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

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 transportation 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 Ranzenhofer	s35 Stewart-Cousins
s44 Breslin	s54 Helming	s11 Liu	s48 Ritchie	
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-Stokes	a118 Smullen
a060 Barron	a048 Eichenstein	a131 Kolb		a022 Solages
a082 Benedetto	a004 Englebright	a105 Lalor	a058 Perry	a114 Stec
a042 Bichotte	a074 Epstein	a013 Lavine	a023 Pheffer Amato	a110 Steck
a079 Blake	a109 Fahy	a134 Lawrence		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).

LBDC 12/20/18

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:

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

PART A

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for enrollees of [managed long term care plans issued certificates of

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

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

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

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

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

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

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

PART B

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

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

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

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

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

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner may promulgate regulations as necessary to establish additional standards for contracts or other arrangements related to the services described in this subdivision.

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

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

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

PART C

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

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

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

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

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

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

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

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

PART D

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

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

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

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

PART E

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

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

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

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

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

§ 11. This act shall take effect immediately and:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand seventeen through March thirty-first, two thousand nineteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand nineteen through March thirty-first, two thousand twenty-four such assessment shall be six percent.

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

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019

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

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

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

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

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

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

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

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

and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019 through March 31, 2024.

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

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

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

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

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

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

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

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

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

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

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 and on and after April 1, 2015 through March 31, 2017 and on and after April 1, 2017 through March 31, 2019<u>, and on and after April 1, 2019 through March 31, 2024</u>;

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

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

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

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

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

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

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

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

law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid enrolled outpatients and for all other behavioral health services except inpatient included in New York state's Medicaid redesign waiver approved by the centers for medicare and Medicaid services (CMS). Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes or any such other fees pursuant to the Medicaid state plan or otherwise approved by CMS in the Medicaid redesign waiver; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2022 for patients in the city of New York, for all rate periods on and after the effective date of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 2022 for patients outside the city of New

York, and for all rate periods on and after the effective date of section [30] 2 of part [B] P of chapter [59] 57 of the laws of [2016] 2017 through March 31, [2020] 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 services. Such waiver may be applied on a provider specific or industry wide basis. Further, such conditions may be waived, as the commissioner determines necessary, to comply with federal rules or regulations governing these payment methodologies. Nothing in this section shall prohibit managed care organizations and providers from negotiating different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be

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

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

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

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

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

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

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

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

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

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

and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31,

2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

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

PART F

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

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

1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019, and between July 1, 2019 and June 30, 2020 or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019, and between July 1, 2019 and June 30, 2020 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health

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

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

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

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June

30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, between July 1, 2015 and June 30, 2016, and between July 1, 2016 and June 30, 2017, between July 1, 2017 and June 30, 2018, [and] between July 1, 2018 and June 30, 2019, and between July 1, 2019 and June 30, 2020 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June

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

30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, to the period July 1, 2015 and June 30, 2016, [and between] <u>to the period</u> July 1, 2016 and June 30, 2017, [and] to the period July 1, 2017 to June 30, 2018, [and] to the period July 1, 2018 to June 30, 2019<u>, and to the period July 1, 2019 to June 30, 2020</u>.

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

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

June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, during the period July 1, 2015 to June 30, 2016, during the period July 1, 2016 to June 30, 2017, during the period July 1, 2017 to June 30, 2018, [and] during the period July 1, 2018 to June 30, 2019, and during the period July 1, 2019 to June 30, 2020 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician

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

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

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

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30,

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

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

June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, or covering the period July 1, 2016 to June 30, 2017, or covering the period July 1, 2017 to June 30, 2018, or covering the period July 1, 2018 to June 30, 2019, or covering the period July 1, 2019 to June 30, 2020 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to

June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, to the period July 1, 2016 to June 30, 2017, and to the period July 1, 2017 to June 30, 2018, and to the period July 1, 2018 to June 30, 2019, and to the period July 1, 2019 to June 30, 2020 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30,

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

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

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

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

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

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

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

available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, or July 1, 2016 to June 30, 2017, or July 1, 2017 to June 30, 2018, or July 1, 2018 to June 30, 2019<u>, or July 1, 2019 to June 30, 2020</u> as applicable.

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

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

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

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

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

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

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

PART G

Section 1. 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.

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

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

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

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

describe methods for the provision of notice and assistance to interested individuals eligible for enrollment in the program, and shall contain such other information as, shall be required by the department. An "eligible individual", for purposes of this section is a person who:

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

(b) is eligible for medical assistance;

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

(d) meets such other criteria, as may be established by the commissioner, which are necessary to effectively implement the objectives of this section.

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

and as documented in the eligible individual's record, including, but not limited to, recruiting, hiring and supervising their personal assistants. For the purposes of this section, personal assistant shall mean an adult who provides services under this section to the eligible individual under the eligible individual's instruction, supervision and direction or under the instruction, supervision and direction of the eligible individual's designated representative, provided that a person legally responsible for an eligible individual's care and support, an eligible individual's spouse or designated representative may not be the personal assistant for the eligible individual; however, a personal assistant may include any other adult relative of the eligible individual, provided, however, that the program determines that the services provided by such relative are consistent with an individual's plan of care and that the aggregate cost for such services does not exceed the aggregate costs for equivalent services provided by a non-relative personal assistant. Such individuals shall be assisted as appropriate with service coverage, supervision, advocacy and management. Providers shall not be liable for fulfillment of responsibilities agreed to be undertaken by the eligible individual. This subdivision, however, shall not diminish the participating provider's liability for failure to exercise reasonable care in properly carrying out its responsibilities under this program, which shall include monitoring such individual's continuing ability to fulfill those responsibilities documented in his or her records. Failure of the individual to carry out his or her agreed to responsibilities may be considered in determining such individual's continued appropriateness for the program.

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

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

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

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

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

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

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

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

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

(i) wage and benefit processing for consumer directed personal assistants;

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

(iii) complying with workers' compensation, disability and unemployment requirements;

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

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

(vi) maintaining records of service authorizations or reauthorizations;

(vii) monitoring the consumer's or, if applicable, the designated representative's continuing ability to fulfill the consumer's responsibilities under the program and promptly notifying the authorizing entity of any circumstance that may affect the consumer's or, if applicable, the designated representative's ability to fulfill such responsibilities;

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

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

(d) Fiscal intermediaries are not responsible for, and fiscal intermediary services shall not include, fulfillment of the responsibilities of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART H

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

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

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

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

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

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

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

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

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

§ 5. This act shall take effect immediately.

PART I

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

ARTICLE 29

PHARMACY BENEFIT MANAGERS

§ 2901. Definitions. For purposes of this article:

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

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

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

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

(1) an officer or employee of a registered or licensed pharmacy benefit manager; or

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

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

§ 2902. Acting without a registration. (a) No person, firm, association, corporation or other entity may act as a pharmacy benefits manager prior to January first, two thousand twenty without having a valid registration as a pharmacy benefit manager filed with the superintendent in accordance with this article and any regulations promulgated thereunder.

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

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

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

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

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

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

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

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

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

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

(2) The superintendent also may address to any pharmacy benefit manager or its officers any inquiry in relation to its provision of pharmacy benefit management services or any matter connected therewith. Every pharmacy benefit manager or person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be, if required by the superintendent, subscribed by such individual, or by such officer or officers of the pharmacy benefit manager, as the superintendent shall designate, and affirmed by them as true under the penalties of perjury.

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

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

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

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

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

§ 2906. Licensing of a pharmacy benefit manager. (a) The superintendent may issue a pharmacy benefit manager's license to any person, firm, association or corporation who or that has complied with the requirements of this article, including regulations promulgated by the superintendent. The superintendent, in consultation with the commissioner of

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

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

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

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

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

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

(5) protection of consumers.

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

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

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

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

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

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

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

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

(f) The superintendent may refuse to issue a pharmacy benefit manager's license if, in the superintendent's judgment, the applicant or any

member, principal, officer or director of the applicant, is not trustworthy and competent to act as or in connection with a pharmacy benefit manager, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(g) Licensees and applicants for a license under this section shall be subject to examination by the superintendent as often as the superintendent may deem it expedient. The superintendent may promulgate regulations establishing methods and procedures for facilitating and verifying compliance with the requirements of this section and such other regulations as necessary.

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

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

(1) violated any insurance laws, or violated any regulation, subpoena or order of the superintendent or of another state's insurance commissioner, or has violated any law in the course of his or her dealings in such capacity;

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

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

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

(B) demonstrated incompetence;

(C) demonstrated untrustworthiness; or

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

(5) improperly withheld, misappropriated or converted any monies or properties received in the course of business in this state or elsewhere;

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

(7) been convicted of a felony;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Within thirty days of the initial pretrial hearing date, a registrant or licensee subject to this article shall report to the superintendent any criminal prosecution of the registrant or licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

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

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

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

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

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

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

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

(1) if the superintendent determines that the duties and responsibilities of such person are subject to appropriate supervision and that such duties and responsibilities will not have an adverse effect upon the public, other registrants or licensees, or the registrant or licensee proposing employment or appointment of such person; or

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

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

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

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

§ 2913. Assessments. Pharmacy benefit managers that file a registration with the department or are licensed by the department shall be assessed by the superintendent for the operating expenses of the department that are solely attributable to regulating such pharmacy benefit managers in such proportions as the superintendent shall deem just and reasonable.

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

(b) "Defined violation" means the commission by a person of an act prohibited by: subsection (a) of section one thousand one hundred two, section one thousand two hundred fourteen, one thousand two hundred seventeen, one thousand two hundred twenty, one thousand three hundred thirteen, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-two, subparagraph (B) of paragraph two of subsection (i) of section one thousand three hundred twenty-four, two thousand one hundred two, two thousand one hundred seventeen, two thousand one hundred twenty-two, two thousand one hundred twenty-three, subsection (p) of section two thousand three hundred thirteen, section two thousand three hundred twenty-four, two thousand five hundred two, two thousand five hundred three, two thousand five hundred four, two thousand six hundred one, two thousand six hundred two, two thousand six hundred three, two thousand six hundred four, two thousand six hundred six, two thousand seven hundred three, two thousand nine hundred two, two thousand nine hundred five, three thousand one hundred nine, three thousand two hundred twenty-four-a, three thousand four hundred twenty-nine, three thousand four hundred thirty-three, paragraph seven of subsection (e) of section three thousand four hundred twenty-six, four

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

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

PART J

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

SUBPART A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

article fifteen of the insurance law, including a health maintenance organization operated as a line of business of a health service corporation licensed under article forty-three of the insurance law, offers coverage that, at a minimum, complies with this section and provides all of the consumer protections required to be provided by a health maintenance organization pursuant to this chapter and regulations, including those consumer protections contained in sections four thousand four hundred three and four thousand four hundred eight-a of this chapter. The requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of [the public health law] this chapter or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred [twenty-two of this article] twenty-eight of the insurance law due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. [Subject to the creditable coverage requirements of subsection (a) of section four thousand three hundred eighteen of the insurance law, the organization may, as an alternative to the use of a pre-existing condition provision, elect to offer contracts without a pre-existing condition provision to such groups but may require that coverage shall not become effective until after a specified affiliation period of not more than sixty days after the application for coverage is submitted. The organization is not required to provide health care

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

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

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

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

SUBPART B

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

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

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

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

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

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

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

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

(ii) with respect to women, such additional preventive care and screenings for mammography 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.

