by a physician, so far as can be discov-  
14 ered, or where no physician able to certify the cause of death as  
15 provided in the public health law and in form as prescribed by the  
16 commissioner of health can be found;

17 [(f)] (e) A death of a person confined in a public institution other  
18 than a hospital, infirmary or nursing home.

19 § 12. Section 4 of the judiciary law, as amended by chapter 264 of the  
20 laws of 2003, is amended to read as follows:

21 § 4. Sittings of courts to be public. The sittings of every court  
22 within this state shall be public, and every citizen may freely attend  
23 the same, except that in all proceedings and trials in cases for  
24 divorce, seduction, [abortion,] rape, assault with intent to commit  
25 rape, criminal sexual act, bastardy or filiation, the court may, in its  
26 discretion, exclude therefrom all persons who are not directly inter-  
27 ested therein, excepting jurors, witnesses, and officers of the court.



1     § 268. Statement of policy and purposes. The purpose of this title is  
2     to codify the establishment of the health benefit exchange in New York,  
3     known as NY State of Health, The Official Health Plan Marketplace  
4     (Marketplace), in conformance with Executive Order 42 (Cuomo) issued  
5     April 12, 2012. The Marketplace shall continue to perform eligibility  
6     determinations for federal and state insurance affordability programs  
7     including medical assistance in accordance with section three hundred  
8     sixty-six of the social services law, child health plus in accordance  
9     with section twenty-five hundred eleven of this chapter, the basic  
10    health program in accordance with section three hundred sixty-nine-gg of  
11    the social services law, and premium tax credits and cost-sharing  
12    reductions, together with performing eligibility determinations for  
13    qualified health plans and such other health insurance programs as  
14    determined by the commissioner. The Marketplace shall also facilitate  
15    enrollment in insurance affordability programs, qualified health plans  
16    and other health insurance programs as determined by the commissioner,  
17    the purchase and sale of qualified health plans and/or other or addi-  
18    tional health plans certified by the Marketplace pursuant to this title,  
19    and shall continue to have the authority to operate a small business  
20    health options program ("SHOP") to assist eligible small employers in  
21    selecting qualified health plans and/or other or additional health plans  
22    certified by the Marketplace and to determine small employer eligibility  
23    for purposes of small employer tax credits. It is the intent of the  
24    legislature, by codifying the Marketplace in state statute, to continue  
25    to promote quality and affordable health coverage and care, reduce the  
26    number of uninsured persons, provide a transparent marketplace, educate  
27    consumers and assist individuals with access to coverage, premium  
28    assistance tax credits and cost-sharing reductions. In addition, the

1 legislature declares the intent that the Marketplace continue to be  
2 properly integrated with insurance affordability programs, including  
3 Medicaid, child health plus and the basic health program, and such other  
4 health insurance programs as determined by the commissioner.

5 § 268-a. Definitions. For purposes of this title, the following defi-  
6 nitions shall apply:

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

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

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

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

21 (a) accident insurance or disability income insurance, or any combina-  
22 tion thereof;

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

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

26 (d) workers' compensation or similar insurance;

27 (e) automobile no-fault insurance;

28 (f) credit insurance;

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

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

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

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

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

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

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



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

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

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

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

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

15     (b) resides in this state;

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

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

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

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

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

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

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

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

14    § 268-b. Establishment of NY State of Health, The Official Health Plan  
15    Marketplace. 1. There is hereby established an office within the depart-  
16    ment of health to be known as the "NY State of Health, The official  
17    health plan Marketplace".

18    2. The purpose of the Marketplace is to facilitate enrollment in  
19    health coverage and the purchase and sale of qualified health plans and  
20    other health plans certified by the Marketplace; enroll individuals in  
21    coverage for which they are eligible in accordance with federal and  
22    state law; enable eligible individuals to receive premium tax credits,  
23    cost-sharing reductions, and to access insurance affordability programs  
24    and other health insurance programs as determined by the commissioner;  
25    assist eligible small employers in selecting qualified health plans  
26    and/or other, or additional health plans certified by the Marketplace  
27    and to qualify for small employer tax credits in accordance with appli-  
28    cable law; and to carry out other functions set forth in this title.

1     § 268-c. Functions of the Marketplace. The Marketplace shall:

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

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

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

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

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

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

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

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

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

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

24     9. Provide the minimum requirements an insurer shall meet to partic-  
25 ipate in the Marketplace, in the best interest of qualified individuals  
26 or eligible individuals;

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

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

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

9 13. Maintain an internet website through which enrollees and prospec-  
10 tive enrollees of qualified health plans and health plans certified by  
11 the Marketplace may obtain standardized comparative information on such  
12 plans and insurance affordability programs.

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

18 15. Operate a program under which the Marketplace awards grants to  
19 entities to serve as navigators in accordance with applicable federal  
20 law and regulations adopted thereunder, and/or a program under which the  
21 Marketplace awards grants to entities to provide community based enroll-  
22 ment assistance in accordance with requirements developed by the Market-  
23 place; and/or a program under which the Marketplace certifies New York  
24 state licensed producers to provide assistance to eligible individuals  
25 and/or small employers pursuant to federal or state law.

26 16. In accordance with applicable federal and state law, inform indi-  
27 viduals of eligibility requirements for the Medicaid program under title  
28 XIX of the social security act and the social services law, the chil-

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

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

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

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

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

19. Enter into agreements as necessary with federal and state agencies and other state Marketplaces to carry out its responsibilities under this title, provided such agreements include adequate protections with respect to the confidentiality of any information to be shared and comply with all state and federal laws and regulations.

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

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

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

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

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

17 § 268-d. Special functions of the Marketplace related to health plan  
18 certification and qualified health plan oversight. 1. Health plans  
19 certified by the Marketplace shall meet the following requirements:

20 (a) The insurer offering the health plan:

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

24 (ii) offers at least one qualified health plan and/or other or addi-  
25 tional health plans authorized for sale by the department of financial  
26 services or the department in each of the silver and gold levels as  
27 required by state law, provided, however, that the Marketplace may

1 require additional benefit levels to be offered by all insurers partic-  
2 ipating in the Marketplace;

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

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

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

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

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

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

27 (ii) provides at least a bronze level of coverage as defined by state  
28 law, unless the plan is certified as a qualified catastrophic plan, as



defined in section 1302(e) of the federal act and the insurance law, and  
shall only be offered to individuals eligible for catastrophic coverage;

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

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

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

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

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

2. The Marketplace shall not exclude a health plan:

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

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

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

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

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

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

15 (A) claims payment policies and practices;

16 (B) periodic financial disclosures;

17 (C) data on enrollment and disenrollment;

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

19 (E) data on rating practices;

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

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

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

26 (ii) the information shall be provided in plain language, as that term  
27 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

1 dental benefits prescribed by the secretary pursuant to section  
2 1302(b)(1)(J) of the federal act, and such other dental benefits as the  
3 Marketplace or secretary may specify in regulations.

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

11 § 268-e. Appeals and appeal hearings; judicial review. 1. Any appli-  
12 cant or enrollee, or any individual authorized to act on behalf of any  
13 such applicant or enrollee, may appeal to the department from determi-  
14 nations of department officials or failures to make determinations upon  
15 grounds specified in subdivision four of this section. The department  
16 must review the appeal de novo and give such person an opportunity for  
17 an appeal hearing. The department may also, on its own motion, review  
18 any decision made or any case in which a decision has not been made by  
19 the Marketplace or a social services official within the time specified  
20 by law or regulations of the department. The department may make such  
21 additional investigation as it may deem necessary, and the commissioner  
22 must make such determination as is justified and in accordance with  
23 applicable law.

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

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

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

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

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

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

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

(i) An initial determination of eligibility, including:

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

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

26    (b) a description of the procedures by which the applicant or enrollee  
27    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 Marketplace.

16 2. The marketplace advisory committee shall consist of up to twenty-  
17 eight members appointed by the commissioner, representative of each  
18 geographic area of the state and including:

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

21 (i) health plan consumer advocates;

22 (ii) small business consumer representatives;

23 (iii) health care provider representatives;

24 (iv) representatives of the health insurance industry;

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

27 (i) licensed insurance producers; and

28 (ii) representatives of labor organizations.

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

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

12     § 268-g. Funding of the Marketplace. 1. The Marketplace shall be fund-  
13 ed by state and federal sources as authorized by applicable law, includ-  
14 ing but not limited to applicable law authorizing the respective insur-  
15 ance affordability programs available through the Marketplace.

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

20     3. Notwithstanding any law to the contrary, and in accordance with  
21 section four of the state finance law, upon request of the director of  
22 the budget, in consultation with the commissioner, the superintendent  
23 and the executive director of the Marketplace, the comptroller is hereby  
24 authorized and directed to sub-allocate or transfer special revenue  
25 federal funds appropriated to the department for planning and implement-  
26 ing various healthcare and insurance reform initiatives authorized by  
27 applicable law. Marketplace moneys sub-allocated or transferred pursu-  
28 ant to this section shall be paid out of the fund upon audit and warrant



1 of the state comptroller on vouchers certified or approved by the  
2 Marketplace.

3 § 268-h. Construction. Nothing in this article, and no action taken by  
4 the Marketplace pursuant hereto, shall be construed to:

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

7 2. exempt insurers, insurance producers or qualified health plans from  
8 this chapter or the insurance law and any regulations promulgated there-  
9 under.

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

16 § 4. This act shall take effect immediately.

17 PART U

18 Section 1. Section 203 of the elder law is amended by adding a new  
19 subdivision 12 to read as follows:

20 12. The director is hereby authorized to implement private pay proto-  
21 cols for all programs administered by the office. These protocols may be  
22 implemented by area agencies on aging at their option and such protocols  
23 may not be applied to clients whose services are paid for with federal  
24 funds or funds designated as federal match. All private payments  
25 received directly by an area agency on aging or indirectly by one of its  
26 contractors shall be used to supplement, not supplant, funds by state,

1 federal, or county appropriations. Private pay payments received under  
2 this subdivision shall be used by the area agency on aging to support  
3 and enhance services or programs provided by the area agency on aging.  
4 Participant payments under this subdivision shall not be required of  
5 individuals with incomes below four hundred percent of the federal  
6 poverty level. No participant, regardless of income, shall be required  
7 to pay for any service that they are receiving at the time these proto-  
8 cols are implemented by the area agency on aging. This subdivision shall  
9 not prevent cost sharing for the programs established pursuant to  
10 section two hundred fourteen of this title for individuals below four  
11 hundred percent of the federal poverty level.

12 § 2. This act shall take effect immediately.

13 PART V

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

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

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

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

3     34. Any payment made pursuant to the state's managed care program,  
4 including payments made by managed long term care plans, shall be deemed  
5 a payment by the state's medical assistance program.

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

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

11     (b) The Medicaid inspector general shall conduct periodic reviews of  
12 the contractual performance of each managed care provider as it relates  
13 to the managed care provider's program integrity obligations under its  
14 contract with the department. The Medicaid inspector general, in consul-  
15 tation with the commissioner, shall publish a list of those contractual  
16 obligations which may be subject to review and how they shall be evalu-  
17 ated, including benchmarks, prior to commencing any review.

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

27     (d) The managed care provider shall be entitled to receive a draft  
28 audit report and final audit report containing the results of the Medi-

1 caid inspector general's review. If the Medicaid inspector general  
2 determines to recover a percentage of the premium as described in para-  
3 graph (c) of this subdivision, the managed care provider shall have an  
4 opportunity to be heard in accordance with section twenty-two of this  
5 chapter.

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

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

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

21 (b) A compliance program that meets Federal requirements for managed  
22 care provider compliance programs, as specified in the contract or  
23 contracts between the department and the Medicaid managed care provider  
24 shall be deemed in compliance with the provisions in this section, so  
25 long as such programs adequately address medical assistance program risk  
26 areas and compliance issues. For purposes of this section, a managed  
27 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. Section 3613 of the public health law is amended by adding a new  
11 subdivision 1-a to read as follows:

12 1-a. Each home care services worker shall obtain an individual  
13 National Provider Identifier (NPI) number from the National Provider  
14 Plan and Provider Enumeration System (NPPES).

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

17 35. Recovery of overpayments from network providers. (a) Where the  
18 Medicaid inspector general during the course of an audit, investigation,  
19 or review, or the deputy attorney general for the Medicaid fraud control  
20 unit during the course of an investigation or prosecution for Medicaid  
21 fraud, identifies medical assistance overpayments made by a managed care  
22 provider or managed long term care plan to its subcontractor or subcon-  
23 tractors or provider or providers, the state shall have the right to  
24 recover the overpayment from the subcontractor or subcontractors,  
25 provider or providers, or the managed care provider or managed long term  
26 care plan.

27 (b) Where the state is unsuccessful in recovering an overpayment from  
28 the subcontractor or subcontractors or provider or providers, the Medi-

caid inspector general may require the managed care provider or managed long term care plan to recover the medical assistance overpayment identified in paragraph (a) of this subdivision on behalf of the state. The managed care provider or managed long term care plan shall remit to the state the full amount of the identified overpayment no later than six months after receiving notice of the overpayment from the state.

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

#### PART W

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

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commis-

1 sioner of mental health. Recovery of such excess income shall be for the  
2 following fiscal periods: for programs in counties located outside of  
3 the city of New York, the applicable fiscal periods shall be January 1,  
4 2003 through December 31, 2009 and January 1, 2011 through December 31,  
5 [2019] 2022; and for programs located within the city of New York, the  
6 applicable fiscal periods shall be July 1, 2003 through June 30, 2010  
7 and July 1, 2011 through June 30, [2019] 2022.

8 § 2. This act shall take effect immediately.

9 PART X

10 Section 1. Subdivision 9 of section 730.10 of the criminal procedure  
11 law, as added by section 1 of part Q of chapter 56 of the laws of 2012,  
12 is amended to read as follows:

13 9. "Appropriate institution" means: (a) a hospital operated by the  
14 office of mental health or a developmental center operated by the office  
15 for people with developmental disabilities; [or] (b) a hospital licensed  
16 by the department of health which operates a psychiatric unit licensed  
17 by the office of mental health, as determined by the commissioner  
18 provided, however, that any such hospital that is not operated by the  
19 state shall qualify as an "appropriate institution" only pursuant to the  
20 terms of an agreement between the commissioner and the hospital; or (c)  
21 a mental health unit operating within a local correctional facility  
22 except those located within a city with a population of one million or  
23 more; provided however, that any such mental health unit operating with-  
24 in a local correctional facility shall qualify as an "appropriate insti-  
25 tution" only pursuant to the terms of an agreement between the commis-  
26 sioner of mental health, director of community services and the sheriff

1 for the respective locality. Nothing in this article shall be construed  
2 as requiring a hospital or local correctional facility to consent to  
3 providing care and treatment to an incapacitated person at such hospital  
4 or local correctional facility. The commissioner of mental health shall  
5 promulgate regulations for demonstration programs at no more than two  
6 counties to implement restoration to competency within a local correc-  
7 tional facility. Subject to annual appropriation, the commissioner of  
8 mental health may, at such commissioner's discretion, make funds avail-  
9 able for state aid grants to any county that develops and operates a  
10 mental health unit within a local correctional facility pursuant to this  
11 section. Nothing in this article shall be construed as requiring a  
12 hospital or local correctional facility to consent to providing care and  
13 treatment to an incapacitated person at such hospital or local correc-  
14 tional facility.

15 § 2. This act shall take effect immediately and shall be deemed to  
16 have been in full force and effect on and after April 1, 2019; provided,  
17 however, that this act shall expire and be deemed repealed March 31,  
18 2024; effective immediately, the addition, amendment and/or repeal of  
19 any rule or regulation necessary for the implementation of this act on  
20 its effective date are authorized to be made and completed on or before  
21 such effective date.

22 PART Y

23 Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter  
24 57 of the laws of 2006, relating to establishing a cost of living  
25 adjustment for designated human services programs, as amended by section



1 1 of part AA of chapter 57 of the laws of 2018, are amended to read as  
2 follows:

3 3-b. Notwithstanding any inconsistent provision of law, beginning  
4 April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and  
5 ending March 31, [2019] 2020, the commissioners shall not include a COLA  
6 for the purpose of establishing rates of payments, contracts or any  
7 other form of reimbursement[, provided that the commissioners of the  
8 office for people with developmental disabilities, the office of mental  
9 health, and the office of alcoholism and substance abuse services shall  
10 not include a COLA beginning April 1, 2017 and ending March 31, 2019].