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

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

(ii) with respect to women, such additional preventive care and screenings for cervical cytology 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.

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

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; [and]

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

(v) 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) through (iv) of this subparagraph.

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

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

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

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

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

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

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

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

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

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

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

(b) 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

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

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

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

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

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

(f) For purposes of this section:

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

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

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

(A) provides for essential health benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) evidence-based items or services for bone mineral density that have in effect a rating of 'A' or 'B' in the current recommendations of 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 (l) of section 3221 of the insurance law, as added by chapter

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

(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; [and]

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

(v) 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) through (iv) of this subparagraph.

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

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

(ii) with respect to women, such additional preventive care and screenings for mammography 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.

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

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

(ii) with respect to women, such additional preventive care and screenings for cervical cytology 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.

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

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

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

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

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

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

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

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

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

hensive guidelines supported by the health resources and services administration; [and]

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

(E) 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 subparagraphs (A) through (D) of this paragraph.

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

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

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

(C) 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 subparagraphs (A) and (B) of this paragraph.

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

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

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

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

(C) 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 subparagraphs (A) and (B) of this paragraph.

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

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

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

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

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

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

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

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

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

(C) 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 subparagraphs (A) and (B) of this paragraph.

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

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

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

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

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

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

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

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

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

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

(mm) A corporation shall not be required to offer the contract holder any benefits that must be made available pursuant to this section if such benefits must be covered pursuant to subsection (kk) of this section. For any contract issued within the health benefit exchange

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

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

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

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

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

(B) The corporation shall offer one contract at each level of coverage as defined in subsection (c) of section [1302(d) of the affordable care

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

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

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

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

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

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

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

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

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

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

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

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

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

(b) 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 contract that provides hospi-tal, surgical, or medical expense coverage and is not a grandfathered

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

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

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

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

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

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

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

(d) Every individual or group contract that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan,

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

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

(f) For purposes of this section:

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

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

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

(A) provides for essential health benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBPART C

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

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

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

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

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

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

(ii) issues a rider to each certificateholder at no premium to be charged to the certificateholder or religious employer for the rider, that provides coverage for medically necessary abortions subject to the same rules as would have been applied to the same category of treatment in the policy issued to the religious employer. The rider shall clearly and conspicuously specify that the religious employer does not administer medically necessary abortion benefits, but that the insurer is issuing a rider for coverage of medically necessary abortions, and shall provide the insurer's contact information for questions; and

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

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

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

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

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

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

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

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

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

SUBPART D

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

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

(b) (1) Every policy delivered or issued for delivery in this state that provides coverage for prescription drugs shall include in the policy a process that allows an insured, the insured's designee, or the 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.

(B) An insurer shall make a determination on an expedited review request 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 twenty-four hours following receipt of the request.

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

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

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

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

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

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

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

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

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

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

(b) (1) Every contract issued by a corporation subject to the provisions of this article that provides coverage for prescription drugs shall include in the contract a process that allows an insured, the insured's designee, or the insured's prescribing health care provider to request a formulary exception. With respect to the process for such a formulary exception, a corporation 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) A corporation 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 contract.

(B) A corporation 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) A corporation 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) A corporation 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 is not covered by the contract.

(B) A corporation shall make a determination on an expedited review request 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 twenty-four hours following receipt of the request.

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

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

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

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

The external appeal agent shall notify the corporation, the insured or the insured's designee and the insured's prescribing health care provider in writing of the external appeal determination within two business days of rendering such determination.

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

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

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

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

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

SUBPART E

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

§ 2607. Discrimination because of sex or marital status. (a) No individual or entity shall refuse to issue any policy of insurance, or cancel or decline to renew [such] the policy because of the sex or marital status of the applicant or policyholder or engage in sexual stereotyping.

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

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

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

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

(1) make any distinction or discrimination between persons as to the premiums or rates charged for the policy or in any other manner whatever;

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

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

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

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

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

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

(8) engage in sexual stereotyping.

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

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

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

(1) make any distinction or discrimination between persons as to the premiums or rates charged for the contract or in any other manner whatever;

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

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

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

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

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

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

(8) engage in sexual stereotyping.

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

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

SUBPART F

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

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

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

(I) the following paragraphs of subsection (b) of section four thousand two hundred sixteen of this chapter:

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

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

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

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

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

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

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

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

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

(ii) where the master policies or contracts were lawfully issued without this state in a jurisdiction where the insurer was authorized to do an insurance business;

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

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

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

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

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

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

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

(1) (A) No policy form shall be delivered or issued for delivery in this state unless it has been filed with and approved by the superintendent as conforming to the requirements of this chapter and not inconsistent with law.

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

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

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

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

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

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

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

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

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

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

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

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

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

(G) For purposes of this paragraph:

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

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

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

§ 5. Subparagraph (E) of paragraph 3 of subsection (a) of section 4237 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 princi-pally 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] individ-uals, 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

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

(iii) The amount of insurance under the policy or contract shall be based upon some plan precluding individual selection either by the insured individuals or by the association. However, with respect to an association, such a plan may permit a number of selections by the association if the selections offered utilize consistent plans of insurance so that the resulting plans of coverage are reasonable. Furthermore, such a plan may permit a limited number of selections by insured individuals if the selections offered utilize consistent plans of insurance for insured individuals so that the resulting plans of coverage are reasonable.

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

(v) The premiums charged shall be reasonable in relation to the benefits provided.

§ 6. Subsection (d) of section 4237-a of the insurance law, as amended 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

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

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

§ 4. Legislative intent. It is hereby declared to be the intent of the legislature in enacting this act, that the laws of this state provide consumer and market protections at least as robust as those under the federal Patient Protection and Affordable Care Act, public law 111-148, as that law existed and was interpreted on January 19, 2017. In addition to any other power conferred by law, the superintendent of financial services is hereby specifically empowered to promulgate regulations under, and issue interpretations of, this act as necessary to ensure that the intent of the legislature as expressed in this section is realized.

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

PART K

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

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

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

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

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

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

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

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

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

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

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

(d) The department [of financial services and the department] shall post on [their websites] its website information about the fund[, eligibility for enrollment in the fund,] and the process for enrollment in the fund.

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

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

5. For the state fiscal year beginning April first, two thousand eleven and ending March thirty-first, two thousand twelve, the state fiscal

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.

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-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART L

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

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

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

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

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

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

(v) Coverage] Except as provided in items (vi) and (vii) of this subparagraph, coverage shall not be required to include the diagnosis and treatment of infertility in connection with: (I) in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (II) the reversal of elective sterilizations; (III) sex change procedures; (IV) cloning; or (V) medical or surgical services or procedures that are deemed to be experimental in accordance with clinical guidelines referenced in [clause (vi)] item (v) of this subparagraph.

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

(I) The determination of "infertility" 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 including "iatrogenic infertility", which means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes;

(II) The identification of experimental procedures and treatments not covered 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;

(III) The identification of the required training, experience and other standards for health care providers for the provision of procedures 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.

(vi) 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 policy.

(vii) Every large group policy delivered or issued for delivery in this state 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 clause (I) of item (v) of this subparagraph. 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 policy. For purposes of this item, 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 insurer providing coverage under this item or item (vi) of this subparagraph shall discriminate based on an insured's expected length of life, present of predicted

disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.

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

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

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

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

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

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

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

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

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

(i) The determination of "infertility" 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;

(ii) The identification of experimental procedures and treatments not covered 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 including "iatrogenic infertility", which means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes;

(iii) The identification of the required training, experience and 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

shall discriminate based on an insured's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.

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

(C) Every policy that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for 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 policy.

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

(ii) No insurer providing coverage under this paragraph shall discriminate based on an insured's expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.

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

PART M

Section 1. This act shall be known and may be cited as the "comprehensive contraception coverage act".

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

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

(A)] 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 paragraph, an insurer shall not be required to provide coverage of male condoms. The following applies to this coverage:

(I) 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 long as at least one is included and covered without cost-sharing and in accordance with this paragraph;

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

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

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

(ii) Voluntary sterilization procedures for women;

(iii) Patient education and counseling on contraception; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(D) 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.]

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

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

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

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

(A) 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 paragraph, a corporation shall not be required to provide coverage of male condoms. The following applies to this coverage:

(i) 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, a corporation is not required to include all such therapeutic and pharmaceutical equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this subsection;

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

a particular contraceptive drug, device, or product based upon a determination of medical necessity for an insured. The insurer shall accept the standard exception form submitted by the insured's attending health care provider;

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

(iv) this coverage shall allow for the dispensing of twelve months worth of a contraceptive at one time;

(B) Voluntary sterilization procedures for women;

(C) Patient education and counseling on contraception; and

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

(2) A corporation subject to this paragraph shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant to this subsection.

(3) Except as otherwise authorized under this subsection, a corporation shall not impose any restrictions or delays on the coverage required under this subsection.

(4) Notwithstanding any other provision of this subsection, a religious employer may request a contract without coverage for federal food and drug administration approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, such contract shall be provided without coverage for contraceptive methods.

This paragraph shall not be construed to deny an enrollee coverage of, and timely access to, contraceptive methods.

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

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

(ii) The entity primarily employs persons who share the religious tenets of the entity.

(iii) The entity serves primarily persons who share the religious tenets of the entity.

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

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

[(2)]<u>(5)</u> (A) Where a group contractholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with paragraph [one] <u>four</u> of this subsection, each enrollee covered under the contract issued to that group contractholder shall have the right to directly purchase the rider required by this subsection from the insurer or health maintenance organization which issued the group contract at the prevailing small group community rate for such rider whether or not the employee is part of a small group.

(B) Where a group contractholder makes an election not to purchase coverage for contraceptive drugs or devices in accordance with paragraph [one] <u>four</u> of this subsection, the insurer or health maintenance organization that provides such coverage shall provide written notice to 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

long as at least one is included and covered without cost-sharing in accordance with this subparagraph;

(bb) if the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, the insurer shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing. An insurer shall defer to the attending health care provider's determination of medical necessity. The superintendent may develop a standard exception form with instructions that an attending health care provider may use to recommend a particular contraceptive drug, device, procedure, service, or product based upon a determination of medical necessity for an insured. The insurer shall accept the standard exception form submitted by the insured's attending health care provider;

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

(dd) this coverage shall allow for the dispensing of twelve months-worth of a contraceptive at one time:

(II) Voluntary sterilization procedures for women;

(III) Patient education and counseling on contraception; and

(IV) Follow-up services related to the drugs, devices, products, and procedures covered under this subparagraph, including management of side effects, counseling for continued adherence, and device insertion and removal.

(ii) An insurer subject to this subparagraph shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant to this subparagraph.

(iii) Except as otherwise authorized under this subparagraph, an insurer shall not impose any restrictions or delays on the coverage required under this subparagraph.

§ 5. Paragraph (d) of subdivision 3 of section 365-a of the social services law, as amended by chapter 909 of the laws of 1974 and as relettered by chapter 82 of the laws of 1995, is amended to read as follows:

(d) family planning services and supplies for eligible persons of childbearing age, including children under twenty-one years of age who can be considered sexually active, who desire such services and supplies, in accordance with the requirements of federal law and regulations and the regulations of the department. Prescription contraceptives, when prescribed based on generally accepted medical practice, may be dispensed at one time or up to twelve times within one year from the date of the prescription. No person shall be compelled or coerced to accept such services or supplies.

§ 6. This act shall take effect January 1, 2020; provided that sections two, three and four of this act shall apply to policies and contracts issued, renewed, modified, altered or amended on and after such date.

PART N

Section 1. Universal access commission. 1. There is hereby created a universal access commission, which shall consider and advise the commis-

sioner of health and the superintendent of financial services on options for achieving universal access to health care in New York State.

2. The universal access commission shall consist of independent health policy and insurance experts appointed by the commissioner and superintendent. The commission shall consult with the legislature and stakeholder groups and convene at least one meeting for members of the public to review and discuss options for achieving universal access to care.

3. The commissioner and superintendent shall select the chair of the commission from among the members of such commission and shall designate at least one employee from each department to assist the commission in the performance of its duties under this section. The commissioner and superintendent shall adopt rules for the governance of the commission, which shall meet as frequently as its business may require and at such other times as determined by the commissioner and superintendent to be necessary.

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

5. The commission shall provide a report to the Governor on the options for achieving universal access to health care in New York State by December 1, 2019.

§ 2. This act shall take effect immediately.

PART O

Section 1. Subdivision 2 of section 605 of the public health law, as amended by section 20 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the core public health services identified in section six hundred two of this title, pursuant to an approved application for state aid, at a rate of no less than thirty-six per centum, except for the city of New York which shall receive no less than twenty per centum, of the difference between the amount of moneys expended by the municipality for public health services required by section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services that are not eligible for state aid pursuant to this article.

§ 2. Subdivision 1 of section 616 of the public health law, as amended by section 27 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by [paragraph (a) of] subdivision two of section six hundred five of this article, [at least] no less than thirty-six per centum, except for the city of New York which shall receive no less than twenty per centum, of the difference between the amount of moneys expended by the municipality for eligible public health services pursuant to an approved application

for state aid during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article.

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

PART P

Section 1. Subdivision 6 of section 1370 of the public health law, as amended by chapter 485 of the laws of 1992, is amended as follows:

6. "Elevated lead levels" means a blood lead level greater than or equal to [ten] five micrograms of lead per deciliter of whole blood or such lower blood lead level as may be established by the department pursuant to rule or regulation.

§ 2. The public health law is amended by adding a new section 1370-f to read as follows:

§ 1370-f. Lead safe residential rental properties. 1. Definitions. For the purposes of this section:

(a) "residential rental property" shall mean a dwelling which is either rented, leased, let or hired out, to be occupied, or is occupied as the home, residence or sleeping place of one or more persons other than the owner's family. Residential rental property shall not include short term rental properties during which guests do not stay in excess of twenty-eight days.

(b) "lead safe" shall mean any residential rental property that:

(i) has been determined through a lead-based paint inspection conducted in accordance with appropriate federal regulations not to contain lead-based paint; or

(ii) meets the minimum standards set forth in regulations promulgated by the commissioner pursuant to this section.

2. The commissioner shall promulgate rules and regulations establishing minimum standards for the maintenance of lead safe residential rental properties. Such rules and regulations shall include:

(a) Minimum standards for maintaining internal and external painted surfaces that contain lead-based paint; and

(b) A schedule by which owners of residential rental property must implement and comply with such minimum standards.

3. It shall be the responsibility of an owner of any residential rental property to maintain such property in a lead safe condition in accordance with rules and regulations promulgated by the commissioner pursuant to this section.

4. All paint on any residential rental property on which the original construction was completed prior to January first, nineteen hundred seventy-eight, shall be presumed to be lead-based paint. This presumption may be overcome by a certification issued by a federally certified lead-based paint inspector or risk assessor that the property has been determined not to contain lead-based paint, or by such other means as may be prescribed by the rules and regulations adopted by the commissioner pursuant to this section.

5. The commissioner, local health officer of a county and, in the City of New York, the commissioner of the New York City department of health and mental hygiene, may enter into an agreement or contract with a municipal government regarding inspection of the lead conditions in residential rental properties and such health department may designate the local housing maintenance code enforcement agency in which the residential rental property is located as an agency authorized to administer and ensure compliance with the provisions of this section

and subsequent regulations pursuant to subdivision one of section thirteen hundred seventy-five of this title.

6. If the commissioner, or other officer having jurisdiction, determines that an owner of residential rental property is in violation of this section or any rules or regulations promulgated pursuant to this section, the commissioner or other officer having jurisdiction shall have the authority to order the abatement of any lead condition present at the residential rental property and assess fines not to exceed two thousand dollars for each violation.

§ 3. This act shall take effect immediately.

PART Q

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

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

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

§ 2. This act shall take effect immediately.

PART R

Section 1. Legislative findings and intent. The legislature finds that maternal mortality and morbidity is a serious public health concern and has a serious family and societal impact. New York state has among the highest maternal mortality rates in the country and racial disparities remain significant. The U.S. Centers for Disease Control and Prevention has determined that a regular process for professional, multi-disciplinary, confidential review of all maternal deaths can help identify the causes of maternal mortality, and those findings can lead to clinical and social change that can help prevent maternal mortality. The same is true for severe maternal morbidity. Confidentiality is important to ensure that full information is made available in the review process to maximize protection of maternal health.

Section 3 of article 17 of the state constitution states: "The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." The legislature finds that the creation of a state maternal mortality review board, and recognition and protection of any maternal mortality review board, including a New York city maternal mortality review board, are a matter of state concern and an important exercise of the legislature's constitutional mandate to protect the public health.

§ 2. The public health law is amended by adding a new section 2509 to read as follows:

§ 2509. Maternal mortality review board. 1. (a) There is hereby established in the department the maternal mortality review board for the purpose of reviewing maternal deaths and severe maternal morbidity and developing findings, recommendations, and best practices to the commissioner to contribute to the prevention of maternal mortality and severe maternal morbidity. The board shall assess the cause of death, factors leading to death and preventability for each maternal death reviewed and, at the discretion of the board, cases of severe maternal morbidity, and shall develop strategies for reducing the risk of maternal mortality and severe maternal morbidity, where cases of severe maternal morbidity were reviewed, taking into account factors such as racial, economic, or other disparities. The boards' findings, recommendations and best practices shall be given to the commissioner for dissemination.

(b) Any maternal morality review board, including a New York city maternal mortality review board, shall provide to the commissioner the results and the findings of its reviews, including recommendations and best practices and upon request information and data, including case summaries, to support statewide surveillance and enforcement.

2. As used in this section:

(a) "Advisory council" and "council" mean the advisory council on maternal mortality and severe maternal morbidity, established under this section.

(b) "Board" means a maternal mortality review board established by this section, referred to in this section as the "state board", or any board operating, including a New York city maternal mortality review board, under this section.

(c) "Maternal death" means the death of a woman during pregnancy or within a year from the end of pregnancy.

(d) "Severe maternal morbidity" means unexpected outcomes of pregnancy, labor, or delivery that result in significant short- or long-term consequences to a woman's health.

3. (a) The members of the state board shall be comprised of multidisciplinary experts in the field of maternal mortality, women's health and public health, and shall include health care professionals and other experts who serve and are representative of the racial and ethnic diversity of the women and mothers of the state.

(b) The state board shall be composed of at least fifteen members, all of whom shall be appointed by the commissioner.

(c) The terms of the state board members shall be three years. The commissioner may choose to reappoint state board members to additional three year terms.

(d) A majority of the appointed membership of the state board, no less than three, shall constitute a quorum.

(e) When any member of the state board fails to attend three consecutive regular meetings, unless such absence is for good cause, that membership may be deemed vacant for purposes of the appointment of a successor.

(f) Meetings of the state board shall be held at least twice a year but may be held more frequently as deemed necessary, subject to request of the department.

(g) Members of the state board shall be indemnified under section seventeen of the public officers law.

(h) Members of the state board shall not be compensated for their participation on the board but may receive reimbursement for their ordinary and necessary expenses of participation.

(i) Membership on a board shall not disqualify any person from holding any public office or employment.

(j) The board is not subject to the open meetings law.

4. (a) The commissioner shall receive upon request from any department, division, board, bureau, commission, local health departments or other agency of the state or political subdivision thereof or any public authority, as well as hospitals established pursuant to article twenty-eight of this chapter, birthing facilities, medical examiners, coroners and coroner physicians and any other facility providing services associated with maternal mortality, such information, including, but not limited to, death records, medical records, autopsy reports, toxicology reports, hospital discharge records, birth records and any other information.

(b) The commissioner shall receive information, including oral or written statements, relating to any maternal death and case of severe maternal morbidity, from any family member or other interested party (including the patient in a case of severe maternal morbidity) relating to any case that may come before the board. Oral statements received under this paragraph shall be transcribed or summarized in writing. The commissioner and the city commissioner shall transmit that information to the board considering the case.

(c) Before transmitting any information to the board, the commissioner, or the city commissioner, shall remove all personal identifying information of the woman, health care practitioner or practitioners or anyone else individually named in such information, as well as the hospital or facility that treated the woman, and any other information such as geographic location that may inadvertently identify the woman, practitioner or facility. This paragraph shall not preclude the trans-

mitting of information to the board that is reasonably necessary to enable the board to perform an appropriate review under this section.

5. Each board:

(a) shall make and report findings, recommendations and best practices to the commissioner regarding the cause of death, factors leading to death, and preventability of each maternal death case, and each case of severe maternal morbidity reviewed by the board, by reviewing relevant information for each case and consulting with experts as needed to evaluate the information for each death; and shall provide such de-identified findings and recommendations, including best practices and strategies for reducing the risk of maternal mortality and severe maternal morbidity, to the advisory council; provided that material provided to the advisory council shall not include any information that would be confidential under this section;

(b) shall develop recommendations to the commissioner for areas of focus, including issues of severe maternal morbidity and issues of racial, economic or other disparities in maternal outcomes;

(c) may, in addition to the findings, recommendations, and best practices made under this subdivision, and consistent with all applicable confidentiality protections, bring any particular matter to the attention of the commissioner;

(d) the state board shall issue a report every other year to the commissioner on its findings, recommendations, and best practices, and it shall be a public document.

6. The commissioner and boards shall each keep confidential any information collected or received under this section that includes personal identifying information of the woman, health care practitioner or practitioners or anyone else individually named in such information, as well

as the hospital or facility that treated the woman, and any other information such as geographic location that may inadvertently identify the woman, practitioner or facility, and shall use the information provided or received under this section solely for the purposes of improvement of the quality of health care of women and to prevent maternal mortality and severe maternal morbidity. This subdivision shall not preclude the transmitting of information to the board that is reasonably necessary to enable the board to perform an appropriate review under this section. All information and records received, meetings conducted, reports and records made and maintained and all books and papers obtained by the commissioner as well as the board shall be confidential and shall not be made open or available, including under article six of the public officers law, and shall be limited to board members as well as those authorized by the commissioner. Such information shall not be discoverable or admissible as evidence in any action in any court or before any other tribunal, board, agency or person.