11 3-c. Notwithstanding any inconsistent provision of law, beginning  
12 April 1, [2019] 2020 and ending March 31, [2022] 2023, the commissioners  
13 shall develop the COLA under this section using the actual U.S. consumer  
14 price index for all urban consumers (CPI-U) published by the United  
15 States department of labor, bureau of labor statistics for the twelve  
16 month period ending in July of the budget year prior to such state  
17 fiscal year, for the purpose of establishing rates of payments,  
18 contracts or any other form of reimbursement.

19 § 2. This act shall take effect immediately and shall be deemed to  
20 have been in full force and effect on and after April 1, 2019; provided,  
21 however, that the amendments to section 1 of part C of chapter 57 of the  
22 laws of 2006 made by section one of this act shall not affect the repeal  
23 of such section and shall be deemed repealed therewith.

1 Section 1. Subdivision 1 of section 2801 of the public health law, as  
2 amended by section 1 of subpart B of part S of chapter 57 of the laws of  
3 2018, is amended to read as follows:

4 1. "Hospital" means a facility or institution engaged principally in  
5 providing services by or under the supervision of a physician or, in the  
6 case of a dental clinic or dental dispensary, of a dentist, or, in the  
7 case of a midwifery birth center, of a midwife, for the prevention,  
8 diagnosis or treatment of human disease, pain, injury, deformity or  
9 physical condition, including, but not limited to, a general hospital,  
10 public health center, diagnostic center, treatment center, dental clinic,  
11 dental dispensary, rehabilitation center other than a facility used  
12 solely for vocational rehabilitation, nursing home, tuberculosis hospital,  
13 chronic disease hospital, maternity hospital, midwifery birth  
14 center, lying-in-asylum, out-patient department, out-patient lodge,  
15 dispensary and a laboratory or central service facility serving one or  
16 more such institutions, but the term hospital shall not include an  
17 institution, sanitarium or other facility engaged principally in providing  
18 services for the prevention, diagnosis or treatment of mental disability  
19 and which is subject to the powers of visitation, examination,  
20 inspection and investigation of the department of mental hygiene except  
21 for those distinct parts of such a facility which provide hospital  
22 service. The provisions of this article shall not apply to a facility or  
23 institution engaged principally in providing services by or under the  
24 supervision of the bona fide members and adherents of a recognized religious  
25 organization whose teachings include reliance on spiritual means  
26 through prayer alone for healing in the practice of the religion of such  
27 organization and where services are provided in accordance with those  
28 teachings. No provision of this article or any other provision of law

1 shall be construed to: (a) limit the volume of mental health [or],  
2 substance use disorder services or developmental disability services  
3 that can be provided by a provider of primary care services licensed  
4 under this article and authorized to provide integrated services in  
5 accordance with regulations issued by the commissioner in consultation  
6 with the commissioner of the office of mental health [and], the commis-  
7 sioner of the office of alcoholism and substance abuse services and the  
8 commissioner of the office for people with developmental disabilities,  
9 including regulations issued pursuant to subdivision seven of section  
10 three hundred sixty-five-1 of the social services law or part L of chap-  
11 ter fifty-six of the laws of two thousand twelve; (b) require a provider  
12 licensed pursuant to article thirty-one of the mental hygiene law or  
13 certified pursuant to article sixteen or article thirty-two of the  
14 mental hygiene law to obtain an operating certificate from the depart-  
15 ment if such provider has been authorized to provide integrated services  
16 in accordance with regulations issued by the commissioner in consulta-  
17 tion with the commissioner of the office of mental health [and], the  
18 commissioner of the office of alcoholism and substance abuse services  
19 and the commissioner of the office for people with developmental disa-  
20 bilities, including regulations issued pursuant to subdivision seven of  
21 section three hundred sixty-five-1 of the social services law or part L  
22 of chapter fifty-six of the laws of two thousand twelve.

23 § 2. Subdivision (f) of section 31.02 of the mental hygiene law, as  
24 added by section 2 of subpart B of part S of chapter 57 of the laws of  
25 2018, is amended to read as follows:

26 (f) No provision of this article or any other provision of law shall  
27 be construed to require a provider licensed pursuant to article twenty-  
28 eight of the public health law or certified pursuant to article sixteen

1 or article thirty-two of this chapter to obtain an operating certificate  
2 from the office of mental health if such provider has been authorized to  
3 provide integrated services in accordance with regulations issued by the  
4 commissioner of the office of mental health in consultation with the  
5 commissioner of the department of health [and], the commissioner of the  
6 office of alcoholism and substance abuse services and the commissioner  
7 of the office for people with developmental disabilities, including  
8 regulations issued pursuant to subdivision seven of section three  
9 hundred sixty-five-1 of the social services law or part L of chapter  
10 fifty-six of the laws of two thousand twelve.

11 § 3. Subdivision (b) of section 32.05 of the mental hygiene law, as  
12 amended by section 3 of subpart B of part S of chapter 57 of the laws of  
13 2018, is amended to read as follow:

14 (b) (i) Methadone, or such other controlled substance designated by  
15 the commissioner of health as appropriate for such use, may be adminis-  
16 tered to an addict, as defined in section thirty-three hundred two of  
17 the public health law, by individual physicians, groups of physicians  
18 and public or private medical facilities certified pursuant to article  
19 twenty-eight or thirty-three of the public health law as part of a chem-  
20 ical dependence program which has been issued an operating certificate  
21 by the commissioner pursuant to subdivision (b) of section 32.09 of this  
22 article, provided, however, that such administration must be done in  
23 accordance with all applicable federal and state laws and regulations.  
24 Individual physicians or groups of physicians who have obtained authori-  
25 zation from the federal government to administer buprenorphine to  
26 addicts may do so without obtaining an operating certificate from the  
27 commissioner. (ii) No provision of this article or any other provision  
28 of law shall be construed to require a provider licensed pursuant to

1 article twenty-eight of the public health law or article thirty-one of  
2 this chapter to obtain an operating certificate from the office of alco-  
3 holism and substance abuse services if such provider has been authorized  
4 to provide integrated services in accordance with regulations issued by  
5 the commissioner of alcoholism and substance abuse services in consulta-  
6 tion with the commissioner of the department of health [and], the  
7 commissioner of the office of mental health and the commissioner of the  
8 office for people with developmental disabilities, including regulations  
9 issued pursuant to subdivision seven of section three hundred sixty-  
10 five-1 of the social services law or part L of chapter fifty-six of the  
11 laws of two thousand twelve.

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

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

27 § 5. This act shall take effect October 1, 2019; provided, however,  
28 that the commissioner of the department of health, the commissioner of

1 the office of mental health, the commissioner of the office of alcohol-  
2 ism and substance abuse services, and the commissioner of the office for  
3 people with developmental disabilities are authorized to issue any rule  
4 or regulation necessary for the implementation of this act on or before  
5 its effective date.

6 PART AA

7 Section 1. Paragraph (a) of subdivision 4 of section 488 of the social  
8 services law, as amended by section 2 of part MM of chapter 58 of the  
9 laws of 2015, is amended to read as follows:

10 (a) a facility or program in which services are provided and which is  
11 operated, licensed or certified by the office of mental health, the  
12 office for people with developmental disabilities or the office of alco-  
13 holism and substance abuse services, including but not limited to  
14 psychiatric centers, [inpatient psychiatric units of a general hospi-  
15 tal,] developmental centers, intermediate care facilities, community  
16 residences, group homes and family care homes, provided, however, that  
17 such term shall not include a secure treatment facility as defined in  
18 section 10.03 of the mental hygiene law, services defined in subpara-  
19 graph four of subdivision (a) of section 16.03 of the mental hygiene  
20 law, [or] services provided in programs or facilities that are operated  
21 by the office of mental health and located in state correctional facili-  
22 ties under the jurisdiction of the department of corrections and commu-  
23 nity supervision or services provided in a unit of a hospital, as  
24 defined in subdivision one of section twenty-eight hundred one of the  
25 public health law that is licensed or certified by the office of mental  
26 health or the office of alcoholism and substance abuse services;

1     § 2. Paragraphs (c), (d) and (e) of subdivision 4 of section 488 of  
2 the social services law, as added by section 1 of part B of chapter 501  
3 of the laws of 2012, paragraph (d) as amended by chapter 126 of the laws  
4 of 2014, and paragraph (e) as amended by chapter 83 of the laws of 2013,  
5 are amended to read as follows:

6     (c) adult care facilities, which shall mean adult homes or enriched  
7 housing programs licensed pursuant to article seven of this chapter: (i)  
8 (A) that have a licensed capacity of eighty or more beds; and (B) in  
9 which at least twenty-five percent of the residents are persons with  
10 serious mental illness as defined by subdivision fifty-two of section  
11 1.03 of the mental hygiene law; (ii) but not including an adult home or  
12 enriched housing program which is authorized to operate fifty-five  
13 percent or more of its total licensed capacity of beds as assisted  
14 living program beds pursuant to section four hundred sixty-one-1 of this  
15 chapter; or

16     (d) [any overnight, summer day and traveling summer day camps for  
17 children with developmental disabilities as defined in regulations  
18 promulgated by the commissioner of health; or

19     (e)] the New York state school for the blind and the New York state  
20 school for the deaf, which operate pursuant to articles eighty-seven and  
21 eighty-eight of the education law; an institution for the instruction of  
22 the deaf and the blind which has a residential component and is subject  
23 to the visitation of the commissioner of education pursuant to article  
24 eighty-five of the education law with respect to its day and residential  
25 components; special act school districts serving students with disabili-  
26 ties; or in-state private schools which have been approved by the  
27 commissioner of education for special education services or programs,  
28 and which have a residential program.





1 services, diagnosis or treatment whether performed by a physician,  
2 psychiatrist [or], a certified and registered psychologist, or a nurse  
3 practitioner when the services rendered are within the lawful scope of  
4 their practice.

5 § 2. Subparagraph (B) of paragraph 25 of subsection (i) of section  
6 3216 of the insurance law, as amended by section 38 of part D of chapter  
7 56 of the laws of 2013, is amended to read as follows:

8 (B) Every policy that provides physician services, medical, major  
9 medical or similar comprehensive-type coverage shall provide coverage  
10 for the screening, diagnosis and treatment of autism spectrum disorder  
11 in accordance with this paragraph and shall not exclude coverage for the  
12 screening, diagnosis or treatment of medical conditions otherwise  
13 covered by the policy because the individual is diagnosed with autism  
14 spectrum disorder. Such coverage may be subject to annual deductibles,  
15 copayments and coinsurance as may be deemed appropriate by the super-  
16 intendent and shall be consistent with those imposed on other benefits  
17 under the policy. [Coverage for applied behavior analysis shall be  
18 subject to a maximum benefit of six hundred eighty hours of treatment  
19 per policy or calendar year per covered individual.] This paragraph  
20 shall not be construed as limiting the benefits that are otherwise  
21 available to an individual under the policy, provided however that such  
22 policy shall not contain any limitations on visits that are solely  
23 applied to the treatment of autism spectrum disorder. No insurer shall  
24 terminate coverage or refuse to deliver, execute, issue, amend, adjust,  
25 or renew coverage to an individual solely because the individual is  
26 diagnosed with autism spectrum disorder or has received treatment for  
27 autism spectrum disorder. Coverage shall be subject to utilization  
28 review and external appeals of health care services pursuant to article

1 forty-nine of this chapter as well as[, ] case management[, ] and other  
2 managed care provisions.

3 § 3. Items (i) and (iii) of subparagraph (C) of paragraph 25 of  
4 subsection (i) of section 3216 of the insurance law, as amended by chap-  
5 ter 596 of the laws of 2011, are amended to read as follows:

6 (i) "autism spectrum disorder" means any pervasive developmental  
7 disorder as defined in the most recent edition of the diagnostic and  
8 statistical manual of mental disorders[, including autistic disorder,  
9 Asperger's disorder, Rett's disorder, childhood disintegrative disorder,  
10 or pervasive developmental disorder not otherwise specified (PDD-NOS)].

11 (iii) "behavioral health treatment" means counseling and treatment  
12 programs, when provided by a licensed provider, and applied behavior  
13 analysis, when provided [or supervised] by a [behavior analyst certified  
14 pursuant to the behavior analyst certification board] person licensed,  
15 certified or otherwise authorized to provide applied behavior analysis,  
16 that are necessary to develop, maintain, or restore, to the maximum  
17 extent practicable, the functioning of an individual. [Individuals that  
18 provide behavioral health treatment under the supervision of a certified  
19 behavior analyst pursuant to this paragraph shall be subject to stand-  
20 ards of professionalism, supervision and relevant experience pursuant to  
21 regulations promulgated by the superintendent in consultation with the  
22 commissioners of health and education.]

23 § 4. Paragraph 25 of subsection (i) of section 3216 of the insurance  
24 law is amended by adding four new subparagraphs (H), (I), (J), and (K)  
25 to read as follows:

26 (H) Coverage under this paragraph shall not apply financial require-  
27 ments or treatment limitations to autism spectrum disorder benefits that  
28 are more restrictive than the predominant financial requirements and

1 treatment limitations applied to substantially all medical and surgical  
2 benefits covered by the policy.

3 (I) The criteria for medical necessity determinations under the policy  
4 with respect to autism spectrum disorder benefits shall be made avail-  
5 able by the insurer to any insured, prospective insured, or in-network  
6 provider upon request.

7 (J) For purposes of this paragraph:

8 (i) "financial requirement" means deductible, copayments, coinsurance  
9 and out-of-pocket expenses;

10 (ii) "predominant" means that a financial requirement or treatment  
11 limitation is the most common or frequent of such type of limit or  
12 requirement; and

13 (iii) "treatment limitation" means limits on the frequency of treat-  
14 ment, number of visits, days of coverage, or other similar limits on the  
15 scope or duration of treatment and includes nonquantitative treatment  
16 limitations such as: medical management standards limiting or excluding  
17 benefits based on medical necessity, or based on whether the treatment  
18 is experimental or investigational; formulary design for prescription  
19 drugs; network tier design; standards for provider admission to partic-  
20 ipate in a network, including reimbursement rates; methods for deter-  
21 mining usual, customary, and reasonable charges; fail-first or step  
22 therapy protocols; exclusions based on failure to complete a course of  
23 treatment; and restrictions based on geographic location, facility type,  
24 provider specialty, and other criteria that limit the scope or duration  
25 of benefits for services provided under the policy.

26 (K) An insurer shall provide coverage under this paragraph, at a mini-  
27 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
28 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

1     § 5. Paragraph 30 of subsection (i) of section 3216 of the insurance  
2 law, as amended by section 1 of part B of chapter 71 of the laws of  
3 2016, is amended to read as follows:

4     (30) (A) Every policy that provides hospital, major medical or similar  
5 comprehensive coverage [must] shall provide inpatient coverage for the  
6 diagnosis and treatment of substance use disorder, including detoxifica-  
7 tion and rehabilitation services. Such inpatient coverage shall include  
8 unlimited medically necessary treatment for substance use disorder  
9 treatment services provided in residential settings [as required by the  
10 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
11 1185a)]. Further, such inpatient coverage shall not apply financial  
12 requirements or treatment limitations, including utilization review  
13 requirements, to inpatient substance use disorder benefits that are more  
14 restrictive than the predominant financial requirements and treatment  
15 limitations applied to substantially all medical and surgical benefits  
16 covered by the policy. [Further, such coverage shall be provided  
17 consistent with the federal Paul Wellstone and Pete Domenici Mental  
18 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

19     (B) Coverage provided under this paragraph may be limited to facili-  
20 ties in New York state [which are certified] that are licensed, certi-  
21 fied or otherwise authorized by the office of alcoholism and substance  
22 abuse services and, in other states, to those which are accredited by  
23 the joint commission as alcoholism, substance abuse, or chemical depend-  
24 ence treatment programs and are similarly licensed, certified or other-  
25 wise authorized in the state in which the facility is located.