7. (a) There is hereby established in the department an advisory council on maternal mortality and severe maternal morbidity.

(b) The advisory council:

(i) may review the findings, recommendations and best practices of the boards;

(ii) may use the boards findings, recommendations and best practices to develop recommendations on policies, best practices, and strategies to prevent maternal mortality and severe maternal morbidity;

(iii) may hold public hearings on those matters; and

(iv) may make findings and issue reports, including an annual report, on such matters;

(c) The advisory council shall consist of at least twenty members, representative of the racial and ethnic diversity of the women and mothers of the state to be determined by the commissioner. Ten of the members of the council shall be representative of the population and health care system of the city of New York. The commissioner shall appoint the chair of the council.

(d) The members of the council shall be comprised of multidisciplinary experts and lay persons knowledgeable in the field of maternal mortality, women's health and public health and shall include members who serve and are representative of the diversity of the women and mothers in medically underserved areas of the state or areas of the state with disproportionately high occurrences of maternal mortality or severe maternal morbidity.

(e) The terms of the council members shall be three years. The commissioner may choose to reappoint council members to additional three-year terms. Vacancies on the council shall be filled by appointment by the commissioner. A majority of the appointed membership of the council shall constitute a quorum. When any member of the council fails to attend three consecutive regular meetings, unless such absence is for good cause, that membership may be deemed vacant for purposes of the appointment of a successor.

(f) Meetings of the council shall be held at least twice a year.

(g) Members of the council shall be indemnified under section seventeen of the public officers law. Members of the council shall not be compensated for their participation on the council but shall receive reimbursement for their ordinary and necessary expenses of participation. Membership on the council shall not disqualify any person from holding any public office or employment.

§ 3. This act shall take effect immediately.

PART S

Section 1. Legislative intent. The legislature finds that comprehensive reproductive health care, including contraception and abortion, is a fundamental component of a woman's health, privacy and equality. The New York Constitution and United States Constitution protect a woman's fundamental right to access safe, legal abortion, courts have repeatedly reaffirmed this right and further emphasized that states may not place undue burdens on women seeking to access such right.

Moreover, the legislature finds, as with other medical procedures, the safety of abortion is furthered by evidence-based practices developed and supported by medical professionals. Abortion is one of the safest medical procedures performed in the United States; the goal of medical regulation should be to improve the quality and availability of health care services.

Furthermore, the legislature declares that it is the public policy of New York State that every individual possesses a fundamental right of privacy and equality with respect to their personal reproductive decisions and should be able to safely effectuate those decisions, including by seeking and obtaining abortion care, free from discrimination in the provision of health care.

Therefore, it is the intent of the legislature to prevent the enforcement of laws or regulations that are not in furtherance of a legitimate state interest in protecting a woman's health that burden abortion access.

§ 2. The public health law is amended by adding a new article 25-A to read as follows:

ARTICLE 25-A

REPRODUCTIVE HEALTH ACT

Section 2599-aa. Policy and purpose.

2599-bb. Abortion.

§ 2599-aa. Policy and purpose. The legislature finds that comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality. Therefore, it is the policy of the state that:

1. Every individual has the fundamental right to choose or refuse contraception or sterilization.

2. Every individual who becomes pregnant has the fundamental right to choose to carry the pregnancy to term, to give birth to a child, or to have an abortion, pursuant to this article.

3. The state shall not discriminate against, deny, or interfere with the exercise of the rights set forth in this section in the regulation or provision of benefits, facilities, services or information.

§ 2599-bb. Abortion. 1. A health care practitioner licensed, certified, or authorized under title eight of the education law, acting within his or her lawful scope of practice, may perform an abortion when, according to the practitioner's reasonable and good faith professional judgment based on the facts of the patient's case: the patient is within twenty-four weeks from the commencement of pregnancy, or there is an absence of fetal viability, or the abortion is necessary to protect the patient's life or health.

2. This article shall be construed and applied consistent with and subject to applicable laws and applicable and authorized regulations governing health care procedures.

§ 3. Section 4164 of the public health law is REPEALED.

§ 4. Subdivision 8 of section 6811 of the education law is REPEALED.

§ 5. Sections 125.40, 125.45, 125.50, 125.55 and 125.60 of the penal law are REPEALED, and the article heading of article 125 of the penal law is amended to read as follows:

HOMICIDE[, ABORTION] AND RELATED OFFENSES

§ 6. Section 125.00 of the penal law is amended to read as follows:

§ 125.00 Homicide defined.

Homicide means conduct which causes the death of a person [or an unborn child with which a female has been pregnant for more than twenty-four weeks] under circumstances constituting murder, manslaughter in the first degree, manslaughter in the second degree, or criminally negligent homicide[, abortion in the first degree or self-abortion in the first degree].

§ 7. The section heading, opening paragraph and subdivision 1 of section 125.05 of the penal law are amended to read as follows:

Homicide[, abortion] and related offenses; [definitions of terms] definition.

The following [definitions are] definition is applicable to this article:

[1.] "Person," when referring to the victim of a homicide, means a human being who has been born and is alive.

§ 7-a. Subdivisions 2 and 3 of section 125.05 of the penal law are REPEALED.

§ 8. Subdivision 2 of section 125.15 of the penal law is REPEALED.

§ 9. Subdivision 3 of section 125.20 of the penal law is REPEALED.

§ 10. Paragraph (b) of subdivision 8 of section 700.05 of the criminal procedure law, as amended by chapter 189 of the laws of 2018, is amended to read as follows:

(b) Any of the following felonies: assault in the second degree as defined in section 120.05 of the penal law, assault in the first degree as defined in section 120.10 of the penal law, reckless endangerment in the first degree as defined in section 120.25 of the penal law, promoting a suicide attempt as defined in section 120.30 of the penal law, strangulation in the second degree as defined in section 121.12 of the penal law, strangulation in the first degree as defined in section 121.13 of the penal law, criminally negligent homicide as defined in section 125.10 of the penal law, manslaughter in the second degree as defined in section 125.15 of the penal law, manslaughter in the first degree as defined in section 125.20 of the penal law, murder in the second degree as defined in section 125.25 of the penal law, murder in the first degree as defined in section 125.27 of the penal law, [abortion in the second degree as defined in section 125.40 of the penal law, abortion in the first degree as defined in section 125.45 of the penal law,] rape in the third degree as defined in section 130.25 of the penal law, rape in the second degree as defined in section 130.30 of the penal law, rape in the first degree as defined in section 130.35 of the penal law, criminal sexual act in the third degree as defined in section 130.40 of the penal law, criminal sexual act in the second degree as defined in section 130.45 of the penal law, criminal sexual act in the first degree as defined in section 130.50 of the penal law, sexual abuse in the first degree as defined in section 130.65 of the penal law, unlawful imprisonment in the first degree as defined in section 135.10

of the penal law, kidnapping in the second degree as defined in section 135.20 of the penal law, kidnapping in the first degree as defined in section 135.25 of the penal law, labor trafficking as defined in section 135.35 of the penal law, aggravated labor trafficking as defined in section 135.37 of the penal law, custodial interference in the first degree as defined in section 135.50 of the penal law, coercion in the first degree as defined in section 135.65 of the penal law, criminal trespass in the first degree as defined in section 140.17 of the penal law, burglary in the third degree as defined in section 140.20 of the penal law, burglary in the second degree as defined in section 140.25 of the penal law, burglary in the first degree as defined in section 140.30 of the penal law, criminal mischief in the third degree as defined in section 145.05 of the penal law, criminal mischief in the second degree as defined in section 145.10 of the penal law, criminal mischief in the first degree as defined in section 145.12 of the penal law, criminal tampering in the first degree as defined in section 145.20 of the penal law, arson in the fourth degree as defined in section 150.05 of the penal law, arson in the third degree as defined in section 150.10 of the penal law, arson in the second degree as defined in section 150.15 of the penal law, arson in the first degree as defined in section 150.20 of the penal law, grand larceny in the fourth degree as defined in section 155.30 of the penal law, grand larceny in the third degree as defined in section 155.35 of the penal law, grand larceny in the second degree as defined in section 155.40 of the penal law, grand larceny in the first degree as defined in section 155.42 of the penal law, health care fraud in the fourth degree as defined in section 177.10 of the penal law, health care fraud in the third degree as defined in section 177.15 of the penal law, health care fraud in the second degree as defined in

section 177.20 of the penal law, health care fraud in the first degree as defined in section 177.25 of the penal law, robbery in the third degree as defined in section 160.05 of the penal law, robbery in the second degree as defined in section 160.10 of the penal law, robbery in the first degree as defined in section 160.15 of the penal law, unlawful use of secret scientific material as defined in section 165.07 of the penal law, criminal possession of stolen property in the fourth degree as defined in section 165.45 of the penal law, criminal possession of stolen property in the third degree as defined in section 165.50 of the penal law, criminal possession of stolen property in the second degree as defined by section 165.52 of the penal law, criminal possession of stolen property in the first degree as defined by section 165.54 of the penal law, trademark counterfeiting in the second degree as defined in section 165.72 of the penal law, trademark counterfeiting in the first degree as defined in section 165.73 of the penal law, forgery in the second degree as defined in section 170.10 of the penal law, forgery in the first degree as defined in section 170.15 of the penal law, criminal possession of a forged instrument in the second degree as defined in section 170.25 of the penal law, criminal possession of a forged instrument in the first degree as defined in section 170.30 of the penal law, criminal possession of forgery devices as defined in section 170.40 of the penal law, falsifying business records in the first degree as defined in section 175.10 of the penal law, tampering with public records in the first degree as defined in section 175.25 of the penal law, offering a false instrument for filing in the first degree as defined in section 175.35 of the penal law, issuing a false certificate as defined in section 175.40 of the penal law, criminal diversion of prescription medications and prescriptions in the second degree as

defined in section 178.20 of the penal law, criminal diversion of prescription medications and prescriptions in the first degree as defined in section 178.25 of the penal law, residential mortgage fraud in the fourth degree as defined in section 187.10 of the penal law, residential mortgage fraud in the third degree as defined in section 187.15 of the penal law, residential mortgage fraud in the second degree as defined in section 187.20 of the penal law, residential mortgage fraud in the first degree as defined in section 187.25 of the penal law, escape in the second degree as defined in section 205.10 of the penal law, escape in the first degree as defined in section 205.15 of the penal law, absconding from temporary release in the first degree as defined in section 205.17 of the penal law, promoting prison contraband in the first degree as defined in section 205.25 of the penal law, hindering prosecution in the second degree as defined in section 205.60 of the penal law, hindering prosecution in the first degree as defined in section 205.65 of the penal law, sex trafficking as defined in section 230.34 of the penal law, sex trafficking of a child as defined in section 230.34-a of the penal law, criminal possession of a weapon in the third degree as defined in subdivisions two, three and five of section 265.02 of the penal law, criminal possession of a weapon in the second degree as defined in section 265.03 of the penal law, criminal possession of a weapon in the first degree as defined in section 265.04 of the penal law, manufacture, transport, disposition and defacement of weapons and dangerous instruments and appliances defined as felonies in subdivisions one, two, and three of section 265.10 of the penal law, sections 265.11, 265.12 and 265.13 of the penal law, or prohibited use of weapons as defined in subdivision two of section 265.35 of the penal law, relating to firearms and other dangerous weapons, or failure to

disclose the origin of a recording in the first degree as defined in section 275.40 of the penal law;

§ 11. Subdivision 1 of section 673 of the county law, as added by chapter 545 of the laws of 1965, is amended to read as follows:

1. A coroner or medical examiner has jurisdiction and authority to investigate the death of every person dying within his county, or whose body is found within the county, which is or appears to be:

(a) A violent death, whether by criminal violence, suicide or casualty;

(b) A death caused by unlawful act or criminal neglect;

(c) A death occurring in a suspicious, unusual or unexplained manner;

(d) [A death caused by suspected criminal abortion;

(e)] A death while unattended by a physician, so far as can be discovered, or where no physician able to certify the cause of death as provided in the public health law and in form as prescribed by the commissioner of health can be found;

[(f)] (e) A death of a person confined in a public institution other than a hospital, infirmary or nursing home.

§ 12. Section 4 of the judiciary law, as amended by chapter 264 of the laws of 2003, is amended to read as follows:

§ 4. Sittings of courts to be public. The sittings of every court within this state shall be public, and every citizen may freely attend the same, except that in all proceedings and trials in cases for divorce, seduction, [abortion,] rape, assault with intent to commit rape, criminal sexual act, bastardy or filiation, the court may, in its discretion, exclude therefrom all persons who are not directly interested therein, excepting jurors, witnesses, and officers of the court.

§ 13. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, that shall not affect the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act, which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 14. This act shall take effect immediately.

PART T

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

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

TITLE VII

NY STATE OF HEALTH

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

legislature declares the intent that the Marketplace continue to be properly integrated with insurance affordability programs, including Medicaid, child health plus and the basic health program, and such other health insurance programs as determined by the commissioner.

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

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

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

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

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

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

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

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

(d) workers' compensation or similar insurance;

(e) automobile no-fault insurance;

(f) credit insurance;

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

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

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

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

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

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

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

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

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

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

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

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

(b) resides in this state;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. In accordance with applicable federal and state law, inform individuals of eligibility requirements for the Medicaid program under title XIX of the social security act and the social services law, the 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.

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

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

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

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

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

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

(a) The insurer offering the health plan:

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

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

require additional benefit levels to be offered by all insurers partic-
ipating in the Marketplace;

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

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

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

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

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

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

(ii) provides at least a bronze level of coverage as defined by state law, unless the plan is certified as a qualified catastrophic plan, as

defined in section 1302(e) of the federal act and the insurance law, and shall only be offered to individuals eligible for catastrophic coverage;

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

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

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

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

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

2. The Marketplace shall not exclude a health plan:

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

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

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

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

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

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

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment and disenrollment;

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

(E) data on rating practices;

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

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

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

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

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

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

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

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

(b) The qualified dental plan or dental plan approved for sale by the department of financial services and/or the department shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric

dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the Marketplace or secretary may specify in regulations.

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

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

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

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

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

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

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

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

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

(i) An initial determination of eligibility, including:

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

(B) eligibility for Medicaid;

(C) eligibility for Child Health Plus;

(D) eligibility for the Basic Health Program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The marketplace advisory committee shall consist of up to twenty-eight members appointed by the commissioner, representative of each geographic area of the state and including:

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

(i) health plan consumer advocates;

(ii) small business consumer representatives;

(iii) health care provider representatives;

(iv) representatives of the health insurance industry;

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

(i) licensed insurance producers; and

(ii) representatives of labor organizations.

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

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

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

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

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, upon request of the director of the budget, in consultation with the commissioner, the superintendent and the executive director of the Marketplace, the comptroller is hereby authorized and directed to sub-allocate or transfer special revenue federal funds appropriated to the department for planning and implementing various healthcare and insurance reform initiatives authorized by applicable law. Marketplace moneys sub-allocated or transferred pursuant to this section shall be paid out of the fund upon audit and warrant

of the state comptroller on vouchers certified or approved by the Marketplace.

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

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

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

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

§ 4. This act shall take effect immediately.

PART U

Section 1. Section 203 of the elder law is amended by adding a new subdivision 12 to read as follows:

12. The director is hereby authorized to implement private pay protocols for all programs administered by the office. These protocols may be implemented by area agencies on aging at their option and such protocols may not be applied to clients whose services are paid for with federal funds or funds designated as federal match. All private payments received directly by an area agency on aging or indirectly by one of its contractors shall be used to supplement, not supplant, funds by state,

federal, or county appropriations. Private pay payments received under this subdivision shall be used by the area agency on aging to support and enhance services or programs provided by the area agency on aging. Participant payments under this subdivision shall not be required of individuals with incomes below four hundred percent of the federal poverty level. No participant, regardless of income, shall be required to pay for any service that they are receiving at the time these protocols are implemented by the area agency on aging. This subdivision shall not prevent cost sharing for the programs established pursuant to section two hundred fourteen of this title for individuals below four hundred percent of the federal poverty level.

§ 2. This act shall take effect immediately.

PART V

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

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

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

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

34. Any payment made pursuant to the state's managed care program, including payments made by managed long term care plans, shall be deemed a payment by the state's medical assistance program.

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

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

(b) The Medicaid inspector general shall conduct periodic reviews of the contractual performance of each managed care provider as it relates to the managed care provider's program integrity obligations under its contract with the department. The Medicaid inspector general, in consultation with the commissioner, shall publish a list of those contractual obligations which may be subject to review and how they shall be evaluated, including benchmarks, prior to commencing any review.

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

(d) The managed care provider shall be entitled to receive a draft audit report and final audit report containing the results of the Medi-

caid inspector general's review. If the Medicaid inspector general determines to recover a percentage of the premium as described in paragraph (c) of this subdivision, the managed care provider shall have an opportunity to be heard in accordance with section twenty-two of this chapter.

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

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

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

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

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

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

§ 5. Section 3613 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-a. Each home care services worker shall obtain an individual National Provider Identifier (NPI) number from the National Provider Plan and Provider Enumeration System (NPPES).

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

35. Recovery of overpayments from network providers. (a) Where the Medicaid inspector general during the course of an audit, investigation, or review, or the deputy attorney general for the Medicaid fraud control unit during the course of an investigation or prosecution for Medicaid fraud, identifies medical assistance overpayments made by a managed care provider or managed long term care plan to its subcontractor or subcontractors or provider or providers, the state shall have the right to recover the overpayment from the subcontractor or subcontractors, provider or providers, or the managed care provider or managed long term care plan.

(b) Where the state is unsuccessful in recovering an overpayment from the subcontractor or subcontractors or provider or providers, the 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-

sioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, [2019] 2022; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, [2019] 2022.

§ 2. This act shall take effect immediately.

PART X

Section 1. Subdivision 9 of section 730.10 of the criminal procedure law, as added by section 1 of part Q of chapter 56 of the laws of 2012, is amended to read as follows:

9. "Appropriate institution" means: (a) a hospital operated by the office of mental health or a developmental center operated by the office for people with developmental disabilities; [or] (b) a hospital licensed by the department of health which operates a psychiatric unit licensed by the office of mental health, as determined by the commissioner provided, however, that any such hospital that is not operated by the state shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner and the hospital; or (c) a mental health unit operating within a local correctional facility except those located within a city with a population of one million or more; provided however, that any such mental health unit operating within a local correctional facility shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner of mental health, director of community services and the sheriff

for the respective locality. Nothing in this article shall be construed as requiring a hospital or local correctional facility to consent to providing care and treatment to an incapacitated person at such hospital or local correctional facility. The commissioner of mental health shall promulgate regulations for demonstration programs at no more than two counties to implement restoration to competency within a local correctional facility. Subject to annual appropriation, the commissioner of mental health may, at such commissioner's discretion, make funds available for state aid grants to any county that develops and operates a mental health unit within a local correctional facility pursuant to this section. Nothing in this article shall be construed as requiring a hospital or local correctional facility to consent to providing care and treatment to an incapacitated person at such hospital or local correctional facility.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that this act shall expire and be deemed repealed March 31, 2024; effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

PART Y

Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section

1 of part AA of chapter 57 of the laws of 2018, are amended to read as
follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, 2016 and beginning April 1, 2017 and ending March 31, [2019] 2020, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement[, provided that the commissioners of the office for people with developmental disabilities, the office of mental health, and the office of alcoholism and substance abuse services shall not include a COLA beginning April 1, 2017 and ending March 31, 2019].

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [2019] 2020 and ending March 31, [2022] 2023, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2019; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART Z

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

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

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

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

(f) No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article sixteen

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

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

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

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

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

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

§ 5. This act shall take effect October 1, 2019; provided, however, that the commissioner of the department of health, the commissioner of

the office of mental health, the commissioner of the office of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities are authorized to issue any rule or regulation necessary for the implementation of this act on or before its effective date.

PART AA

Section 1. Paragraph (a) of subdivision 4 of section 488 of the social services law, as amended by section 2 of part MM of chapter 58 of the laws of 2015, is amended to read as follows:

(a) a facility or program in which services are provided and which is operated, licensed or certified by the office of mental health, the office for people with developmental disabilities or the office of alcoholism and substance abuse services, including but not limited to psychiatric centers, [inpatient psychiatric units of a general hospital,] developmental centers, intermediate care facilities, community residences, group homes and family care homes, provided, however, that such term shall not include a secure treatment facility as defined in section 10.03 of the mental hygiene law, services defined in subparagraph four of subdivision (a) of section 16.03 of the mental hygiene law, [or] services provided in programs or facilities that are operated by the office of mental health and located in state correctional facilities under the jurisdiction of the department of corrections and community supervision or services provided in a unit of a hospital, as defined in subdivision one of section twenty-eight hundred one of the public health law that is licensed or certified by the office of mental health or the office of alcoholism and substance abuse services;

§ 2. Paragraphs (c), (d) and (e) of subdivision 4 of section 488 of the social services law, as added by section 1 of part B of chapter 501 of the laws of 2012, paragraph (d) as amended by chapter 126 of the laws of 2014, and paragraph (e) as amended by chapter 83 of the laws of 2013, are amended to read as follows:

(c) adult care facilities, which shall mean adult homes or enriched housing programs licensed pursuant to article seven of this chapter: (i) (A) that have a licensed capacity of eighty or more beds; and (B) in which at least twenty-five percent of the residents are persons with serious mental illness as defined by subdivision fifty-two of section 1.03 of the mental hygiene law; (ii) but not including an adult home or enriched housing program which is authorized to operate fifty-five percent or more of its total licensed capacity of beds as assisted living program beds pursuant to section four hundred sixty-one-l of this chapter; or

(d) [any overnight, summer day and traveling summer day camps for children with developmental disabilities as defined in regulations promulgated by the commissioner of health; or

(e)] the New York state school for the blind and the New York state school for the deaf, which operate pursuant to articles eighty-seven and eighty-eight of the education law; an institution for the instruction of the deaf and the blind which has a residential component and is subject to the visitation of the commissioner of education pursuant to article eighty-five of the education law with respect to its day and residential components; special act school districts serving students with disabilities; or in-state private schools which have been approved by the commissioner of education for special education services or programs, and which have a residential program.