26     (C) Coverage provided under this paragraph may be subject to annual  
27 deductibles and co-insurance as deemed appropriate by the superintendent

1 and that are consistent with those imposed on other benefits within a  
2 given policy.

3 (D) This subparagraph shall apply to facilities in this state that are  
4 licensed, certified or otherwise authorized by the office of alcoholism  
5 and substance abuse services that are participating in the insurer's  
6 provider network. Coverage provided under this paragraph shall not be  
7 subject to preauthorization. Coverage provided under this paragraph  
8 shall also not be subject to concurrent utilization review during the  
9 first [fourteen] twenty-one days of the inpatient admission provided  
10 that the facility notifies the insurer of both the admission and the  
11 initial treatment plan within [forty-eight hours] two business days of  
12 the admission. The facility shall perform daily clinical review of the  
13 patient, including the periodic consultation with the insurer to ensure  
14 that the facility is using the evidence-based and peer reviewed clinical  
15 review tool utilized by the insurer which is designated by the office of  
16 alcoholism and substance abuse services and appropriate to the age of  
17 the patient, to ensure that the inpatient treatment is medically neces-  
18 sary for the patient. Any utilization review of treatment provided under  
19 this subparagraph may include a review of all services provided during  
20 such inpatient treatment, including all services provided during the  
21 first [fourteen] twenty-one days of such inpatient treatment. Provided,  
22 however, the insurer shall only deny coverage for any portion of the  
23 initial [fourteen] twenty-one day inpatient treatment on the basis that  
24 such treatment was not medically necessary if such inpatient treatment  
25 was contrary to the evidence-based and peer reviewed clinical review  
26 tool utilized by the insurer which is designated by the office of alco-  
27 holism and substance abuse services. An insured shall not have any  
28 financial obligation to the facility for any treatment under this

1 subparagraph other than any copayment, coinsurance, or deductible other-  
2 wise required under the policy.

3 (E) An insurer shall make available to any insured, prospective  
4 insured, or in-network provider, upon request, the criteria for medical  
5 necessity determinations under the policy with respect to inpatient  
6 substance use disorder benefits.

7 (F) For purposes of this paragraph:

8 (i) "financial requirement" means deductible, copayments, coinsurance  
9 and out-of-pocket expenses;

10 (ii) "predominant" means that a financial requirement or treatment  
11 limitation is the most common or frequent of such type of limit or  
12 requirement;

13 (iii) "treatment limitation" means limits on the frequency of treat-  
14 ment, number of visits, days of coverage, or other similar limits on the  
15 scope or duration of treatment and includes nonquantitative treatment  
16 limitations such as: medical management standards limiting or excluding  
17 benefits based on medical necessity, or based on whether the treatment  
18 is experimental or investigational; formulary design for prescription  
19 drugs; network tier design; standards for provider admission to partic-  
20 ipate in a network, including reimbursement rates; methods for determin-  
21 ing usual, customary, and reasonable charges; fail-first or step therapy  
22 protocols; exclusions based on failure to complete a course of treat-  
23 ment; and restrictions based on geographic location, facility type,  
24 provider specialty, and other criteria that limit the scope or duration  
25 of benefits for services provided under the policy; and

26 (iv) "substance use disorder" shall have the meaning set forth in the  
27 most recent edition of the diagnostic and statistical manual of mental  
28 disorders or the most recent edition of another generally recognized

1 independent standard of current medical practice, such as the interna-  
2 tional classification of diseases.

3 (G) An insurer shall provide coverage under this paragraph, at a mini-  
4 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
5 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

6 § 6. Paragraph 31 of subsection (i) of section 3216 of the insurance  
7 law, as added by chapter 41 of the laws of 2014 and subparagraph (E) as  
8 added by section 3 of part MM of chapter 57 of the laws of 2018, is  
9 amended to read as follows:

10 (31) (A) Every policy that provides medical, major medical or similar  
11 comprehensive-type coverage [must] shall provide outpatient coverage for  
12 the diagnosis and treatment of substance use disorder, including detoxi-  
13 fication and rehabilitation services. Such coverage shall not apply  
14 financial requirements or treatment limitations to outpatient substance  
15 use disorder benefits that are more restrictive than the predominant  
16 financial requirements and treatment limitations applied to substantial-  
17 ly all medical and surgical benefits covered by the policy. [Further,  
18 such coverage shall be provided consistent with the federal Paul Well-  
19 stone and Pete Domenici Mental Health Parity and Addiction Equity Act of  
20 2008 (29 U.S.C. § 1185a).]

21 (B) Coverage under this paragraph may be limited to facilities in New  
22 York state [certified] that are licensed, certified or otherwise author-  
23 ized by the office of alcoholism and substance abuse services [or  
24 licensed by such office as outpatient clinics or medically supervised  
25 ambulatory] to provide outpatient substance [abuse programs] use disor-  
26 der services and, in other states, to those which are accredited by the  
27 joint commission as alcoholism or chemical dependence substance abuse

1 treatment programs and are similarly licensed, certified, or otherwise  
2 authorized in the state in which the facility is located.

3 (C) Coverage provided under this paragraph may be subject to annual  
4 deductibles and co-insurance as deemed appropriate by the superintendent  
5 and that are consistent with those imposed on other benefits within a  
6 given policy.

7 (D) A policy providing coverage for substance use disorder services  
8 pursuant to this paragraph shall provide up to twenty outpatient visits  
9 per policy or calendar year to an individual who identifies him or  
10 herself as a family member of a person suffering from substance use  
11 disorder and who seeks treatment as a family member who is otherwise  
12 covered by the applicable policy pursuant to this paragraph. The cover-  
13 age required by this paragraph shall include treatment as a family  
14 member pursuant to such family member's own policy provided such family  
15 member:

16 (i) does not exceed the allowable number of family visits provided by  
17 the applicable policy pursuant to this paragraph; and

18 (ii) is otherwise entitled to coverage pursuant to this paragraph and  
19 such family member's applicable policy.

20 (E) This subparagraph shall apply to facilities in this state that are  
21 licensed, certified or otherwise authorized by the office of alcoholism  
22 and substance abuse services for the provision of outpatient, intensive  
23 outpatient, outpatient rehabilitation and opioid treatment that are  
24 participating in the insurer's provider network. Coverage provided under  
25 this paragraph shall not be subject to preauthorization. Coverage  
26 provided under this paragraph shall not be subject to concurrent review  
27 for the first [two] three weeks of continuous treatment, not to exceed  
28 [fourteen] twenty-one visits, provided the facility notifies the insurer



1 of both the start of treatment and the initial treatment plan within  
2 [forty-eight hours] two business days. The facility shall perform clin-  
3 ical assessment of the patient at each visit, including the periodic  
4 consultation with the insurer to ensure that the facility is using the  
5 evidence-based and peer reviewed clinical review tool utilized by the  
6 insurer which is designated by the office of alcoholism and substance  
7 abuse services and appropriate to the age of the patient, to ensure that  
8 the outpatient treatment is medically necessary for the patient. Any  
9 utilization review of the treatment provided under this subparagraph may  
10 include a review of all services provided during such outpatient treat-  
11 ment, including all services provided during the first [two] three weeks  
12 of continuous treatment, not to exceed [fourteen] twenty-one visits, of  
13 such outpatient treatment. Provided, however, the insurer shall only  
14 deny coverage for any portion of the initial [two] three weeks of  
15 continuous treatment, not to exceed [fourteen] twenty-one visits, for  
16 outpatient treatment on the basis that such treatment was not medically  
17 necessary if such outpatient treatment was contrary to the evidence-  
18 based and peer reviewed clinical review tool utilized by the insurer  
19 which is designated by the office of alcoholism and substance abuse  
20 services. An insured shall not have any financial obligation to the  
21 facility for any treatment under this subparagraph other than any copay-  
22 ment, coinsurance, or deductible otherwise required under the policy.

23 (F) The criteria for medical necessity determinations under the policy  
24 with respect to outpatient substance use disorder benefits shall be made  
25 available by the insurer to any insured, prospective insured, or in-net-  
26 work provider upon request.

27 (G) For purposes of this paragraph:

1     (i) "financial requirement" means deductible, copayments, coinsurance  
2     and out-of-pocket expenses;

3     (ii) "predominant" means that a financial requirement or treatment  
4     limitation is the most common or frequent of such type of limit or  
5     requirement;

6     (iii) "treatment limitation" means limits on the frequency of treat-  
7     ment, number of visits, days of coverage, or other similar limits on the  
8     scope or duration of treatment and includes nonquantitative treatment  
9     limitations such as: medical management standards limiting or excluding  
10    benefits based on medical necessity, or based on whether the treatment  
11    is experimental or investigational; formulary design for prescription  
12    drugs; network tier design; standards for provider admission to partic-  
13    ipate in a network, including reimbursement rates; methods for determin-  
14    ing usual, customary, and reasonable charges; fail-first or step therapy  
15    protocols; exclusions based on failure to complete a course of treat-  
16    ment; and restrictions based on geographic location, facility type,  
17    provider specialty, and other criteria that limit the scope or duration  
18    of benefits for services provided under the policy; and

19    (iv) "substance use disorder" shall have the meaning set forth in the  
20    most recent edition of the diagnostic and statistical manual of mental  
21    disorders or the most recent edition of another generally recognized  
22    independent standard of current medical practice such as the interna-  
23    tional classification of diseases.

24    (H) An insurer shall provide coverage under this paragraph, at a mini-  
25    mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
26    Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 7. Paragraph 31-a of subsection (i) of section 3216 of the insurance law, as added by section 1 of part B of chapter 69 of the laws of 2016, is amended to read as follows:

(31-a) [(A)] Every policy that provides medical, major medical or similar comprehensive-type coverage and provides coverage for prescription drugs for medication for the treatment of a substance use disorder shall include immediate access, without prior authorization, to [a five day emergency supply] the formulary forms of prescribed medications covered under the policy for the treatment of substance use disorder [where an emergency condition exists], including a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization, except where otherwise prohibited by law. Further, coverage [of an emergency supply] without prior authorization shall include formulary forms of medication for opioid overdose reversal otherwise covered under the policy prescribed or dispensed to an individual covered by the policy.

[(B) For purposes of this paragraph, an "emergency condition" means a substance use disorder condition that manifests itself by acute symptoms of sufficient severity, including severe pain or the expectation of severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

(ii) serious impairment to such person's bodily functions;

(iii) serious dysfunction of any bodily organ or part of such person;

(iv) serious disfigurement of such person; or

1 (v) a condition described in clause (i), (ii), or (iii) of section  
2 1867(e)(1)(A) of the Social Security Act.

3 (C) Coverage provided under this paragraph may be subject to copay-  
4 ments, coinsurance, and annual deductibles that are consistent with  
5 those imposed on other benefits within the policy; provided, however, no  
6 policy shall impose an additional copayment or coinsurance on an insured  
7 who received an emergency supply of medication and then received up to a  
8 thirty day supply of the same medication in the same thirty day period  
9 in which the emergency supply of medication was dispensed. This subpara-  
10 graph shall not preclude the imposition of a copayment or coinsurance on  
11 the initial emergency supply of medication in an amount that is less  
12 than the copayment or coinsurance otherwise applicable to a thirty day  
13 supply of such medication, provided that the total sum of the copayments  
14 or coinsurance for an entire thirty day supply of the medication does  
15 not exceed the copayment or coinsurance otherwise applicable to a thirty  
16 day supply of such medication.]

17 § 8. Subsection (i) of section 3216 of the insurance law is amended by  
18 adding a new paragraph 35 to read as follows:

19 (35) (A) Every policy delivered or issued for delivery in this state  
20 that provides coverage for inpatient hospital care or coverage for  
21 physician services shall provide coverage for the diagnosis and treat-  
22 ment of mental health conditions as follows:

23 (i) where the policy provides coverage for inpatient hospital care,  
24 benefits for inpatient care in a hospital as defined by subdivision ten  
25 of section 1.03 of the mental hygiene law and benefits for outpatient  
26 care provided in a facility issued an operating certificate by the  
27 commissioner of mental health pursuant to the provisions of article  
28 thirty-one of the mental hygiene law, or in a facility operated by the

1 office of mental health, or, for care provided in other states, to simi-  
2 larly licensed or certified hospitals or facilities; and

3 (ii) where the policy provides coverage for physician services, bene-  
4 fits for outpatient care provided by a psychiatrist or psychologist  
5 licensed to practice in this state, a licensed clinical social worker  
6 who meets the requirements of subparagraph (D) of paragraph four of  
7 subsection (1) of section three thousand two hundred twenty-one of this  
8 article, a nurse practitioner licensed to practice in this state, or a  
9 professional corporation or university faculty practice corporation  
10 thereof.

11 (B) Coverage required by this paragraph may be subject to annual  
12 deductibles, copayments and coinsurance as may be deemed appropriate by  
13 the superintendent and shall be consistent with those imposed on other  
14 benefits under the policy.

15 (C) Coverage under this paragraph shall not apply financial require-  
16 ments or treatment limitations to mental health benefits that are more  
17 restrictive than the predominant financial requirements and treatment  
18 limitations applied to substantially all medical and surgical benefits  
19 covered by the policy.

20 (D) The criteria for medical necessity determinations under the policy  
21 with respect to mental health benefits shall be made available by the  
22 insurer to any insured, prospective insured, or in-network provider upon  
23 request.

24 (E) For purposes of this paragraph:

25 (i) "financial requirement" means deductible, copayments, coinsurance  
26 and out-of-pocket expenses;

1     (ii) "predominant" means that a financial requirement or treatment  
2 limitation is the most common or frequent of such type of limit or  
3 requirement;

4     (iii) "treatment limitation" means limits on the frequency of treat-  
5 ment, number of visits, days of coverage, or other similar limits on the  
6 scope or duration of treatment and includes nonquantitative treatment  
7 limitations such as: medical management standards limiting or excluding  
8 benefits based on medical necessity, or based on whether the treatment  
9 is experimental or investigational; formulary design for prescription  
10 drugs; network tier design; standards for provider admission to partic-  
11 ipate in a network, including reimbursement rates; methods for determin-  
12 ing usual, customary, and reasonable charges; fail-first or step therapy  
13 protocols; exclusions based on failure to complete a course of treat-  
14 ment; and restrictions based on geographic location, facility type,  
15 provider specialty, and other criteria that limit the scope or duration  
16 of benefits for services provided under the policy; and

17     (iv) "mental health condition" means any mental health disorder as  
18 defined in the most recent edition of the diagnostic and statistical  
19 manual of mental disorders or the most recent edition of another gener-  
20 ally recognized independent standard of current medical practice such as  
21 the international classification of diseases.

22     (F) An insurer shall provide coverage under this paragraph, at a mini-  
23 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
24 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

25     (G) This subparagraph shall apply to hospitals in this state that are  
26 licensed by the office of mental health that are participating in the  
27 insurer's provider network. Where the policy provides coverage for inpa-  
28 tient hospital care, benefits for inpatient hospital care in a hospital

1 as defined by subdivision ten of section 1.03 of the mental hygiene law  
2 provided to individuals who have not attained the age of eighteen shall  
3 not be subject to preauthorization. Coverage provided under this para-  
4 graph shall also not be subject to concurrent utilization review during  
5 the first fourteen days of the inpatient admission, provided the facili-  
6 ty notifies the insurer of both the admission and the initial treatment  
7 plan within two business days of the admission, performs daily clinical  
8 review of the patient, and participates in periodic consultation with  
9 the insurer to ensure that the facility is using the evidence-based and  
10 peer reviewed clinical review criteria utilized by the insurer which is  
11 approved by the office of mental health and appropriate to the age of  
12 the patient, to ensure that the inpatient care is medically necessary  
13 for the patient. All treatment provided under this subparagraph may be  
14 reviewed retrospectively. Where care is denied retrospectively, an  
15 insured shall not have any financial obligation to the facility for any  
16 treatment under this subparagraph other than any copayment, coinsurance,  
17 or deductible otherwise required under the policy.