§ 3. This act shall take effect August 1, 2019 and shall apply to reports of abuse or neglect made on or after such date; provided that, any reports of abuse or neglect reported to the justice center prior to the effective date of this act shall be completed by the justice center.

PART BB

Section 1. This part enacts into law major components of legislation which are necessary to effectuate provisions relating to mental health and substance use disorder treatment. Each component is wholly contained within a Subpart identified as Subparts A through E. The effective date for each particular provision contained within such Subpart is set forth in the last section of such Subpart. Any provision in any section contained within a Subpart, including the effective date of the Subpart, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Subpart in which it is found. Section three of this Part sets forth the general effective date of this Part.

SUBPART A

Section 1. Paragraph 4 of subsection (i) of section 3216 of the insurance law is amended to read as follows:

(4) If a policy provides for reimbursement for psychiatric or psychological services or for diagnosis and treatment of mental[,nervous, or emotional disorders or ailments,] <u>health conditions</u> however defined in the policy, the insured shall be entitled to reimbursement for such

services, diagnosis or treatment whether performed by a physician, psychiatrist [or], a certified and registered psychologist, or a nurse practitioner when the services rendered are within the lawful scope of their practice.

§ 2. Subparagraph (B) of paragraph 25 of subsection (i) of section 3216 of the insurance law, as amended by section 38 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(B) Every policy that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. [Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per policy or calendar year per covered individual.] This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article

forty-nine of this chapter as well as[,] case management[,] and other managed care provisions.

§ 3. Items (i) and (iii) of subparagraph (C) of paragraph 25 of subsection (i) of section 3216 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

(i) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders[, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS)].

(iii) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided [or supervised] by a [behavior analyst certified pursuant to the behavior analyst certification board] person licensed, certified or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. [Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this paragraph shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.]

§ 4. Paragraph 25 of subsection (i) of section 3216 of the insurance law is amended by adding four new subparagraphs (H), (I), (J), and (K) to read as follows:

(H) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and

treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(I) The criteria for medical necessity determinations under the policy with respect to autism spectrum disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(J) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement; and

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy.

(K) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 5. Paragraph 30 of subsection (i) of section 3216 of the insurance law, as amended by section 1 of part B of chapter 71 of the laws of 2016, is amended to read as follows:

(30)(A) Every policy that provides hospital, major medical or similar comprehensive coverage [must] shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings [as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a)]. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. [Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

(B) Coverage provided under this paragraph may be limited to facilities in New York state [which are certified] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse, or chemical dependence treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(C) Coverage provided under this paragraph may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent

and that are consistent with those imposed on other benefits within a given policy.

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first [fourteen] twenty-one days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within [forty-eight hours] two business days of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [fourteen] twenty-one days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [fourteen] twenty-one day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. 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 policy.

(E) An insurer shall make available to any insured, prospective insured, or in-network provider, upon request, the criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits.

(F) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized

independent standard of current medical practice, such as the international classification of diseases.

(G) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 6. Paragraph 31 of subsection (i) of section 3216 of the insurance law, as added by chapter 41 of the laws of 2014 and subparagraph (E) as added by section 3 of part MM of chapter 57 of the laws of 2018, is amended to read as follows:

(31) (A) Every policy that provides medical, major medical or similar comprehensive-type coverage [must] shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. [Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

(B) Coverage under this paragraph may be limited to facilities in New York state [certified] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services [or licensed by such office as outpatient clinics or medically supervised ambulatory] to provide outpatient substance [abuse programs] use disorder services and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence substance abuse

treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

(C) Coverage provided under this paragraph may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given policy.

(D) A policy providing coverage for substance use disorder services pursuant to this paragraph shall provide up to twenty outpatient visits per policy or calendar year to an individual who identifies him or herself as a family member of a person suffering from substance use disorder and who seeks treatment as a family member who is otherwise covered by the applicable policy pursuant to this paragraph. The coverage required by this paragraph shall include treatment as a family member pursuant to such family member's own policy provided such family member:

(i) does not exceed the allowable number of family visits provided by the applicable policy pursuant to this paragraph; and

(ii) is otherwise entitled to coverage pursuant to this paragraph and such family member's applicable policy.

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, provided the facility notifies the insurer

of both the start of treatment and the initial treatment plan within [forty-eight hours] two business days. The facility shall perform clinical assessment of the patient at each visit, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. 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 policy.

(F) The criteria for medical necessity determinations under the policy with respect to outpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(G) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(H) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental 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

(v) a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(C) Coverage provided under this paragraph may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the policy; provided, however, no policy shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This subparagraph shall not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]

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

(35) (A) Every policy delivered or issued for delivery in this state that provides coverage for inpatient hospital care or coverage for physician services shall provide coverage for the diagnosis and treatment of mental health conditions as follows:

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the

office of mental health, or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

(ii) where the policy provides coverage for physician services, benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subparagraph (D) of paragraph four of subsection (1) of section three thousand two hundred twenty-one of this article, a nurse practitioner licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof.

(B) Coverage required by this paragraph may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy.

(C) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(D) The criteria for medical necessity determinations under the policy with respect to mental health benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(E) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(F) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(G) This subparagraph shall apply to hospitals in this state that are licensed by the office of mental health that are participating in the insurer's provider network. Where the policy 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 insurer 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 insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer 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 policy.

§ 9. Paragraphs 17, 19 and 20 of subsection 2 of section 3217-a of the insurance law, paragraph 17 as amended and paragraphs 19 and 20 as added by section 1 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph 21 is added to read as follows:

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of alcoholism and substance abuse

services, and any restrictions regarding the availability of the individual provider's services; and [in addition,] (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the insurer's website and the insurer shall update the website within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

(19) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) the amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; [and]

(20) information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[.]; and

(21) the most recent comparative analysis performed by the insurer to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under those acts.

§ 10. Subsection (b) of section 3217-b of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) No insurer subject to this article shall by contract, written policy [or], written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such insurer which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall an insurer subject to this article take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such insurer which may violate this chapter including paragraphs thirty, as added by chapter forty-one of the laws of 2014, thirty-one, thirty-one-a and thirty-five of subsection (i) of section thirty-two hundred sixteen and paragraphs five, six, seven, seven-a and seven-b of subsection (l) of section thirty-two hundred twenty-one of this article.

§ 11. Subparagraph (A) of paragraph 4 of subsection (l) of section 3221 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(A) Every insurer delivering a group policy or issuing a group policy for delivery, in this state, [which] that provides reimbursement for psychiatric or psychological services or for the diagnosis and treatment of mental[, nervous or emotional disorders and ailments] health conditions, however defined in such policy, by physicians, psychiatrists or psychologists, [must] shall make available and if requested by the policyholder provide the same coverage to insureds for such services when

performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

§ 12. Subparagraph (D) of paragraph 4 of subsection (l) of section 3221 of the insurance law, as amended by section 50 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state where the policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental[, nervous or emotional disorders and ailments] <u>health conditions</u>, however defined in such policy, by physicians, psychiatrists or psychologists, shall provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either: (i) three or more additional years experience in psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior that are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental

department, providing services for diagnosis or treatment of mental[, nervous or emotional disorders or ailments] health conditions; (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection (e) of this section, or (iii) a combination of the experience specified in items (i) and (ii) of this subparagraph totaling three years, satisfactory to the state board for social work.

§ 13. Subparagraphs (A) and (B) of paragraph 5 of subsection (l) of section 3221 of the insurance law, as amended by chapter 502 of the laws of 2007, are amended to read as follows:

(A) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services shall provide [as part of such policy broad-based] coverage for the diagnosis and treatment of mental[, nervous or emotional disorders or ailments, however defined in such policy, at least equal to the coverage provided for other] health conditions and:

(i) where the policy provides coverage for inpatient hospital care, benefits for inpatient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law[, which benefits may be limited to not less than thirty days of active treatment in any contract year, plan year or calendar year,] and benefits for outpatient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law, or in a facility operated by the office of mental health[, which benefits may be limited to not less than twenty

visits in any contract year, plan year or calendar year. Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day of treatment.] or, for care provided in other states, to similarly licensed or certified hospitals or facilities; and

(ii) where the policy provides coverage for physician services, it shall include benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subparagraph (D) of paragraph four of this subsection, a nurse practitioner licensed to practice in this state, or a professional corporation or university faculty practice corporation thereof. [Such benefits may be limited to not less than twenty visits in any contract year, plan year, or calendar year.]

[(iii)] (B) Coverage required by this paragraph may be [provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the policy. Such coverage may be] subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. [In the event that a policy provides coverage for both inpatient hospital care and physician services, the aggregate of the benefits for outpatient care obtained under this paragraph may be limited to not less than twenty visits in any contract year, plan year or calendar year.

(iv) In this paragraph, "active treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

(B) (i) Every insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which provides coverage for inpatient hospital care or coverage for physician services, shall provide comparable coverage for adults and children with biologically based mental illness. Such group policies issued or delivered in this state shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the policy, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a policy provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the policy is written under one license or two licenses.

(ii) For purposes of this paragraph, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, bulimia, and anorexia.] Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the policy.

§ 14. Subparagraphs (C), (D) and (E) of paragraph 5 of subsection (l) of section 3221 of the insurance law are REPEALED and five new subparagraphs (C), (D), (E), (F) and (G) are added to read as follows:

(C) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(D) The criteria for medical necessity determinations under the policy with respect to mental health benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(E) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treat-

ment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(F) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

(G) This subparagraph shall apply to hospitals in this state that are licensed by the office of mental health that are participating in the insurer's provider network. Where the policy 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 insurer 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 insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review criteria utilized by the insurer 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 policy.

§ 15. Subparagraphs (A), (B) and (D) of paragraph 6 of subsection (l) of section 3221 of the insurance law, as amended by section 2 of part B of chapter 71 of the laws of 2016, are amended and three new subparagraphs (E), (F) and (G) are added to read as follows:

(A) Every policy that provides hospital, major medical or similar comprehensive coverage [must] shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings [as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a)]. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. [Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

(B) Coverage provided under this paragraph may be limited to facilities in New York state [which are certified] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse or chemical depend-

ence treatment programs and are similarly licensed, certified, or otherwise authorized in the state in which the facility is located.

(D) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall also not be subject to concurrent utilization review during the first [fourteen] twenty-one days of the inpatient admission provided that the facility notifies the insurer of both the admission and the initial treatment plan within [forty-eight hours] two business days of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Any utilization review of treatment provided under this subparagraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [fourteen] twenty-one days of such inpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [fourteen] twenty-one day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. 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 policy.