18 § 9. Paragraphs 17, 19 and 20 of subsection 2 of section 3217-a of the  
19 insurance law, paragraph 17 as amended and paragraphs 19 and 20 as added  
20 by section 1 of part H of chapter 60 of the laws of 2014, are amended  
21 and a new paragraph 21 is added to read as follows:

22 (17) where applicable, a listing by specialty, which may be in a sepa-  
23 rate document that is updated annually, of the name, address, and tele-  
24 phone number of all participating providers, including facilities, and:  
25 (A) whether the provider is accepting new patients; (B) in the case of  
26 mental health or substance use disorder services providers, any affil-  
27 iations with participating facilities certified or authorized by the  
28 office of mental health or the office of alcoholism and substance abuse

1 services, and any restrictions regarding the availability of the indi-  
2 vidual provider's services; and [in addition,] (C) in the case of physi-  
3 cians, board certification, languages spoken and any affiliations with  
4 participating hospitals. The listing shall also be posted on the insur-  
5 er's website and the insurer shall update the website within fifteen  
6 days of the addition or termination of a provider from the insurer's  
7 network or a change in a physician's hospital affiliation;

8 (19) with respect to out-of-network coverage:

9 (A) a clear description of the methodology used by the insurer to  
10 determine reimbursement for out-of-network health care services;

11 (B) the amount that the insurer will reimburse under the methodology  
12 for out-of-network health care services set forth as a percentage of the  
13 usual and customary cost for out-of-network health care services; and

14 (C) examples of anticipated out-of-pocket costs for frequently billed  
15 out-of-network health care services; [and]

16 (20) information in writing and through an internet website that  
17 reasonably permits an insured or prospective insured to estimate the  
18 anticipated out-of-pocket cost for out-of-network health care services  
19 in a geographical area or zip code based upon the difference between  
20 what the insurer will reimburse for out-of-network health care services  
21 and the usual and customary cost for out-of-network health care  
22 services[.]; and

23 (21) the most recent comparative analysis performed by the insurer to  
24 assess the provision of its covered services in accordance with the Paul  
25 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity  
26 Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal  
27 guidance or regulations issued under those acts.



1     § 10. Subsection (b) of section 3217-b of the insurance law, as added  
2 by chapter 705 of the laws of 1996, is amended to read as follows:

3     (b) No insurer subject to this article shall by contract, written  
4 policy [or], written procedure or practice prohibit or restrict any  
5 health care provider from filing a complaint, making a report or  
6 commenting to an appropriate governmental body regarding the policies or  
7 practices of such insurer which the provider believes may negatively  
8 impact upon the quality of, or access to, patient care. Nor shall an  
9 insurer subject to this article take any adverse action, including but  
10 not limited to refusing to renew or execute a contract or agreement with  
11 a health care provider as retaliation against a health care provider for  
12 filing a complaint, making a report or commenting to an appropriate  
13 governmental body regarding policies or practices of such insurer which  
14 may violate this chapter including paragraphs thirty, as added by chap-  
15 ter forty-one of the laws of 2014, thirty-one, thirty-one-a and thirty-  
16 five of subsection (i) of section thirty-two hundred sixteen and para-  
17 graphs five, six, seven, seven-a and seven-b of subsection (1) of  
18 section thirty-two hundred twenty-one of this article.

19     § 11. Subparagraph (A) of paragraph 4 of subsection (1) of section  
20 3221 of the insurance law, as amended by chapter 230 of the laws of  
21 2004, is amended to read as follows:

22     (A) Every insurer delivering a group policy or issuing a group policy  
23 for delivery, in this state, [which] that provides reimbursement for  
24 psychiatric or psychological services or for the diagnosis and treatment  
25 of mental[, nervous or emotional disorders and ailments] health condi-  
26 tions, however defined in such policy, by physicians, psychiatrists or  
27 psychologists, [must] shall make available and if requested by the poli-  
28 cyholder provide the same coverage to insureds for such services when

1 performed by a licensed clinical social worker, within the lawful scope  
2 of his or her practice, who is licensed pursuant to article one hundred  
3 fifty-four of the education law. Written notice of the availability of  
4 such coverage shall be delivered to the policyholder prior to inception  
5 of such group policy and annually thereafter, except that this notice  
6 shall not be required where a policy covers two hundred or more employ-  
7 ees or where the benefit structure was the subject of collective  
8 bargaining affecting persons who are employed in more than one state.

9 § 12. Subparagraph (D) of paragraph 4 of subsection (1) of section  
10 3221 of the insurance law, as amended by section 50 of part D of chapter  
11 56 of the laws of 2013, is amended to read as follows:

12 (D) In addition to the requirements of subparagraph (A) of this para-  
13 graph, every insurer issuing a group policy for delivery in this state  
14 where the policy provides reimbursement to insureds for psychiatric or  
15 psychological services or for the diagnosis and treatment of mental[,  
16 nervous or emotional disorders and ailments] health conditions, however  
17 defined in such policy, by physicians, psychiatrists or psychologists,  
18 shall provide the same coverage to insureds for such services when  
19 performed by a licensed clinical social worker, within the lawful scope  
20 of his or her practice, who is licensed pursuant to subdivision two of  
21 section seven thousand seven hundred four of the education law and in  
22 addition shall have either: (i) three or more additional years experi-  
23 ence in psychotherapy, which for the purposes of this subparagraph shall  
24 mean the use of verbal methods in interpersonal relationships with the  
25 intent of assisting a person or persons to modify attitudes and behavior  
26 that are intellectually, socially or emotionally maladaptive, under  
27 supervision, satisfactory to the state board for social work, in a  
28 facility, licensed or incorporated by an appropriate governmental

1 department, providing services for diagnosis or treatment of mental[,  
2 nervous or emotional disorders or ailments] health conditions; (ii)  
3 three or more additional years experience in psychotherapy under the  
4 supervision, satisfactory to the state board for social work, of a  
5 psychiatrist, a licensed and registered psychologist or a licensed clin-  
6 ical social worker qualified for reimbursement pursuant to subsection  
7 (e) of this section, or (iii) a combination of the experience specified  
8 in items (i) and (ii) of this subparagraph totaling three years, satis-  
9 factory to the state board for social work.

10 § 13. Subparagraphs (A) and (B) of paragraph 5 of subsection (1) of  
11 section 3221 of the insurance law, as amended by chapter 502 of the laws  
12 of 2007, are amended to read as follows:

13 (A) Every insurer delivering a group or school blanket policy or issu-  
14 ing a group or school blanket policy for delivery, in this state, which  
15 provides coverage for inpatient hospital care or coverage for physician  
16 services shall provide [as part of such policy broad-based] coverage for  
17 the diagnosis and treatment of mental[, nervous or emotional disorders  
18 or ailments, however defined in such policy, at least equal to the  
19 coverage provided for other] health conditions and:

20 (i) where the policy provides coverage for inpatient hospital care,  
21 benefits for inpatient care in a hospital as defined by subdivision ten  
22 of section 1.03 of the mental hygiene law[, which benefits may be limit-  
23 ed to not less than thirty days of active treatment in any contract  
24 year, plan year or calendar year,] and benefits for outpatient care  
25 provided in a facility issued an operating certificate by the commis-  
26 sioner of mental health pursuant to the provisions of article thirty-one  
27 of the mental hygiene law, or in a facility operated by the office of  
28 mental health[, which benefits may be limited to not less than twenty

1 visits in any contract year, plan year or calendar year. Benefits for  
2 partial hospitalization program services shall be provided as an offset  
3 to covered inpatient days at a ratio of two partial hospitalization  
4 visits to one inpatient day of treatment.] or, for care provided in  
5 other states, to similarly licensed or certified hospitals or facili-  
6 ties; and

7 (ii) where the policy provides coverage for physician services, it  
8 shall include benefits for outpatient care provided by a psychiatrist or  
9 psychologist licensed to practice in this state, a licensed clinical  
10 social worker who meets the requirements of subparagraph (D) of para-  
11 graph four of this subsection, a nurse practitioner licensed to practice  
12 in this state, or a professional corporation or university faculty prac-  
13 tice corporation thereof. [Such benefits may be limited to not less than  
14 twenty visits in any contract year, plan year, or calendar year.]

15 [(iii)] (B) Coverage required by this paragraph may be [provided on a  
16 contract year, plan year or calendar year basis and shall be consistent  
17 with the provision of other benefits under the policy. Such coverage may  
18 be] subject to annual deductibles, co-pays and coinsurance as may be  
19 deemed appropriate by the superintendent and shall be consistent with  
20 those imposed on other benefits under the policy. [In the event that a  
21 policy provides coverage for both inpatient hospital care and physician  
22 services, the aggregate of the benefits for outpatient care obtained  
23 under this paragraph may be limited to not less than twenty visits in  
24 any contract year, plan year or calendar year.

25 (iv) In this paragraph, "active treatment" means treatment furnished  
26 in conjunction with inpatient confinement for mental, nervous or  
27 emotional disorders or ailments that meet standards prescribed pursuant  
28 to the regulations of the commissioner of mental health.

1 (B) (i) Every insurer delivering a group or school blanket policy or  
2 issuing a group or school blanket policy for delivery, in this state,  
3 which provides coverage for inpatient hospital care or coverage for  
4 physician services, shall provide comparable coverage for adults and  
5 children with biologically based mental illness. Such group policies  
6 issued or delivered in this state shall also provide such comparable  
7 coverage for children with serious emotional disturbances. Such coverage  
8 shall be provided under the terms and conditions otherwise applicable  
9 under the policy, including network limitations or variations, exclu-  
10 sions, co-pays, coinsurance, deductibles or other specific cost sharing  
11 mechanisms. Provided further, where a policy provides both in-network  
12 and out-of-network benefits, the out-of-network benefits may have  
13 different coinsurance, co-pays, or deductibles, than the in-network  
14 benefits, regardless of whether the policy is written under one license  
15 or two licenses.

16 (ii) For purposes of this paragraph, the term "biologically based  
17 mental illness" means a mental, nervous, or emotional condition that is  
18 caused by a biological disorder of the brain and results in a clinically  
19 significant, psychological syndrome or pattern that substantially limits  
20 the functioning of the person with the illness. Such biologically based  
21 mental illnesses are defined as schizophrenia/psychotic disorders, major  
22 depression, bipolar disorder, delusional disorders, panic disorder,  
23 obsessive compulsive disorders, bulimia, and anorexia.] Provided that no  
24 copayment or coinsurance imposed for outpatient mental health services  
25 provided in a facility licensed, certified or otherwise authorized by  
26 the office of mental health shall exceed the copayments or coinsurance  
27 imposed for a primary care office visit under the policy.

1     § 14. Subparagraphs (C), (D) and (E) of paragraph 5 of subsection (1)  
2 of section 3221 of the insurance law are REPEALED and five new subpara-  
3 graphs (C), (D), (E), (F) and (G) are added to read as follows:

4     (C) Coverage under this paragraph shall not apply financial require-  
5 ments or treatment limitations to mental health benefits that are more  
6 restrictive than the predominant financial requirements and treatment  
7 limitations applied to substantially all medical and surgical benefits  
8 covered by the policy.

9     (D) The criteria for medical necessity determinations under the policy  
10 with respect to mental health benefits shall be made available by the  
11 insurer to any insured, prospective insured, or in-network provider upon  
12 request.

13     (E) For purposes of this paragraph:

14     (i) "financial requirement" means deductible, copayments, coinsurance  
15 and out-of-pocket expenses;

16     (ii) "predominant" means that a financial requirement or treatment  
17 limitation is the most common or frequent of such type of limit or  
18 requirement;

19     (iii) "treatment limitation" means limits on the frequency of treat-  
20 ment, number of visits, days of coverage, or other similar limits on the  
21 scope or duration of treatment and includes nonquantitative treatment  
22 limitations such as: medical management standards limiting or excluding  
23 benefits based on medical necessity, or based on whether the treatment  
24 is experimental or investigational; formulary design for prescription  
25 drugs; network tier design; standards for provider admission to partic-  
26 ipate in a network, including reimbursement rates; methods for determin-  
27 ing usual, customary, and reasonable charges; fail-first or step therapy  
28 protocols; exclusions based on failure to complete a course of treat-

1 ment; and restrictions based on geographic location, facility type,  
2 provider specialty, and other criteria that limit the scope or duration  
3 of benefits for services provided under the policy; and

4 (iv) "mental health condition" means any mental health disorder as  
5 defined in the most recent edition of the diagnostic and statistical  
6 manual of mental disorders or the most recent edition of another gener-  
7 ally recognized independent standard of current medical practice such as  
8 the international classification of diseases.

9 (F) An insurer shall provide coverage under this paragraph, at a mini-  
10 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
11 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

12 (G) This subparagraph shall apply to hospitals in this state that are  
13 licensed by the office of mental health that are participating in the  
14 insurer's provider network. Where the policy provides coverage for inpa-  
15 tient hospital care, benefits for inpatient hospital care in a hospital  
16 as defined by subdivision ten of section 1.03 of the mental hygiene law  
17 provided to individuals who have not attained the age of eighteen shall  
18 not be subject to preauthorization. Coverage provided under this para-  
19 graph shall also not be subject to concurrent utilization review during  
20 the first fourteen days of the inpatient admission, provided the facili-  
21 ty notifies the insurer of both the admission and the initial treatment  
22 plan within two business days of the admission, performs daily clinical  
23 review of the patient, and participates in periodic consultation with  
24 the insurer to ensure that the facility is using the evidence-based and  
25 peer reviewed clinical review criteria utilized by the insurer which is  
26 approved by the office of mental health and appropriate to the age of  
27 the patient, to ensure that the inpatient care is medically necessary  
28 for the patient. All treatment provided under this subparagraph may be

1 reviewed retrospectively. Where care is denied retrospectively, an  
2 insured shall not have any financial obligation to the facility for any  
3 treatment under this subparagraph other than any copayment, coinsurance,  
4 or deductible otherwise required under the policy.

5 § 15. Subparagraphs (A), (B) and (D) of paragraph 6 of subsection (1)  
6 of section 3221 of the insurance law, as amended by section 2 of part B  
7 of chapter 71 of the laws of 2016, are amended and three new subpara-  
8 graphs (E), (F) and (G) are added to read as follows:

9 (A) Every policy that provides hospital, major medical or similar  
10 comprehensive coverage [must] shall provide inpatient coverage for the  
11 diagnosis and treatment of substance use disorder, including detoxifica-  
12 tion and rehabilitation services. Such inpatient coverage shall include  
13 unlimited medically necessary treatment for substance use disorder  
14 treatment services provided in residential settings [as required by the  
15 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
16 1185a)]. Further, such inpatient coverage shall not apply financial  
17 requirements or treatment limitations, including utilization review  
18 requirements, to inpatient substance use disorder benefits that are more  
19 restrictive than the predominant financial requirements and treatment  
20 limitations applied to substantially all medical and surgical benefits  
21 covered by the policy. [Further, such coverage shall be provided  
22 consistent with the federal Paul Wellstone and Pete Domenici Mental  
23 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

24 (B) Coverage provided under this paragraph may be limited to facili-  
25 ties in New York state [which are certified] that are licensed, certi-  
26 fied or otherwise authorized by the office of alcoholism and substance  
27 abuse services and, in other states, to those which are accredited by  
28 the joint commission as alcoholism, substance abuse or chemical depend-



1   ence treatment programs and are similarly licensed, certified, or other-  
2   wise authorized in the state in which the facility is located.

3       (D) This subparagraph shall apply to facilities in this state that are  
4   licensed, certified or otherwise authorized by the office of alcoholism  
5   and substance abuse services that are participating in the insurer's  
6   provider network. Coverage provided under this paragraph shall not be  
7   subject to preauthorization. Coverage provided under this paragraph  
8   shall also not be subject to concurrent utilization review during the  
9   first [fourteen] twenty-one days of the inpatient admission provided  
10  that the facility notifies the insurer of both the admission and the  
11  initial treatment plan within [forty-eight hours] two business days of  
12  the admission. The facility shall perform daily clinical review of the  
13  patient, including the periodic consultation with the insurer to ensure  
14  that the facility is using the evidence-based and peer reviewed clinical  
15  review tool utilized by the insurer which is designated by the office of  
16  alcoholism and substance abuse services and appropriate to the age of  
17  the patient, to ensure that the inpatient treatment is medically neces-  
18  sary for the patient. Any utilization review of treatment provided under  
19  this subparagraph may include a review of all services provided during  
20  such inpatient treatment, including all services provided during the  
21  first [fourteen] twenty-one days of such inpatient treatment. Provided,  
22  however, the insurer shall only deny coverage for any portion of the  
23  initial [fourteen] twenty-one day inpatient treatment on the basis that  
24  such treatment was not medically necessary if such inpatient treatment  
25  was contrary to the evidence-based and peer reviewed clinical review  
26  tool utilized by the insurer which is designated by the office of alco-  
27  holism and substance abuse services. An insured shall not have any  
28  financial obligation to the facility for any treatment under this

1 subparagraph other than any copayment, coinsurance, or deductible other-  
2 wise required under the policy.

3 (E) The criteria for medical necessity determinations under the policy  
4 with respect to inpatient substance use disorder benefits shall be made  
5 available by the insurer to any insured, prospective insured, or in-net-  
6 work provider upon request.

7 (F) For purposes of this paragraph:

8 (i) "financial requirement" means deductible, copayments, coinsurance  
9 and out-of-pocket expenses;

10 (ii) "predominant" means that a financial requirement or treatment  
11 limitation is the most common or frequent of such type of limit or  
12 requirement;

13 (iii) "treatment limitation" means limits on the frequency of treat-  
14 ment, number of visits, days of coverage, or other similar limits on the  
15 scope or duration of treatment and includes nonquantitative treatment  
16 limitations such as: medical management standards limiting or excluding  
17 benefits based on medical necessity, or based on whether the treatment  
18 is experimental or investigational; formulary design for prescription  
19 drugs; network tier design; standards for provider admission to partic-  
20 ipate in a network, including reimbursement rates; methods for determin-  
21 ing usual, customary, and reasonable charges; fail-first or step therapy  
22 protocols; exclusions based on failure to complete a course of treat-  
23 ment; and restrictions based on geographic location, facility type,  
24 provider specialty, and other criteria that limit the scope or duration  
25 of benefits for services provided under the policy; and

26 (iv) "substance use disorder" shall have the meaning set forth in the  
27 most recent edition of the diagnostic and statistical manual of mental  
28 disorders or the most recent edition of another generally recognized

1 independent standard of current medical practice such as the interna-  
2 tional classification of diseases.

3 (G) An insurer shall provide coverage under this paragraph, at a mini-  
4 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
5 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

6 § 16. Subparagraphs (A) and (B) of paragraph 7 of subsection (1) of  
7 section 3221 of the insurance law, as amended by chapter 41 of the laws  
8 of 2014, are amended and a new subparagraph (C-1) is added to read as  
9 follows:

10 (A) Every policy that provides medical, major medical or similar  
11 comprehensive-type coverage [must] shall provide outpatient coverage for  
12 the diagnosis and treatment of substance use disorder, including detoxi-  
13 fication and rehabilitation services. Such coverage shall not apply  
14 financial requirements or treatment limitations to outpatient substance  
15 use disorder benefits that are more restrictive than the predominant  
16 financial requirements and treatment limitations applied to substantial-  
17 ly all medical and surgical benefits covered by the policy. [Further,  
18 such coverage shall be provided consistent with the federal Paul Well-  
19 stone and Pete Domenici Mental Health Parity and Addiction Equity Act of  
20 2008 (29 U.S.C. § 1185a).]

21 (B) Coverage under this paragraph may be limited to facilities in New  
22 York state that are licensed, certified or otherwise authorized by the  
23 office of alcoholism and substance abuse services [or licensed by such  
24 office as outpatient clinics or medically supervised ambulatory  
25 substance abuse programs] to provide outpatient substance use disorder  
26 services and, in other states, to those which are accredited by the  
27 joint commission as alcoholism or chemical dependence treatment programs

1 and similarly licensed, certified or otherwise authorized in the state  
2 in which the facility is located.

3 (C-1) A large group policy that provides coverage under this paragraph  
4 may not impose copayments or coinsurance for outpatient substance use  
5 disorder services that exceeds the copayment or coinsurance imposed for  
6 a primary care office visit. Provided that only one such copayment may  
7 be imposed for all services provided in a single day by a facility  
8 licensed, certified or otherwise authorized by the office of alcoholism  
9 and substance abuse services to provide outpatient substance use disor-  
10 der services.

11 § 17. Subparagraph (E) of paragraph 7 of subsection (1) of section  
12 3221 of the insurance law, as added by section 4 of part MM of chapter  
13 57 of the laws of 2018, is amended and three new subparagraphs (F), (G)  
14 and (H) are added to read as follows:

15 (E) This subparagraph shall apply to facilities in this state that are  
16 licensed, certified or otherwise authorized by the office of alcoholism  
17 and substance abuse services for the provision of outpatient, intensive  
18 outpatient, outpatient rehabilitation and opioid treatment that are  
19 participating in the insurer's provider network. Coverage provided under  
20 this paragraph shall not be subject to preauthorization. Coverage  
21 provided under this paragraph shall not be subject to concurrent review  
22 for the first [two] three weeks of continuous treatment, not to exceed  
23 [fourteen] twenty-one visits, provided the facility notifies the insurer  
24 of both the start of treatment and the initial treatment plan within  
25 [forty-eight hours] two business days. The facility shall perform clin-  
26 ical assessment of the patient at each visit, including the periodic  
27 consultation with the insurer to ensure that the facility is using the  
28 evidence-based and peer reviewed clinical review tool utilized by the

1 insurer which is designated by the office of alcoholism and substance  
2 abuse services and appropriate to the age of the patient, to ensure that  
3 the outpatient treatment is medically necessary for the patient. Any  
4 utilization review of the treatment provided under this subparagraph may  
5 include a review of all services provided during such outpatient treat-  
6 ment, including all services provided during the first [two] three weeks  
7 of continuous treatment, not to exceed [fourteen] twenty-one visits, of  
8 such outpatient treatment. Provided, however, the insurer shall only  
9 deny coverage for any portion of the initial [two] three weeks of  
10 continuous treatment, not to exceed [fourteen] twenty-one visits, for  
11 outpatient treatment on the basis that such treatment was not medically  
12 necessary if such outpatient treatment was contrary to the evidence-  
13 based and peer reviewed clinical review tool utilized by the insurer  
14 which is designated by the office of alcoholism and substance abuse  
15 services. An insured shall not have any financial obligation to the  
16 facility for any treatment under this subparagraph other than any copay-  
17 ment, coinsurance, or deductible otherwise required under the policy.

18 (F) The criteria for medical necessity determinations under the policy  
19 with respect to outpatient substance use disorder benefits shall be made  
20 available by the insurer to any insured, prospective insured, or in-net-  
21 work provider upon request.

22 (G) For purposes of this paragraph:

23 (i) "financial requirement" means deductible, copayments, coinsurance  
24 and out-of-pocket expenses;

25 (ii) "predominant" means that a financial requirement or treatment  
26 limitation is the most common or frequent of such type of limit or  
27 requirement;

1     (iii) "treatment limitation" means limits on the frequency of treat-  
2 ment, number of visits, days of coverage, or other similar limits on the  
3 scope or duration of treatment and includes nonquantitative treatment  
4 limitations such as: medical management standards limiting or excluding  
5 benefits based on medical necessity, or based on whether the treatment  
6 is experimental or investigational; formulary design for prescription  
7 drugs; network tier design; standards for provider admission to partic-  
8 ipate in a network, including reimbursement rates; methods for determin-  
9 ing usual, customary, and reasonable charges; fail-first or step therapy  
10 protocols; exclusions based on failure to complete a course of treat-  
11 ment; and restrictions based on geographic location, facility type,  
12 provider specialty, and other criteria that limit the scope or duration  
13 of benefits for services provided under the policy; and

14     (iv) "substance use disorder" shall have the meaning set forth in the  
15 most recent edition of the diagnostic and statistical manual of mental  
16 disorders or the most recent edition of another generally recognized  
17 independent standard of current medical practice such as the interna-  
18 tional classification of diseases.

19     (H) An insurer shall provide coverage under this paragraph, at a mini-  
20 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
21 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

22     § 18. Paragraph 7-b of subsection (1) of section 3221 of the insurance  
23 law, as added by section 2 of part B of chapter 69 of the laws of 2016,  
24 is amended to read as follows:

25     (7-b) [(A)] Every policy that provides medical, major medical or simi-  
26 lar comprehensive-type coverage and provides coverage for prescription  
27 drugs for medication for the treatment of a substance use disorder shall  
28 include immediate access, without prior authorization, [to a five day

1 emergency supply] to the formulary forms of prescribed medications  
2 covered under the policy for the treatment of substance use disorder  
3 [where an emergency condition exists], including a prescribed drug or  
4 medication associated with the management of opioid withdrawal and/or  
5 stabilization, except where otherwise prohibited by law. Further, cover-  
6 age [of an emergency supply] without prior authorization shall include  
7 formulary forms medication for opioid overdose reversal otherwise  
8 covered under the policy prescribed or dispensed to an individual  
9 covered by the policy.

10 [(B) For purposes of this paragraph, an "emergency condition" means a  
11 substance use disorder condition that manifests itself by acute symptoms  
12 of sufficient severity, including severe pain or the expectation of  
13 severe pain, such that a prudent layperson, possessing an average know-  
14 ledge of medicine and health, could reasonably expect the absence of  
15 immediate medical attention to result in:

16 (i) placing the health of the person afflicted with such condition in  
17 serious jeopardy, or in the case of a behavioral condition, placing the  
18 health of such person or others in serious jeopardy;

19 (ii) serious impairment to such person's bodily functions;

20 (iii) serious dysfunction of any bodily organ or part of such person;

21 (iv) serious disfigurement of such person; or

22 (v) a condition described in clause (i), (ii), or (iii) of section  
23 1867(e) (1) (A) of the Social Security Act.

24 (C) Coverage provided under this paragraph may be subject to copay-  
25 ments, coinsurance, and annual deductibles that are consistent with  
26 those imposed on other benefits within the policy; provided, however, no  
27 policy shall impose an additional copayment or coinsurance on an insured  
28 who received an emergency supply of medication and then received up to a

1 thirty day supply of the same medication in the same thirty day period  
2 in which the emergency supply of medication was dispensed. This subpara-  
3 graph shall not preclude the imposition of a copayment or coinsurance on  
4 the initial emergency supply of medication in an amount that is less  
5 than the copayment or coinsurance otherwise applicable to a thirty day  
6 supply of such medication, provided that the total sum of the copayments  
7 or coinsurance for an entire thirty day supply of the medication does  
8 not exceed the copayment or coinsurance otherwise applicable to a thirty  
9 day supply of such medication.]

10 § 19. Subparagraph (B) of paragraph 17 of subsection (1) of section  
11 3221 of the insurance law, as amended by section 39 of part D of chapter  
12 56 of the laws of 2013, is amended to read as follows:

13 (B) Every group or blanket policy that provides physician services,  
14 medical, major medical or similar comprehensive-type coverage shall  
15 provide coverage for the screening, diagnosis and treatment of autism  
16 spectrum disorder in accordance with this paragraph and shall not  
17 exclude coverage for the screening, diagnosis or treatment of medical  
18 conditions otherwise covered by the policy because the individual is  
19 diagnosed with autism spectrum disorder. Such coverage may be subject to  
20 annual deductibles, copayments and coinsurance as may be deemed appro-  
21 priate by the superintendent and shall be consistent with those imposed  
22 on other benefits under the group or blanket policy. [Coverage for  
23 applied behavior analysis shall be subject to a maximum benefit of six  
24 hundred eighty hours of treatment per policy or calendar year per  
25 covered individual.] This paragraph shall not be construed as limiting  
26 the benefits that are otherwise available to an individual under the  
27 group or blanket policy, provided however that such policy shall not  
28 contain any limitations on visits that are solely applied to the treat-



1 ment of autism spectrum disorder. No insurer shall terminate coverage or  
2 refuse to deliver, execute, issue, amend, adjust, or renew coverage to  
3 an individual solely because the individual is diagnosed with autism  
4 spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external  
5 appeals of health care services pursuant to article forty-nine of this  
6 chapter as well as[,] case management[,] and other managed care  
7 provisions.  
8

9 § 20. Items (i) and (iii) of subparagraph (C) of paragraph 17 of  
10 subsection (1) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:  
11

12 (i) "autism spectrum disorder" means any pervasive developmental  
13 disorder as defined in the most recent edition of the diagnostic and  
14 statistical manual of mental disorders[, including autistic disorder,  
15 Asperger's disorder, Rett's disorder, childhood disintegrative disorder,  
16 or pervasive developmental disorder not otherwise specified (PDD-NOS)].

17 (iii) "behavioral health treatment" means counseling and treatment  
18 programs, when provided by a licensed provider, and applied behavior  
19 analysis, when provided [or supervised] by a [behavior analyst] person  
20 licensed, certified [pursuant to the behavior analyst certification  
21 board,] or otherwise authorized to provide applied behavior analysis,  
22 that are necessary to develop, maintain, or restore, to the maximum  
23 extent practicable, the functioning of an individual. [Individuals that  
24 provide behavioral health treatment under the supervision of a certified  
25 behavior analyst pursuant to this paragraph shall be subject to standards of professionalism, supervision and relevant experience pursuant to  
26 regulations promulgated by the superintendent in consultation with the  
27 commissioners of health and education.]  
28

1     § 21. Paragraph 17 of subsection (1) of section 3221 of the insurance  
2 law is amended by adding four new subparagraphs (H), (I), (J) and (K) to  
3 read as follows:

4     (H) Coverage under this paragraph shall not apply financial require-  
5 ments or treatment limitations to autism spectrum disorder benefits that  
6 are more restrictive than the predominant financial requirements and  
7 treatment limitations applied to substantially all medical and surgical  
8 benefits covered by the policy.

9     (I) The criteria for medical necessity determinations under the policy  
10 with respect to outpatient substance use disorder benefits shall be  
11 made available by the insurer to any insured, prospective insured, or  
12 in-network provider upon request.

13     (J) For purposes of this paragraph:

14     (i) "financial requirement" means deductible, copayments, coinsurance  
15 and out-of-pocket expenses;

16     (ii) "predominant" means that a financial requirement or treatment  
17 limitation is the most common or frequent of such type of limit or  
18 requirement; and

19     (iii) "treatment limitation" means limits on the frequency of treat-  
20 ment, number of visits, days of coverage, or other similar limits on  
21 the scope or duration of treatment and includes nonquantitative treat-  
22 ment limitations such as: medical management standards limiting or  
23 excluding benefits based on medical necessity, or based on whether the  
24 treatment is experimental or investigational; formulary design for  
25 prescription drugs; network tier design; standards for provider admis-  
26 sion to participate in a network, including reimbursement rates; methods  
27 for determining usual, customary, and reasonable charges; fail-first or  
28 step therapy protocols; exclusions based on failure to complete a course

1 of treatment; and restrictions based on geographic location, facility  
2 type, provider specialty, and other criteria that limit the scope or  
3 duration of benefits for services provided under the policy.

4 (K) An insurer shall provide coverage under this paragraph, at a mini-  
5 mum, consistent with the federal Paul Wellstone and Pete Domenici Mental  
6 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

7 § 22. Paragraphs 1, 2, and 3 of subsection (g) of section 4303 of the  
8 insurance law, as amended by chapter 502 of the laws of 2007, are  
9 amended to read as follows:

10 [(1)] A medical expense indemnity corporation, hospital service corpo-  
11 ration or a health service corporation, [which] that provides group,  
12 group remittance or school blanket coverage for inpatient hospital  
13 care[,] or coverage for physician services shall provide as part of its  
14 contract [broad-based] coverage for the diagnosis and treatment of  
15 mental[, nervous or emotional disorders or ailments, however defined in  
16 such contract, at least equal to the coverage provided for other] health  
17 conditions and [shall include]:

18 [(A)]

19 (1) where the contract provides coverage for inpatient hospital care,  
20 benefits for in-patient care in a hospital as defined by subdivision ten  
21 of section 1.03 of the mental hygiene law[, which benefits may be limit-  
22 ed to not less than thirty days of active treatment in any contract  
23 year, plan year or calendar year.