(E) The criteria for medical necessity determinations under the policy with respect to inpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(F) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized

independent standard of current medical practice such as the international classification of diseases.

(G) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 16. Subparagraphs (A) and (B) of paragraph 7 of subsection (l) of section 3221 of the insurance law, as amended by chapter 41 of the laws of 2014, are amended and a new subparagraph (C-1) is added to read as follows:

(A) Every policy that provides medical, major medical or similar comprehensive-type coverage [must] shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. [Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

(B) Coverage under this paragraph may be limited to facilities in New York state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services [or licensed by such office as outpatient clinics or medically supervised ambulatory substance abuse programs] to provide outpatient substance use disorder services and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence treatment programs

and similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(C-1) A large group policy that provides coverage under this paragraph may not impose copayments or coinsurance for outpatient substance use disorder services that exceeds the copayment or coinsurance imposed for a primary care office visit. Provided that only one such copayment may be imposed for all services provided in a single day by a facility licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services to provide outpatient substance use disorder services.

§ 17. Subparagraph (E) of paragraph 7 of subsection (l) of section 3221 of the insurance law, as added by section 4 of part MM of chapter 57 of the laws of 2018, is amended and three new subparagraphs (F), (G) and (H) are added to read as follows:

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within [forty-eight hours] two business days. The facility shall perform clinical assessment of the patient at each visit, including the periodic consultation with the insurer to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the

insurer which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of alcoholism and substance abuse services. 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 policy.

(F) The criteria for medical necessity determinations under the policy with respect to outpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(G) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy; and

(iv) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(H) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 18. Paragraph 7-b of subsection (l) of section 3221 of the insurance law, as added by section 2 of part B of chapter 69 of the laws of 2016, is amended to read as follows:

(7-b) [(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] to 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 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

(v) a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(C) Coverage provided under this paragraph may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the policy; provided, however, no policy shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a

thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This subparagraph shall not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]

§ 19. Subparagraph (B) of paragraph 17 of subsection (l) of section 3221 of the insurance law, as amended by section 39 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(B) Every group or blanket policy that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the group or blanket policy. [Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per policy or calendar year per covered individual.] This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the group or blanket policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treat-

ment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as[,] case management[,] and other managed care provisions.

§ 20. Items (i) and (iii) of subparagraph (C) of paragraph 17 of subsection (l) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

(i) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders[, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS)].

(iii) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided [or supervised] by a [behavior analyst] <u>person licensed,</u> certified [pursuant to the behavior analyst certification board,] <u>or otherwise authorized to provide applied behavior analysis,</u> that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. [Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this paragraph shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.]

§ 21. Paragraph 17 of subsection (l) of section 3221 of the insurance law is amended by adding four new subparagraphs (H), (I), (J) and (K) to read as follows:

(H) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(I) The criteria for medical necessity determinations under the policy with respect to outpatient substance use disorder benefits shall be made available by the insurer to any insured, prospective insured, or in-network provider upon request.

(J) For purposes of this paragraph:

(i) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(ii) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement; and

(iii) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course

of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the policy.

(K) An insurer shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 22. Paragraphs 1, 2, and 3 of subsection (g) of section 4303 of the insurance law, as amended by chapter 502 of the laws of 2007, are amended to read as follows:

[(1)] A medical expense indemnity corporation, hospital service corporation or a health service corporation, [which] that provides group, group remittance or school blanket coverage for inpatient hospital care[,] or coverage for physician services shall provide as part of its contract [broad-based] coverage for the diagnosis and treatment of mental[, nervous or emotional disorders or ailments, however defined in such contract, at least equal to the coverage provided for other] health conditions and [shall include]:

[(A)]

(1) where the contract provides coverage for inpatient hospital care, benefits for in-patient care in a hospital as defined by subdivision ten of section 1.03 of the mental hygiene law[, which benefits may be limited to not less than thirty days of active treatment in any contract year, plan year or calendar year.

(B)] or for inpatient care provided in other states, to similarly licensed hospitals, and benefits for out-patient care provided in a facility issued an operating certificate by the commissioner of mental health pursuant to the provisions of article thirty-one of the mental hygiene law or in a facility operated by the office of mental health[,

which benefits may be limited to not less than twenty visits in any contract year, plan year or calendar year. Benefits for partial hospitalization program services shall be provided as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day of treatment.

(C) Such coverage may be provided on a contract year, plan year or calendar year basis and shall be consistent with the provision of other benefits under the contract.] or for out-patient care provided in other states, to similarly certified facilities; and

(2) where the contract provides coverage for physician services benefits for outpatient care provided by a psychiatrist or psychologist licensed to practice in this state, a licensed clinical social worker who meets the requirements of subsection (n) of this section, a nurse practitioner licensed to practice on this state, or professional corporation or university faculty practice corporation thereof.

(3) Such coverage may be subject to annual deductibles, co-pays and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. Provided that no copayment or coinsurance imposed for outpatient mental health services provided in a facility licensed, certified or otherwise authorized by the office of mental health shall exceed the copayments or coinsurance imposed for a primary care office visit under the contract.

[(D) For the purpose of this subsection, "active treatment" means treatment furnished in conjunction with in-patient confinement for mental, nervous or emotional disorders or ailments that meet such standards as shall be prescribed pursuant to the regulations of the commissioner of mental health.

(E) In the event the group remittance group or contract holder is provided coverage under this subsection and under paragraph one of subsection (h) of this section from the same health service corporation, or under a contract that is jointly underwritten by two health service corporations or by a health service corporation and a medical expense indemnity corporation, the aggregate of the benefits for outpatient care obtained under subparagraph (B) of this paragraph and paragraph one of subsection (h) of this section may be limited to not less than twenty visits in any contract year, plan year or calendar year.

(2) (A) A hospital service corporation or a health service corporation, which provides group, group remittance or school blanket coverage for inpatient hospital care, shall provide comparable coverage for adults and children with biologically based mental illness. Such hospital service corporation or health service corporation shall also provide such comparable coverage for children with serious emotional disturbances. Such coverage shall be provided under the terms and conditions otherwise applicable under the contract, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles or other specific cost sharing mechanisms. Provided further, where a contract provides both in-network and out-of-network benefits, the out-of-network benefits may have different coinsurance, co-pays, or deductibles, than the in-network benefits, regardless of whether the contract is written under one license or two licenses.

(B) For purposes of this subsection, the term "biologically based mental illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based

mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorders, anorexia, and bulimia.

(3) For purposes of this subsection, the term "children with serious emotional disturbances" means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

(A) serious suicidal symptoms or other life-threatening self-destructive behaviors;

(B) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);

(C) behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or

(D) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.]

§ 23. Paragraphs 4 and 5 of subsection (g) of section 4303 of the insurance law are REPEALED and five new paragraphs 4, 5, 6, 7 and 8 are added to read as follows:

(4) Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract.

(5) The criteria for medical necessity determinations under the contract with respect to mental health benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(6) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "mental health condition" means any mental health disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(7) A corporation shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 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-

nosis and treatment of [mental, nervous or emotional disorders and ailments] mental health conditions, however defined in such contract, [must] shall make available and if requested by all persons holding individual contracts in a group whose premiums are paid by a remitting agent or by the contract holder in the case of a group contract issued pursuant to section four thousand three hundred five of this article, provide the same coverage for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to article one hundred fifty-four of the education law. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection. Such coverage shall be made available at the inception of all new contracts and, with respect to all other contracts, at any anniversary date subject to evidence of insurability. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract and annually thereafter, except that this notice shall not be required where a [policy] contract covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

§ 26. Subsection (k) of section 4303 of the insurance law, as amended by section 3 of part B of chapter 71 of the laws of 2016, is amended to read as follows:

(k)(1) Every contract that provides hospital, major medical or similar comprehensive coverage [must] shall provide inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such inpatient coverage shall include unlimited medically necessary treatment for substance use disorder

treatment services provided in residential settings [as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a)]. Further, such inpatient coverage shall not apply financial requirements or treatment limitations, including utilization review requirements, to inpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract. [Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

(2) Coverage provided under this subsection may be limited to facilities in New York state [which are certified] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission as alcoholism, substance abuse, or chemical dependence treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3) Coverage provided under this subsection may be subject to annual deductibles and co-insurance as deemed appropriate by the superintendent and that are consistent with those imposed on other benefits within a given contract.

(4) This paragraph shall apply to facilities in this state [certified] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall also not be subject to concurrent utilization review during the first [fourteen] twenty-one days of the inpatient admission

provided that the facility notifies the corporation of both the admission and the initial treatment plan within [forty-eight hours] two business days of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient. Any utilization review of treatment provided under this paragraph may include a review of all services provided during such inpatient treatment, including all services provided during the first [fourteen] twenty-one days of such inpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial [fourteen] twenty-one day inpatient treatment on the basis that such treatment was not medically necessary if such inpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. An insured shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(5) The criteria for medical necessity determinations under the contract with respect to inpatient substance use disorder benefits shall be made available by the corporation to any insured, prospective insured or in-network provider upon request.

(6) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement;

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(7) A corporation shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 27. Paragraphs 1 and 2 of subsection (l) of section 4303 of the insurance law, as amended by chapter 41 of the laws of 2014, are amended and a new paragraph 3-a is added to read as follows:

(1) Every contract that provides medical, major medical or similar comprehensive-type coverage [must] shall provide outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. Such coverage shall not apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the contract. [Further, such coverage shall be provided consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).]

(2) Coverage under this subsection may be limited to facilities in New York state that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services [or licensed by such office as outpatient clinics or medically supervised ambulatory] to provide outpatient substance [abuse programs] use disorder services and, in other states, to those which are accredited by the joint commission as alcoholism or chemical dependence substance abuse treatment programs and are similarly licensed, certified or otherwise authorized in the state in which the facility is located.

(3-a) A contract that provides large group coverage that provides coverage for outpatient substance use disorder services under this subsection may not impose copayments or coinsurance for outpatient substance use disorder services that exceed the copayment or coinsurance imposed for a primary care office visit. Provided that only one such copayment may be imposed for all services provided in a single day by a facility licensed, certified or otherwise authorized by the office of

alcoholism and substance abuse services to provide outpatient substance use disorder services.

§ 28. Paragraph 5 of subsection (l) of section 4303 of the insurance law, as added by section 5 of part MM of chapter 57 of the laws of 2018, is amended and three new paragraphs 6, 7 and 8 are added to read as follows:

(5) This paragraph shall apply to facilities in this state [certified] that are licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within [forty-eight hours] two business days. The facility shall perform clinical assessment of the patient at each visit, including the periodic consultation with the corporation to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, of such outpatient treatment. Provided, however, the

corporation shall only deny coverage for any portion of the initial [two] three weeks of continuous treatment, not to exceed [fourteen] twenty-one visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of alcoholism and substance abuse services. A subscriber shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

(6) The criteria for medical necessity determinations under the contract with respect to outpatient substance use disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(7) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement.

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determin-

ing usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract; and

(D) "substance use disorder" shall have the meaning set forth in the most recent edition of the diagnostic and statistical manual of mental disorders or the most recent edition of another generally recognized independent standard of current medical practice such as the international classification of diseases.