24 (B)] or for inpatient care provided in other states, to similarly  
25 licensed hospitals, and benefits for out-patient care provided in a  
26 facility issued an operating certificate by the commissioner of mental  
27 health pursuant to the provisions of article thirty-one of the mental  
28 hygiene law or in a facility operated by the office of mental health[,]

1 which benefits may be limited to not less than twenty visits in any  
2 contract year, plan year or calendar year. Benefits for partial hospi-  
3 talization program services shall be provided as an offset to covered  
4 inpatient days at a ratio of two partial hospitalization visits to one  
5 inpatient day of treatment.

6 (C) Such coverage may be provided on a contract year, plan year or  
7 calendar year basis and shall be consistent with the provision of other  
8 benefits under the contract.] or for out-patient care provided in other  
9 states, to similarly certified facilities; and

10 (2) where the contract provides coverage for physician services bene-  
11 fits for outpatient care provided by a psychiatrist or psychologist  
12 licensed to practice in this state, a licensed clinical social worker  
13 who meets the requirements of subsection (n) of this section, a nurse  
14 practitioner licensed to practice on this state, or professional corpo-  
15 ration or university faculty practice corporation thereof.

16 (3) Such coverage may be subject to annual deductibles, co-pays and  
17 coinsurance as may be deemed appropriate by the superintendent and shall  
18 be consistent with those imposed on other benefits under the contract.  
19 Provided that no copayment or coinsurance imposed for outpatient mental  
20 health services provided in a facility licensed, certified or otherwise  
21 authorized by the office of mental health shall exceed the copayments or  
22 coinsurance imposed for a primary care office visit under the contract.

23 [(D) For the purpose of this subsection, "active treatment" means  
24 treatment furnished in conjunction with in-patient confinement for  
25 mental, nervous or emotional disorders or ailments that meet such stand-  
26 ards as shall be prescribed pursuant to the regulations of the commis-  
27 sioner of mental health.

1 (E) In the event the group remittance group or contract holder is  
2 provided coverage under this subsection and under paragraph one of  
3 subsection (h) of this section from the same health service corporation,  
4 or under a contract that is jointly underwritten by two health service  
5 corporations or by a health service corporation and a medical expense  
6 indemnity corporation, the aggregate of the benefits for outpatient care  
7 obtained under subparagraph (B) of this paragraph and paragraph one of  
8 subsection (h) of this section may be limited to not less than twenty  
9 visits in any contract year, plan year or calendar year.

10 (2) (A) A hospital service corporation or a health service corpo-  
11 ration, which provides group, group remittance or school blanket cover-  
12 age for inpatient hospital care, shall provide comparable coverage for  
13 adults and children with biologically based mental illness. Such hospi-  
14 tal service corporation or health service corporation shall also provide  
15 such comparable coverage for children with serious emotional disturb-  
16 ances. Such coverage shall be provided under the terms and conditions  
17 otherwise applicable under the contract, including network limitations  
18 or variations, exclusions, co-pays, coinsurance, deductibles or other  
19 specific cost sharing mechanisms. Provided further, where a contract  
20 provides both in-network and out-of-network benefits, the out-of-network  
21 benefits may have different coinsurance, co-pays, or deductibles, than  
22 the in-network benefits, regardless of whether the contract is written  
23 under one license or two licenses.

24 (B) For purposes of this subsection, the term "biologically based  
25 mental illness" means a mental, nervous, or emotional condition that is  
26 caused by a biological disorder of the brain and results in a clinically  
27 significant, psychological syndrome or pattern that substantially limits  
28 the functioning of the person with the illness. Such biologically based

1 mental illnesses are defined as schizophrenia/psychotic disorders, major  
2 depression, bipolar disorder, delusional disorders, panic disorder,  
3 obsessive compulsive disorders, anorexia, and bulimia.

4 (3) For purposes of this subsection, the term "children with serious  
5 emotional disturbances" means persons under the age of eighteen years  
6 who have diagnoses of attention deficit disorders, disruptive behavior  
7 disorders, or pervasive development disorders, and where there are one  
8 or more of the following:

9 (A) serious suicidal symptoms or other life-threatening self-destructive  
10 behaviors;

11 (B) significant psychotic symptoms (hallucinations, delusion, bizarre  
12 behaviors);

13 (C) behavior caused by emotional disturbances that placed the child at  
14 risk of causing personal injury or significant property damage; or

15 (D) behavior caused by emotional disturbances that placed the child at  
16 substantial risk of removal from the household.]

17 § 23. Paragraphs 4 and 5 of subsection (g) of section 4303 of the  
18 insurance law are REPEALED and five new paragraphs 4, 5, 6, 7 and 8 are  
19 added to read as follows:

20 (4) Coverage under this paragraph shall not apply financial require-  
21 ments or treatment limitations to mental health benefits that are more  
22 restrictive than the predominant financial requirements and treatment  
23 limitations applied to substantially all medical and surgical benefits  
24 covered by the contract.

25 (5) The criteria for medical necessity determinations under the  
26 contract with respect to mental health benefits shall be made available  
27 by the corporation to any insured, prospective insured, or in-network  
28 provider upon request.

1     (6) For purposes of this subsection:

2     (A) "financial requirement" means deductible, copayments, coinsurance  
3     and out-of-pocket expenses;

4     (B) "predominant" means that a financial requirement or treatment  
5     limitation is the most common or frequent of such type of limit or  
6     requirement;

7     (C) "treatment limitation" means limits on the frequency of treatment,  
8     number of visits, days of coverage, or other similar limits on the  
9     scope or duration of treatment and includes nonquantitative treatment  
10    limitations such as: medical management standards limiting or excluding  
11    benefits based on medical necessity, or based on whether the treatment  
12    is experimental or investigational; formulary design for prescription  
13    drugs; network tier design; standards for provider admission to partic-  
14    ipate in a network, including reimbursement rates; methods for deter-  
15    mining usual, customary, and reasonable charges; fail-first or step  
16    therapy protocols; exclusions based on failure to complete a course of  
17    treatment; and restrictions based on geographic location, facility type,  
18    provider specialty, and other criteria that limit the scope or duration  
19    of benefits for services provided under the contract; and

20    (D) "mental health condition" means any mental health disorder as  
21    defined in the most recent edition of the diagnostic and statistical  
22    manual of mental disorders or the most recent edition of another gener-  
23    ally recognized independent standard of current medical practice such as  
24    the international classification of diseases.

25    (7) A corporation shall provide coverage under this paragraph, at a  
26    minimum, consistent with the federal Paul Wellstone and Pete Domenici  
27    Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
28    1185a).

(8) This subparagraph shall apply to hospitals in this state that are licensed by the office of mental health that are participating in the corporation's provider network. Where the contract provides coverage for inpatient hospital care, benefits for inpatient hospital care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law provided to individuals who have not attained the age of eighteen shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first fourteen days of the inpatient admission, provided the facility notifies the corporation of both the admission and the initial treatment plan within two business days of the admission, performs daily clinical review of the patient, and participates in periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the corporation which is approved by the office of mental health and appropriate to the age of the patient, to ensure that the inpatient care is medically necessary for the patient. All treatment provided under this subparagraph may be reviewed retrospectively. Where care is denied retrospectively, an insured shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

§ 24. Subsection (h) of section 4303 of the insurance law is REPEALED.

§ 25. Subsection (i) of section 4303 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(i) A medical expense indemnity corporation or health service corporation [which] that provides coverage for physicians, psychiatrists or psychologists for psychiatric or psychological services or for the diag-



1 nosis and treatment of [mental, nervous or emotional disorders and  
2 ailments] mental health conditions, however defined in such contract,  
3 [must] shall make available and if requested by all persons holding  
4 individual contracts in a group whose premiums are paid by a remitting  
5 agent or by the contract holder in the case of a group contract issued  
6 pursuant to section four thousand three hundred five of this article,  
7 provide the same coverage for such services when performed by a licensed  
8 clinical social worker, within the lawful scope of his or her practice,  
9 who is licensed pursuant to article one hundred fifty-four of the educa-  
10 tion law. The state board for social work shall maintain a list of all  
11 licensed clinical social workers qualified for reimbursement under this  
12 subsection. Such coverage shall be made available at the inception of  
13 all new contracts and, with respect to all other contracts, at any anni-  
14 versary date subject to evidence of insurability. Written notice of the  
15 availability of such coverage shall be delivered to the group remitting  
16 agent or group contract holder prior to inception of such contract and  
17 annually thereafter, except that this notice shall not be required where  
18 a [policy] contract covers two hundred or more employees or where the  
19 benefit structure was the subject of collective bargaining affecting  
20 persons who are employed in more than one state.

21 § 26. Subsection (k) of section 4303 of the insurance law, as amended  
22 by section 3 of part B of chapter 71 of the laws of 2016, is amended to  
23 read as follows:

24 (k) (1) Every contract that provides hospital, major medical or similar  
25 comprehensive coverage [must] shall provide inpatient coverage for the  
26 diagnosis and treatment of substance use disorder, including detoxifica-  
27 tion and rehabilitation services. Such inpatient coverage shall include  
28 unlimited medically necessary treatment for substance use disorder

1 treatment services provided in residential settings [as required by the  
2 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
3 1185a)]. Further, such inpatient coverage shall not apply financial  
4 requirements or treatment limitations, including utilization review  
5 requirements, to inpatient substance use disorder benefits that are more  
6 restrictive than the predominant financial requirements and treatment  
7 limitations applied to substantially all medical and surgical benefits  
8 covered by the contract. [Further, such coverage shall be provided  
9 consistent with the federal Paul Wellstone and Pete Domenici Mental  
10 Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

11 (2) Coverage provided under this subsection may be limited to facili-  
12 ties in New York state [which are certified] that are licensed, certi-  
13 fied or otherwise authorized by the office of alcoholism and substance  
14 abuse services and, in other states, to those which are accredited by  
15 the joint commission as alcoholism, substance abuse, or chemical depend-  
16 ence treatment programs and are similarly licensed, certified or other-  
17 wise authorized in the state in which the facility is located.

18 (3) Coverage provided under this subsection may be subject to annual  
19 deductibles and co-insurance as deemed appropriate by the superintendent  
20 and that are consistent with those imposed on other benefits within a  
21 given contract.

22 (4) This paragraph shall apply to facilities in this state [certified]  
23 that are licensed, certified or otherwise authorized by the office of  
24 alcoholism and substance abuse services that are participating in the  
25 corporation's provider network. Coverage provided under this subsection  
26 shall not be subject to preauthorization. Coverage provided under this  
27 subsection shall also not be subject to concurrent utilization review  
28 during the first [fourteen] twenty-one days of the inpatient admission

1 provided that the facility notifies the corporation of both the admis-  
2 sion and the initial treatment plan within [forty-eight hours] two busi-  
3 ness days of the admission. The facility shall perform daily clinical  
4 review of the patient, including the periodic consultation with the  
5 corporation to ensure that the facility is using the evidence-based and  
6 peer reviewed clinical review tool utilized by the corporation which is  
7 designated by the office of alcoholism and substance abuse services and  
8 appropriate to the age of the patient, to ensure that the inpatient  
9 treatment is medically necessary for the patient. Any utilization review  
10 of treatment provided under this paragraph may include a review of all  
11 services provided during such inpatient treatment, including all  
12 services provided during the first [fourteen] twenty-one days of such  
13 inpatient treatment. Provided, however, the corporation shall only deny  
14 coverage for any portion of the initial [fourteen] twenty-one day inpa-  
15 tient treatment on the basis that such treatment was not medically  
16 necessary if such inpatient treatment was contrary to the evidence-based  
17 and peer reviewed clinical review tool utilized by the corporation which  
18 is designated by the office of alcoholism and substance abuse services.  
19 An insured shall not have any financial obligation to the facility for  
20 any treatment under this paragraph other than any copayment, coinsu-  
21 rance, or deductible otherwise required under the contract.

22 (5) The criteria for medical necessity determinations under the  
23 contract with respect to inpatient substance use disorder benefits  
24 shall be made available by the corporation to any insured, prospective  
25 insured or in-network provider upon request.

26 (6) For purposes of this subsection:

27 (A) "financial requirement" means deductible, copayments, coinsurance  
28 and out-of-pocket expenses;

1 (B) "predominant" means that a financial requirement or treatment  
2 limitation is the most common or frequent of such type of limit or  
3 requirement;

4 (C) "treatment limitation" means limits on the frequency of treatment,  
5 number of visits, days of coverage, or other similar limits on the  
6 scope or duration of treatment and includes nonquantitative treatment  
7 limitations such as: medical management standards limiting or excluding  
8 benefits based on medical necessity, or based on whether the treatment  
9 is experimental or investigational; formulary design for prescription  
10 drugs; network tier design; standards for provider admission to partic-  
11 ipate in a network, including reimbursement rates; methods for deter-  
12 mining usual, customary, and reasonable charges; fail-first or step  
13 therapy protocols; exclusions based on failure to complete a course of  
14 treatment; and restrictions based on geographic location, facility type,  
15 provider specialty, and other criteria that limit the scope or duration  
16 of benefits for services provided under the contract; and

17 (D) "substance use disorder" shall have the meaning set forth in the  
18 most recent edition of the diagnostic and statistical manual of mental  
19 disorders or the most recent edition of another generally recognized  
20 independent standard of current medical practice such as the interna-  
21 tional classification of diseases.

22 (7) A corporation shall provide coverage under this paragraph, at a  
23 minimum, consistent with the federal Paul Wellstone and Pete Domenici  
24 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
25 1185a).

26 § 27. Paragraphs 1 and 2 of subsection (1) of section 4303 of the  
27 insurance law, as amended by chapter 41 of the laws of 2014, are amended  
28 and a new paragraph 3-a is added to read as follows:

1 (1) Every contract that provides medical, major medical or similar  
2 comprehensive-type coverage [must] shall provide outpatient coverage for  
3 the diagnosis and treatment of substance use disorder, including detoxi-  
4 fication and rehabilitation services. Such coverage shall not apply  
5 financial requirements or treatment limitations to outpatient substance  
6 use disorder benefits that are more restrictive than the predominant  
7 financial requirements and treatment limitations applied to substantial-  
8 ly all medical and surgical benefits covered by the contract. [Further,  
9 such coverage shall be provided consistent with the federal Paul Well-  
10 stone and Pete Domenici Mental Health Parity and Addiction Equity Act of  
11 2008 (29 U.S.C. § 1185a).]

12 (2) Coverage under this subsection may be limited to facilities in New  
13 York state that are licensed, certified or otherwise authorized by the  
14 office of alcoholism and substance abuse services [or licensed by such  
15 office as outpatient clinics or medically supervised ambulatory] to  
16 provide outpatient substance [abuse programs] use disorder services and,  
17 in other states, to those which are accredited by the joint commission  
18 as alcoholism or chemical dependence substance abuse treatment programs  
19 and are similarly licensed, certified or otherwise authorized in the  
20 state in which the facility is located.

21 (3-a) A contract that provides large group coverage that provides  
22 coverage for outpatient substance use disorder services under this  
23 subsection may not impose copayments or coinsurance for outpatient  
24 substance use disorder services that exceed the copayment or coinsurance  
25 imposed for a primary care office visit. Provided that only one such  
26 copayment may be imposed for all services provided in a single day by a  
27 facility licensed, certified or otherwise authorized by the office of

1 alcoholism and substance abuse services to provide outpatient substance  
2 use disorder services.

3 § 28. Paragraph 5 of subsection (1) of section 4303 of the insurance  
4 law, as added by section 5 of part MM of chapter 57 of the laws of 2018,  
5 is amended and three new paragraphs 6, 7 and 8 are added to read as  
6 follows:

7 (5) This paragraph shall apply to facilities in this state [certified]  
8 that are licensed, certified or otherwise authorized by the office of  
9 alcoholism and substance abuse services for the provision of outpatient,  
10 intensive outpatient, outpatient rehabilitation and opioid treatment  
11 that are participating in the corporation's provider network. Coverage  
12 provided under this subsection shall not be subject to preauthorization.  
13 Coverage provided under this subsection shall not be subject to concur-  
14 rent review for the first [two] three weeks of continuous treatment, not  
15 to exceed [fourteen] twenty-one visits, provided the facility notifies  
16 the corporation of both the start of treatment and the initial treatment  
17 plan within [forty-eight hours] two business days. The facility shall  
18 perform clinical assessment of the patient at each visit, including the  
19 periodic consultation with the corporation to ensure that the facility  
20 is using the evidence-based and peer reviewed clinical review tool  
21 utilized by the corporation which is designated by the office of alco-  
22 holism and substance abuse services and appropriate to the age of the  
23 patient, to ensure that the outpatient treatment is medically necessary  
24 for the patient. Any utilization review of the treatment provided under  
25 this paragraph may include a review of all services provided during such  
26 outpatient treatment, including all services provided during the first  
27 [two] three weeks of continuous treatment, not to exceed [fourteen]  
28 twenty-one visits, of such outpatient treatment. Provided, however, the

1 corporation shall only deny coverage for any portion of the initial  
2 [two] three weeks of continuous treatment, not to exceed [fourteen]  
3 twenty-one visits, for outpatient treatment on the basis that such  
4 treatment was not medically necessary if such outpatient treatment was  
5 contrary to the evidence-based and peer reviewed clinical review tool  
6 utilized by the corporation which is designated by the office of alco-  
7 holism and substance abuse services. A subscriber shall not have any  
8 financial obligation to the facility for any treatment under this para-  
9 graph other than any copayment, coinsurance, or deductible otherwise  
10 required under the contract.

11 (6) The criteria for medical necessity determinations under the  
12 contract with respect to outpatient substance use disorder benefits  
13 shall be made available by the corporation to any insured, prospective  
14 insured, or in-network provider upon request.

15 (7) For purposes of this subsection:

16 (A) "financial requirement" means deductible, copayments, coinsurance  
17 and out-of-pocket expenses;

18 (B) "predominant" means that a financial requirement or treatment  
19 limitation is the most common or frequent of such type of limit or  
20 requirement.

21 (C) "treatment limitation" means limits on the frequency of treatment,  
22 number of visits, days of coverage, or other similar limits on the scope  
23 or duration of treatment and includes nonquantitative treatment limita-  
24 tions such as: medical management standards limiting or excluding bene-  
25 fits based on medical necessity, or based on whether the treatment is  
26 experimental or investigational; formulary design for prescription  
27 drugs; network tier design; standards for provider admission to partic-  
28 ipate in a network, including reimbursement rates; methods for determin-

1 ing usual, customary, and reasonable charges; fail-first or step therapy  
2 protocols; exclusions based on failure to complete a course of treat-  
3 ment; and restrictions based on geographic location, facility type,  
4 provider specialty, and other criteria that limit the scope or duration  
5 of benefits for services provided under the contract; and

6 (D) "substance use disorder" shall have the meaning set forth in the  
7 most recent edition of the diagnostic and statistical manual of mental  
8 disorders or the most recent edition of another generally recognized  
9 independent standard of current medical practice such as the interna-  
10 tional classification of diseases.

11 (8) A corporation shall provide coverage under this paragraph, at a  
12 minimum, consistent with the federal Paul Wellstone and Pete Domenici  
13 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
14 1185a).

15 § 29. Subsection (1-2) of section 4303 of the insurance law, as added  
16 by section 3 of part B of chapter 69 of the laws of 2016, is amended to  
17 read as follows:

18 (1-2) [(1)] Every contract that provides medical, major medical or  
19 similar comprehensive-type coverage and provides coverage for  
20 prescription drugs for medication for the treatment of a substance use  
21 disorder shall include immediate access, without prior authorization, to  
22 [a five day emergency supply] the formulary forms of prescribed medica-  
23 tions covered under the contract for the treatment of substance use  
24 disorder [where an emergency condition exists], including a prescribed  
25 drug or medication associated with the management of opioid withdrawal  
26 and/or stabilization, except where otherwise prohibited by law. Further,  
27 coverage [of an emergency supply] without prior authorization shall  
28 include formulary forms of medication for opioid overdose reversal



1 otherwise covered under the contract prescribed or dispensed to an indi-  
2 vidual covered by the contract.

3 [(2) For purposes of this paragraph, an "emergency condition" means a  
4 substance use disorder condition that manifests itself by acute symptoms  
5 of sufficient severity, including severe pain or the expectation of  
6 severe pain, such that a prudent layperson, possessing an average know-  
7 ledge of medicine and health, could reasonably expect the absence of  
8 immediate medical attention to result in:

9 (i) placing the health of the person afflicted with such condition in  
10 serious jeopardy, or in the case of a behavioral condition, placing the  
11 health of such person or others in serious jeopardy;

12 (ii) serious impairment to such person's bodily functions;

13 (iii) serious dysfunction of any bodily organ or part of such person;

14 (iv) serious disfigurement of such person; or

15 (v) a condition described in clause (i), (ii) or (iii) of section  
16 1867(e) (1) (A) of the Social Security Act.

17 (3) Coverage provided under this subsection may be subject to copay-  
18 ments, coinsurance, and annual deductibles that are consistent with  
19 those imposed on other benefits within the contract; provided, however,  
20 no contract shall impose an additional copayment or coinsurance on an  
21 insured who received an emergency supply of medication and then received  
22 up to a thirty day supply of the same medication in the same thirty day  
23 period in which the emergency supply of medication was dispensed. This  
24 paragraph shall not preclude the imposition of a copayment or coinsu-  
25 rance on the initial limited supply of medication in an amount that is  
26 less than the copayment or coinsurance otherwise applicable to a thirty  
27 day supply of such medication, provided that the total sum of the copay-  
28 ments or coinsurance for an entire thirty day supply of the medication

1 does not exceed the copayment or coinsurance otherwise applicable to a  
2 thirty day supply of such medication.]

3 § 30. Subsection (n) of section 4303 of the insurance law, as amended  
4 by chapter 230 of the laws of 2004, is amended to read as follows:

5 (n) In addition to the requirements of subsection (i) of this section,  
6 every health service or medical expense indemnity corporation issuing a  
7 group contract pursuant to this section or a group remittance contract  
8 for delivery in this state which contract provides reimbursement to  
9 subscribers or physicians, psychiatrists or psychologists for psychiat-  
10 ric or psychological services or for the diagnosis and treatment of  
11 [mental, nervous or emotional disorders and ailments,] mental health  
12 conditions, however defined in such contract, must provide the same  
13 coverage to persons covered under the group contract for such services  
14 when performed by a licensed clinical social worker, within the lawful  
15 scope of his or her practice, who is licensed pursuant to subdivision  
16 two of section seven thousand seven hundred four of the education law  
17 and in addition shall have either (i) three or more additional years  
18 experience in psychotherapy, which for the purposes of this subsection  
19 shall mean the use of verbal methods in interpersonal relationships with  
20 the intent of assisting a person or persons to modify attitudes and  
21 behavior which are intellectually, socially or emotionally maladaptive,  
22 under supervision, satisfactory to the state board for social work, in a  
23 facility, licensed or incorporated by an appropriate governmental  
24 department, providing services for diagnosis or treatment of [mental,  
25 nervous or emotional disorders or ailments,] mental health conditions,  
26 or (ii) three or more additional years experience in psychotherapy under  
27 the supervision, satisfactory to the state board for social work, of a  
28 psychiatrist, a licensed and registered psychologist or a licensed clin-

1 ical social worker qualified for reimbursement pursuant to subsection  
2 (i) of this section, or (iii) a combination of the experience specified  
3 in paragraphs (i) and (ii) totaling three years, satisfactory to the  
4 state board for social work. The state board for social work shall  
5 maintain a list of all licensed clinical social workers qualified for  
6 reimbursement under this subsection.

7 § 31. Paragraph 2 of subsection (ee) of section 4303 of the insurance  
8 law, as amended by section 40 of part D of chapter 56 of the laws of  
9 2013, is amended to read as follows:

10 (2) Every contract that provides physician services, medical, major  
11 medical or similar comprehensive-type coverage shall provide coverage  
12 for the screening, diagnosis and treatment of autism spectrum disorder  
13 in accordance with this paragraph and shall not exclude coverage for the  
14 screening, diagnosis or treatment of medical conditions otherwise  
15 covered by the contract because the individual is diagnosed with autism  
16 spectrum disorder. Such coverage may be subject to annual deductibles,  
17 copayments and coinsurance as may be deemed appropriate by the super-  
18 intendent and shall be consistent with those imposed on other benefits  
19 under the contract. [Coverage for applied behavior analysis shall be  
20 subject to a maximum benefit of six hundred eighty hours of treatment  
21 per contract or calendar year per covered individual.] This paragraph  
22 shall not be construed as limiting the benefits that are otherwise  
23 available to an individual under the contract, provided however that  
24 such contract shall not contain any limitations on visits that are sole-  
25 ly applied to the treatment of autism spectrum disorder. No insurer  
26 shall terminate coverage or refuse to deliver, execute, issue, amend,  
27 adjust, or renew coverage to an individual solely because the individual  
28 is diagnosed with autism spectrum disorder or has received treatment for

1 autism spectrum disorder. Coverage shall be subject to utilization  
2 review and external appeals of health care services pursuant to article  
3 forty-nine of this chapter as well as[,] case management[,] and other  
4 managed care provisions.

5 § 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of  
6 section 4303 of the insurance law, as amended by chapter 596 of the laws  
7 of 2011, are amended to read as follows:

8 (A) "autism spectrum disorder" means any pervasive developmental  
9 disorder as defined in the most recent edition of the diagnostic and  
10 statistical manual of mental disorders[, including autistic disorder,  
11 Asperger's disorder, Rett's disorder, childhood disintegrative disorder,  
12 or pervasive developmental disorder not otherwise specified (PDD-NOS)].

13 (C) "behavioral health treatment" means counseling and treatment  
14 programs, when provided by a licensed provider, and applied behavior  
15 analysis, when provided [or supervised] by a [behavior analyst certified  
16 pursuant to the behavior analyst certification board] person that is  
17 licensed, certified or otherwise authorized to provide applied behavior  
18 analysis, that are necessary to develop, maintain, or restore, to the  
19 maximum extent practicable, the functioning of an individual. [Individ-  
20 uals that provide behavioral health treatment under the supervision of a  
21 certified behavior analyst pursuant to this subsection shall be subject  
22 to standards of professionalism, supervision and relevant experience  
23 pursuant to regulations promulgated by the superintendent in consulta-  
24 tion with the commissioners of health and education.]

25 § 33. Subsection (ee) of section 4303 of the insurance law is amended  
26 by adding four new paragraphs 8, 9, 10, and 11 to read as follows:

27 (8) Coverage under this paragraph shall not apply financial require-  
28 ments or treatment limitations to autism spectrum disorder benefits that

1 are more restrictive than the predominant financial requirements and  
2 treatment limitations applied to substantially all medical and surgical  
3 benefits covered by the policy.

4 (9) The criteria for medical necessity determinations under the  
5 contract with respect to autism spectrum disorder benefits shall be made  
6 available by the corporation to any insured, prospective insured, or  
7 in-network provider upon request.

8 (10) For purposes of this subsection:

9 (A) "financial requirement" means deductible, copayments, coinsurance  
10 and out-of-pocket expenses;

11 (B) "predominant" means that a financial requirement or treatment  
12 limitation is the most common or frequent of such type of limit or  
13 requirement; and

14 (C) "treatment limitation" means limits on the frequency of treatment,  
15 number of visits, days of coverage, or other similar limits on the scope  
16 or duration of treatment and includes nonquantitative treatment limita-  
17 tions such as: medical management standards limiting or excluding bene-  
18 fits based on medical necessity, or based on whether the treatment is  
19 experimental or investigational; formulary design for prescription  
20 drugs; network tier design; standards for provider admission to partic-  
21 ipate in a network, including reimbursement rates; methods for determin-  
22 ing usual, customary, and reasonable charges; fail-first or step therapy  
23 protocols; exclusions based on failure to complete a course of treat-  
24 ment; and restrictions based on geographic location, facility type,  
25 provider specialty, and other criteria that limit the scope or duration  
26 of benefits for services provided under the contract.

27 (11) A corporation shall provide coverage under this subsection, at a  
28 minimum, consistent with the federal Paul Wellstone and Pete Domenici

1 Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §  
2 1185a).

3 § 34. Paragraphs 17, 20 and 21 of subsection (a) of section 4324 of  
4 the insurance law, paragraph 17 as amended and paragraphs 20 and 21 as  
5 added by section 8 of part H of chapter 60 of the laws of 2014, are  
6 amended and a new paragraph 22 is added to read as follows:

7 (17) where applicable, a listing by specialty, which may be in a sepa-  
8 rate document that is updated annually, of the name, address, and tele-  
9 phone number of all participating providers, including facilities, [and  
10 in addition,] and: (A) whether the provider is accepting new patients;  
11 (B) in the case of mental health or substance use disorder services  
12 providers, any affiliations with participating facilities certified or  
13 authorized by the office of mental health or the office of alcoholism  
14 and substance abuse services, and any restrictions regarding the avail-  
15 ability of the individual provider's services; (C) in the case of physi-  
16 cians, board certification, languages spoken and any affiliations with  
17 participating hospitals. The listing shall also be posted on the corpo-  
18 ration's website and the corporation shall update the website within  
19 fifteen days of the addition or termination of a provider from the  
20 corporation's network or a change in a physician's hospital affiliation;

21 (20) with respect to out-of-network coverage:

22 (A) a clear description of the methodology used by the corporation to  
23 determine reimbursement for out-of-network health care services;

24 (B) a description of the amount that the corporation will reimburse  
25 under the methodology for out-of-network health care services set forth  
26 as a percentage of the usual and customary cost for out-of-network  
27 health care services; and

1 (C) examples of anticipated out-of-pocket costs for frequently billed  
2 out-of-network health care services; [and]

3 (21) information in writing and through an internet website that  
4 reasonably permits a subscriber or prospective subscriber to estimate  
5 the anticipated out-of-pocket cost for out-of-network health care  
6 services in a geographical area or zip code based upon the difference  
7 between what the corporation will reimburse for out-of-network health  
8 care services and the usual and customary cost for out-of-network health  
9 care services[.]; and

10 (22) the most recent comparative analysis performed by the corporation  
11 to assess the provision of its covered services in accordance with the  
12 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction  
13 Equity Act of 2008, 42 U.S.C. 18031 (j), and any amendments to, and  
14 federal guidance or regulations issued under, those Acts.

15 § 35. Subsection (b) of section 4325 of the insurance law, as added by  
16 chapter 705 of the laws of 1996, is amended to read as follows:

17 (b) No corporation organized under this article shall by contract,  
18 written policy [or], written procedure or practice prohibit or restrict  
19 any health care provider from filing a complaint, making a report or  
20 commenting to an appropriate governmental body regarding the policies or  
21 practices of such corporation which the provider believes may negatively  
22 impact upon the quality of or access to patient care. Nor shall a corpo-  
23 ration organized under this article take any adverse action, including  
24 but not limited to refusing to renew or execute a contract or agreement  
25 with a health care provider as retaliation against a health care provid-  
26 er for filing a complaint, making a report or commenting to an appropri-  
27 ate governmental body regarding policies or practices of such corpo-  
28 ration which may violate this chapter including subsection (g), (k),

1 (1), (1-1) or (1-2) of section forty-three hundred three of this arti-  
2 cle.

3 § 36. Subparagraph (C) of paragraph 1 of subsection (b) of section  
4 4900 of the insurance law, as added by chapter 41 of the laws of 2014,  
5 is amended and a new subparagraph (D) is added to read as follows:

6 (C) for purposes of a determination involving substance use disorder  
7 treatment:

8 (i) a physician who possesses a current and valid non-restricted  
9 license to practice medicine and who specializes in behavioral health  
10 and has experience in the delivery of substance use disorder courses of  
11 treatment; or

12 (ii) a health care professional other than a licensed physician who  
13 specializes in behavioral health and has experience in the delivery of  
14 substance use disorder courses of treatment and, where applicable,  
15 possesses a current and valid non-restricted license, certificate or  
16 registration or, where no provision for a license, certificate or regis-  
17 tration exists, is credentialed by the national accrediting body appro-  
18 priate to the profession; [and] or

19 (D) for purposes of a determination involving treatment for a mental  
20 health condition:

21 (i) a physician who possesses a current and valid non-restricted  
22 license to practice medicine and who specializes in behavioral health  
23 and has experience in the delivery of mental health courses or treat-  
24 ment; or

25 (ii) a health care professional other than a licensed physician who  
26 specializes in behavioral health and has experience in the delivery of  
27 mental health courses of treatment and, where applicable, possesses a  
28 current and valid non-restricted license, certificate, or registration



1 or, where no provision for a license, certificate or registration  
2 exists, is credentialed by the national accrediting body appropriate to  
3 the profession; and

4 § 37. Paragraph 9 of subsection (a) of section 4902 of the insurance  
5 law, as amended by section 1 of part A of chapter 69 of the laws of  
6 2016, is amended to read as follows:

7 (9) When conducting utilization review for purposes of determining  
8 health care coverage for substance use disorder treatment, a utilization  
9 review agent shall utilize an evidence-based and peer reviewed clinical  
10 review [tools designated by the office of alcoholism and substance abuse  
11 services that are appropriate to the age of the patient and consistent  
12 with the treatment service levels within the office of alcoholism and  
13 substance abuse services system] tool that is appropriate to the age of  
14 the patient. When conducting such utilization review for treatment  
15 provided in this state, a utilization review agent shall utilize an  
16 evidence-based and peer reviewed clinical tool designated by the office  
17 of alcoholism and substance abuse services that is consistent with the  
18 treatment service levels within the office of alcoholism and substance  
19 abuse services system. All approved tools shall have inter rater reli-  
20 ability testing completed by December thirty-first, two thousand  
21 sixteen.

22 § 38. Subsection (a) of section 4902 of the insurance law is amended  
23 by adding a new paragraph 12 to read as follows:

24 (12) When conducting utilization review for purposes of determining  
25 health care coverage for a mental health condition, a utilization review  
26 agent shall utilize evidence-based and peer reviewed clinical review  
27 criteria that is appropriate to the age of the patient. The utilization  
28 review agent shall use clinical review criteria deemed appropriate and

1 approved for such use by the commissioner of the office of mental  
2 health, in consultation with the commissioner of health and the super-  
3 intendent. Approved clinical review criteria shall have inter rater  
4 reliability testing completed by December thirty-first, two thousand  
5 nineteen.

6 § 39. Paragraph (b) of subsection 5 of section 4403 of the public  
7 health law, as added by chapter 705 of the laws of 1996, is amended to  
8 read as follows:

9 (b) The following criteria shall be considered by the commissioner at  
10 the time of a review: (i) the availability of appropriate and timely  
11 care that is provided in compliance with the standards of the Federal  
12 Americans with Disability Act to assure access to health care for the  
13 enrollee population; (ii) the network's ability to provide culturally  
14 and linguistically competent care to meet the needs of the enrollee  
15 population; [and] (iii) the availability of appropriate and timely care  
16 that is in compliance with the standards of the Paul Wellstone and Pete  
17 Domenici Mental Health Parity and Addiction Equity Act of 2008, 42  
18 U.S.C. 18031(j), and any amendments to, and federal guidance and regu-  
19 lations issued under those Acts, which shall include an analysis of the  
20 rate of out-of-network utilization for covered mental health and  
21 substance use disorder services as compared to the rate of out-of-net-  
22 work utilization for the respective category of medical services; and  
23 (iv) with the exception of initial licensure, the number of grievances  
24 filed by enrollees relating to waiting times for appointments, appropri-  
25 ateness of referrals and other indicators of plan capacity.

26 § 40. Subdivision 3 of section 4406-c of the public health law, as  
27 added by chapter 705 of the laws of 1996, is amended to read as follows:

1 3. No health care plan shall by contract, written policy [or], written  
2 procedure or practice prohibit or restrict any health care provider from  
3 filing a complaint, making a report or commenting to an appropriate  
4 governmental body regarding the policies or practices of such health  
5 care plan which the provider believes may negatively impact upon the  
6 quality of, or access to, patient care. Nor shall a health care plan  
7 take any adverse action, including but not limited to refusing to renew  
8 or execute a contract or agreement with a health care provider as retal-  
9 iation against a health care provider for filing a complaint, making a  
10 report or commenting to an appropriate governmental body regarding poli-  
11 cies or practices of such health care plan which may violate this chap-  
12 ter or the insurance law including subsection (g), (k), (l), (l-1) or  
13 (l-2) of section forty-three hundred three of the insurance law.

14 § 41. Paragraphs (r), (t) and (u) of subdivision 1 of section 4408 of  
15 the public health law, paragraph (r) as amended and paragraphs (t) and  
16 (u) as added by section 18 of part H of chapter 60 of the laws of 2014,  
17 are amended and a new paragraph (v) is added to read as follows:

18 (r) a listing by specialty, which may be in a separate document that  
19 is updated annually, of the name, address and telephone number of all  
20 participating providers, including facilities, [and, in addition,] and:  
21 (i) whether the provider is accepting new patients; (ii) in the case of  
22 mental health or substance use disorder services providers, any affil-  
23 iations with participating facilities certified or authorized by the  
24 office of mental health or the office of alcoholism and substance abuse  
25 services, and any restrictions regarding the availability of the indi-  
26 vidual provider's services; and (iii) in the case of physicians, board  
27 certification, languages spoken and any affiliations with participating  
28 hospitals. The listing shall also be posted on the health maintenance

1 organization's website and the health maintenance organization shall  
2 update the website within fifteen days of the addition or termination of  
3 a provider from the health maintenance organization's network or a  
4 change in a physician's hospital affiliation;

5 (t) with respect to out-of-network coverage:

6 (i) a clear description of the methodology used by the health mainte-  
7 nance organization to determine reimbursement for out-of-network health  
8 care services;

9 (ii) the amount that the health maintenance organization will reim-  
10 burse under the methodology for out-of-network health care services set  
11 forth as a percentage of the usual and customary cost for out-of-network  
12 health care services;

13 (iii) examples of anticipated out-of-pocket costs for frequently  
14 billed out-of-network health care services; [and]

15 (u) information in writing and through an internet website that  
16 reasonably permits an enrollee or prospective enrollee to estimate the  
17 anticipated out-of-pocket cost for out-of-network health care services  
18 in a geographical area or zip code based upon the difference between  
19 what the health maintenance organization will reimburse for out-of-net-  
20 work health care services and the usual and customary cost for out-of-  
21 network health care services[.]; and

22 (v) the most recent comparative analysis performed by the health main-  
23 tenance organization to assess the provision of its covered services in  
24 accordance with the Paul Wellstone and Pete Dominici Mental Health Pari-  
25 ty and Addiction Equity Act of 2008, 42 U.S.C. 18031(j) and any amend-  
26 ments to, and federal guidance and regulations issued under, those Acts.

27 § 42. Subparagraph (iii) of paragraph (a) of subdivision 2 of section  
28 4900 of the public health law, as added by chapter 41 of the laws of

1 2014, is amended and a new subparagraph (iv) is added to read as  
2 follows:

3 (iii) for purposes of a determination involving substance use disorder  
4 treatment:

5 (A) a physician who possesses a current and valid non-restricted  
6 license to practice medicine and who specializes in behavioral health  
7 and has experience in the delivery of substance use disorder courses of  
8 treatment; or

9 (B) a health care professional other than a licensed physician who  
10 specializes in behavioral health and has experience in the delivery of  
11 substance use disorder courses of treatment and, where applicable,  
12 possesses a current and valid non-restricted license, certificate or  
13 registration or, where no provision for a license, certificate or regis-  
14 tration exists, is credentialed by the national accrediting body appro-  
15 priate to the profession; [and] or

16 (iv) for purposes of a determination involving treatment for a mental  
17 health condition:

18 (A) a physician who possesses a current and valid non-restricted  
19 license to practice medicine and who specializes in behavioral health  
20 and has experience in the delivery of mental health courses of treat-  
21 ment; or

22 (B) a health care professional other than a licensed physician who  
23 specializes in behavioral health and has experience in the delivery of a  
24 mental health courses of treatment and, where applicable, possesses a  
25 current and valid non-restricted license, certificate, or registration  
26 or, where no provision for a license, certificate or registration  
27 exists, is credentialed by the national accrediting body appropriate to  
28 the profession; and

§ 43. Paragraph (i) of subdivision 1 of section 4902 of the public health law, as amended by section 2 of part A of chapter 69 of the laws of 2016, is amended and a new paragraph (j) is added to read as follows:

(i) When conducting utilization review for purposes of determining health care coverage for substance use disorder treatment, a utilization review agent shall utilize an evidence-based and peer reviewed clinical review [tools designated by the office of alcoholism and substance abuse services that are appropriate to the age of the patient and consistent with the treatment service levels within the office of alcoholism and substance abuse services system] tool that is appropriate to the age of the patient. When conducting such utilization review for treatment provided in this state, a utilization review agent shall utilize an evidence-based and peer reviewed clinical tool designated by the office of alcoholism and substance abuse services that is consistent with the treatment service levels within the office of alcoholism and substance abuse services system. All approved tools shall have inter rater reliability testing completed by December thirty-first, two thousand sixteen.

(j) When conducting utilization review for purposes of determining health care coverage for a mental health condition, a utilization review agent shall utilize evidence-based and peer reviewed clinical review criteria that is appropriate to the age of the patient. The utilization review agent shall use clinical review criteria deemed appropriate and approved for such use by the commissioner of the office of mental health, in consultation with the commissioner and the superintendent of financial services. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

1       § 44. This act shall take effect on the first of January next succeed-  
2 ing the date on which it shall have become a law and shall apply to all  
3 policies and contracts issued, renewed, modified, altered or amended on  
4 or after such date; provided, however, notwithstanding any provision of  
5 law to the contrary, nothing in this act shall limit the rights accruing  
6 to employees pursuant to a collective bargaining agreement with any  
7 state or local government employer for the unexpired term of such agree-  
8 ment where such agreement is in effect on the effective date of this act  
9 and so long as such agreement remains in effect thereafter or the eligi-  
10 bility of any member of an employee organization to join a health insur-  
11 ance plan open to him or her pursuant to such a collectively negotiated  
12 agreement.

13 SUBPART B

14       Section 1. Subdivision 1 of section 2803-u of the public health law,  
15 as added by section 1 of part C of chapter 70 of the laws of 2016, is  
16 amended to read as follows:

17 1. The office of alcoholism and substance abuse services, in consulta-  
18 tion with the department, shall develop or utilize existing educational  
19 materials to be provided to general hospitals to disseminate to individ-  
20 uals with a documented substance use disorder or who appear to have or  
21 be at risk for a substance use disorder during discharge planning pursu-  
22 ant to section twenty-eight hundred three-i of this [chapter] article.  
23 Such materials shall include information regarding the various types of  
24 treatment and recovery services, including but not limited to: inpa-  
25 tient, outpatient, and medication-assisted treatment; how to recognize  
26 the need for treatment services; information for individuals to deter-

1 mine what type and level of treatment is most appropriate and what  
2 resources are available to them; and any other information the commis-  
3 sioner deems appropriate. General hospitals shall include in their poli-  
4 cies and procedures treatment protocols, consistent with medical stand-  
5 ards, to be utilized by the emergency departments in general hospitals  
6 for the appropriate use of medication-assisted treatment, including  
7 buprenorphine, prior to discharge, or referral protocols for evaluation  
8 of medication-assisted treatment when initiation in an emergency depart-  
9 ment of a general hospital is not feasible.

10 § 2. This act shall take effect immediately.

11 SUBPART C

12 Section 1. Subparagraph (v) of paragraph (a) of subdivision 2 of  
13 section 3343-a of the public health law is REPEALED and subparagraphs  
14 (vi), (vii), (viii), (ix) and (x) are renumbered subparagraphs (v),  
15 (vi), (vii), (viii) and (ix).

16 § 2. This act shall take effect immediately.

17 SUBPART D

18 Section 1. Paragraph (r) of subdivision 4 of section 364-j of the  
19 social services law, as amended by section 39 of part A of chapter 56 of  
20 the laws of 2013, is amended to read as follows:

21 (r) A managed care provider shall provide services to participants  
22 pursuant to an order of a court of competent jurisdiction, provided  
23 however, that such services shall be within such provider's or plan's  
24 benefit package and are reimbursable under title xix of the federal



1 social security act, provided that services for a substance use disorder  
2 shall be provided by a program licensed, certified or otherwise author-  
3 ized by the office of alcoholism and substance abuse services.

4 § 2. This act shall take effect immediately; provided, however that  
5 the amendments to paragraph (r) of subdivision 4 of section 364-j of the  
6 social services law made by section one of this act shall not affect the  
7 repeal of such section and shall be deemed to be repealed therewith.

8 SUBPART E

9 Section 1. Subdivision (b) of schedule I of section 3306 of the public  
10 health law is amended by adding nineteen new paragraphs 58, 59, 60, 61,  
11 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75 and 76 to read as  
12 follows:

13 (58) N-(1-phenethylpiperidin-4-yl)-N-phenylbutyramide. Other name:  
14 Butyryl Fentanyl.

15 (59) N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-yl]-N-phenylpro-  
16 pionamide. Other name: Beta-Hydroxythiofentanyl.

17 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylfuran-2-carboxamide. Other  
18 name: Furanyl Fentanyl.

19 (61) 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide.  
20 Other name: U-47700.

21 (62) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide. Other names:  
22 Acryl Fentanyl or Acryloylfentanyl.

23 (63) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide.  
24 Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fenta-  
25 nyl.

- 1     (64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide.
- 2     Other names: ortho-fluorofentanyl or 2-fluorofentanyl.
- 3     (65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide.
- 4     Other name: tetrahydrofuryl fentanyl.
- 5     (66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other
- 6     name: methoxyacetyl fentanyl.
- 7     (67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide.
- 8     Other name: cyclopropyl fentanyl.
- 9     (68) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide. Other name:
- 10    Valeryl fentanyl.
- 11    (69) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other
- 12    name: para-fluorobutyrylfentanyl.
- 13    (70) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide.
- 14    Other name: para-methoxybutyryl fentanyl.
- 15    (71) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide.
- 16    Other name: para-chloroisobutyryl fentanyl.
- 17    (72) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide. Other name:
- 18    isobutyryl fentanyl.
- 19    (73) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide.
- 20    Other name: cyclopentyl fentanyl.
- 21    (74) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)
- 22    acetamide. Other name: Ocfentanil.
- 23    (75) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine. Other name: MT-45.
- 24    (76) Fentanyl-related substances, their isomers, esters, ethers, salts
- 25    and salts of isomers, esters and ethers.
- 26    (i) Fentanyl-related substance means any substance not otherwise list-
- 27    ed in this section, that is structurally related to fentanyl by one or
- 28    more of the following modifications:

1 (A) Replacement of the phenyl portion of the phenethyl group by any  
2 monocycle, whether or not further substituted in or on the monocycle;

3 (B) Substitution in or on the phenethyl group with alkyl, alkenyl,  
4 alkoxyl, hydroxyl, halo, haloalkyl, amino or nitro groups;

5 (C) Substitution in or on the piperidine ring with alkyl, alkenyl,  
6 alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino or nitro groups;

7 (D) Replacement of the aniline ring with any aromatic monocycle wheth-  
8 er or not further substituted in or on the aromatic monocycle; and/or

9 (E) Replacement of the N-propionyl group by another acyl group.

10 § 2. Section 3308 of the public health law is amended by adding a new  
11 subdivision 7 to read as follows:

12 7. The commissioner may, by regulation, classify as a Schedule I  
13 controlled substance in section three thousand three hundred six of this  
14 article any substance listed in Schedule I of the federal schedules of  
15 controlled substances in 21 USC §812 or 21 CFR §1308.11.

16 § 3. This act shall take effect on the ninetieth day after it shall  
17 have become a law.

18 § 2. Severability clause. If any clause, sentence, paragraph, subdivi-  
19 sion, section or part of this act shall be adjudged by any court of  
20 competent jurisdiction to be invalid, such judgment shall not affect,  
21 impair, or invalidate the remainder thereof, but shall be confined in  
22 its operation to the clause, sentence, paragraph, subdivision, section  
23 or part thereof directly involved in the controversy in which such judg-  
24 ment shall have been rendered. It has hereby declared to be the intent  
25 of the legislature that this act would have been enacted even if such  
26 invalid provisions had not been included herein.

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

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

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