(8) A corporation shall provide coverage under this paragraph, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 29. Subsection (1-2) of section 4303 of the insurance law, as added by section 3 of part B of chapter 69 of the laws of 2016, is amended to read as follows:

(1-2) [(1)] Every contract 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 contract 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 contract prescribed or dispensed to an individual covered by the contract.

[(2) 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

(v) a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(3) Coverage provided under this subsection may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the contract; provided, however, no contract shall impose an additional copayment or coinsurance on an insured who received an emergency supply of medication and then received up to a thirty day supply of the same medication in the same thirty day period in which the emergency supply of medication was dispensed. This paragraph shall not preclude the imposition of a copayment or coinsurance on the initial limited supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a thirty day supply of such medication, provided that the total sum of the copayments or coinsurance for an entire thirty day supply of the medication

does not exceed the copayment or coinsurance otherwise applicable to a thirty day supply of such medication.]

§ 30. Subsection (n) of section 4303 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(n) In addition to the requirements of subsection (i) of this section, every health service or medical expense indemnity corporation issuing a group contract pursuant to this section or a group remittance contract for delivery in this state which contract provides reimbursement to subscribers or physicians, psychiatrists or psychologists for psychiatric or psychological services or for the diagnosis and treatment of [mental, nervous or emotional disorders and ailments,] mental health conditions, however defined in such contract, must provide the same coverage to persons covered under the group contract for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either (i) three or more additional years experience in psychotherapy, which for the purposes of this subsection shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior which are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of [mental, nervous or emotional disorders or ailments,] mental health conditions, or (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clin-

ical social worker qualified for reimbursement pursuant to subsection (i) of this section, or (iii) a combination of the experience specified in paragraphs (i) and (ii) totaling three years, satisfactory to the state board for social work. The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under this subsection.

§ 31. Paragraph 2 of subsection (ee) of section 4303 of the insurance law, as amended by section 40 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(2) Every contract that provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the contract because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. [Coverage for applied behavior analysis shall be subject to a maximum benefit of six hundred eighty hours of treatment per contract or calendar year per covered individual.] This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the contract, provided however that such contract shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for

autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as[,] case management[,] and other managed care provisions.

§ 32. Subparagraphs (A) and (C) of paragraph 3 of subsection (ee) of section 4303 of the insurance law, as amended by chapter 596 of the laws of 2011, are amended to read as follows:

(A) "autism spectrum disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders[, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified (PDD-NOS)].

(C) "behavioral health treatment" means counseling and treatment programs, when provided by a licensed provider, and applied behavior analysis, when provided [or supervised] by a [behavior analyst certified pursuant to the behavior analyst certification board] person that is licensed, certified or otherwise authorized to provide applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. [Individuals that provide behavioral health treatment under the supervision of a certified behavior analyst pursuant to this subsection shall be subject to standards of professionalism, supervision and relevant experience pursuant to regulations promulgated by the superintendent in consultation with the commissioners of health and education.]

§ 33. Subsection (ee) of section 4303 of the insurance law is amended by adding four new paragraphs 8, 9, 10, and 11 to read as follows:

(8) Coverage under this paragraph shall not apply financial requirements or treatment limitations to autism spectrum disorder benefits that

are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.

(9) The criteria for medical necessity determinations under the contract with respect to autism spectrum disorder benefits shall be made available by the corporation to any insured, prospective insured, or in-network provider upon request.

(10) For purposes of this subsection:

(A) "financial requirement" means deductible, copayments, coinsurance and out-of-pocket expenses;

(B) "predominant" means that a financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement; and

(C) "treatment limitation" means limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment and includes nonquantitative treatment limitations such as: medical management standards limiting or excluding benefits based on medical necessity, or based on whether the treatment is experimental or investigational; formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the contract.

(11) A corporation shall provide coverage under this subsection, at a minimum, consistent with the federal Paul Wellstone and Pete Domenici

Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

§ 34. Paragraphs 17, 20 and 21 of subsection (a) of section 4324 of the insurance law, paragraph 17 as amended and paragraphs 20 and 21 as added by section 8 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph 22 is added to read as follows:

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, [and in addition,] and: (A) whether the provider is accepting new patients; (B) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of alcoholism and substance abuse services, and any restrictions regarding the availability of the individual provider's services; (C) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the corporation's website and the corporation shall update the website within fifteen days of the addition or termination of a provider from the corporation's network or a change in a physician's hospital affiliation;

(20) with respect to out-of-network coverage:

(A) a clear description of the methodology used by the corporation to determine reimbursement for out-of-network health care services;

(B) a description of the amount that the corporation will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

(C) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; [and]

(21) information in writing and through an internet website that reasonably permits a subscriber or prospective subscriber to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the corporation will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[.]; and

(22) the most recent comparative analysis performed by the corporation to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031 (j), and any amendments to, and federal guidance or regulations issued under, those Acts.

§ 35. Subsection (b) of section 4325 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) No corporation organized under this article shall by contract, written policy [or], written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such corporation which the provider believes may negatively impact upon the quality of or access to patient care. Nor shall a corporation organized under this article take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such corporation which may violate this chapter including subsection (g), (k),

(1), (1-1) or (1-2) of section forty-three hundred three of this article.

§ 36. Subparagraph (C) of paragraph 1 of subsection (b) of section 4900 of the insurance law, as added by chapter 41 of the laws of 2014, is amended and a new subparagraph (D) is added to read as follows:

(C) for purposes of a determination involving substance use disorder treatment:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; [and] or

(D) for purposes of a determination involving treatment for a mental health condition:

(i) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses or treatment; or

(ii) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration

or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; and

§ 37. Paragraph 9 of subsection (a) of section 4902 of the insurance law, as amended by section 1 of part A of chapter 69 of the laws of 2016, is amended to read as follows:

(9) 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.

§ 38. Subsection (a) of section 4902 of the insurance law is amended by adding a new paragraph 12 to read as follows:

(12) 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 of health and the superintendent. Approved clinical review criteria shall have inter rater reliability testing completed by December thirty-first, two thousand nineteen.

§ 39. Paragraph (b) of subsection 5 of section 4403 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) The following criteria shall be considered by the commissioner at the time of a review: (i) the availability of appropriate and timely care that is provided in compliance with the standards of the Federal Americans with Disability Act to assure access to health care for the enrollee population; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population; [and] (iii) the availability of appropriate and timely care that is in compliance with the standards of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance and regulations issued under those Acts, which shall include an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services; and (iv) with the exception of initial licensure, the number of grievances filed by enrollees relating to waiting times for appointments, appropriateness of referrals and other indicators of plan capacity.

§ 40. Subdivision 3 of section 4406-c of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

3. No health care plan shall by contract, written policy [or], written procedure or practice prohibit or restrict any health care provider from filing a complaint, making a report or commenting to an appropriate governmental body regarding the policies or practices of such health care plan which the provider believes may negatively impact upon the quality of, or access to, patient care. Nor shall a health care plan take any adverse action, including but not limited to refusing to renew or execute a contract or agreement with a health care provider as retaliation against a health care provider for filing a complaint, making a report or commenting to an appropriate governmental body regarding policies or practices of such health care plan which may violate this chapter or the insurance law including subsection (g), (k), (l), (l-1) or (l-2) of section forty-three hundred three of the insurance law.

§ 41. Paragraphs (r), (t) and (u) of subdivision 1 of section 4408 of the public health law, paragraph (r) as amended and paragraphs (t) and (u) as added by section 18 of part H of chapter 60 of the laws of 2014, are amended and a new paragraph (v) is added to read as follows:

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, [and, in addition,] and: (i) whether the provider is accepting new patients; (ii) in the case of mental health or substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of alcoholism and substance abuse services, and any restrictions regarding the availability of the individual provider's services; and (iii) in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the health maintenance

organization's website and the health maintenance organization shall update the website within fifteen days of the addition or termination of a provider from the health maintenance organization's network or a change in a physician's hospital affiliation;

(t) with respect to out-of-network coverage:

(i) a clear description of the methodology used by the health maintenance organization to determine reimbursement for out-of-network health care services;

(ii) the amount that the health maintenance organization will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services;

(iii) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; [and]

(u) information in writing and through an internet website that reasonably permits an enrollee or prospective enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health maintenance organization will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services[.]; and

(v) the most recent comparative analysis performed by the health maintenance organization to assess the provision of its covered services in accordance with the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j) and any amendments to, and federal guidance and regulations issued under, those Acts.

§ 42. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 4900 of the public health law, as added by chapter 41 of the laws of

2014, is amended and a new subparagraph (iv) is added to read as follows:

(iii) for purposes of a determination involving substance use disorder treatment:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of substance use disorder courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession; [and] or

(iv) for purposes of a determination involving treatment for a mental health condition:

(A) a physician who possesses a current and valid non-restricted license to practice medicine and who specializes in behavioral health and has experience in the delivery of mental health courses of treatment; or

(B) a health care professional other than a licensed physician who specializes in behavioral health and has experience in the delivery of a mental health courses of treatment and, where applicable, possesses a current and valid non-restricted license, certificate, or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to 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.

§ 44. This act shall take effect on the first of January next succeeding the date on which it shall have become a law and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date; provided, however, notwithstanding any provision of law to the contrary, nothing in this act shall limit the rights accruing to employees pursuant to a collective bargaining agreement with any state or local government employer for the unexpired term of such agreement where such agreement is in effect on the effective date of this act and so long as such agreement remains in effect thereafter or the eligibility of any member of an employee organization to join a health insurance plan open to him or her pursuant to such a collectively negotiated agreement.

SUBPART B

Section 1. Subdivision 1 of section 2803-u of the public health law, as added by section 1 of part C of chapter 70 of the laws of 2016, is amended to read as follows:

1. The office of alcoholism and substance abuse services, in consultation with the department, shall develop or utilize existing educational materials to be provided to general hospitals to disseminate to individuals with a documented substance use disorder or who appear to have or be at risk for a substance use disorder during discharge planning pursuant to section twenty-eight hundred three-i of this [chapter] article. Such materials shall include information regarding the various types of treatment and recovery services, including but not limited to: inpatient, outpatient, and medication-assisted treatment; how to recognize the need for treatment services; information for individuals to deter-

mine what type and level of treatment is most appropriate and what resources are available to them; and any other information the commissioner deems appropriate. General hospitals shall include in their policies and procedures treatment protocols, consistent with medical standards, to be utilized by the emergency departments in general hospitals for the appropriate use of medication-assisted treatment, including buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department of a general hospital is not feasible.

§ 2. This act shall take effect immediately.

SUBPART C

Section 1. Subparagraph (v) of paragraph (a) of subdivision 2 of section 3343-a of the public health law is REPEALED and subparagraphs (vi), (vii), (viii), (ix) and (x) are renumbered subparagraphs (v), (vi), (vii), (viii) and (ix).

§ 2. This act shall take effect immediately.

SUBPART D

Section 1. Paragraph (r) of subdivision 4 of section 364-j of the social services law, as amended by section 39 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(r) A managed care provider shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal

social security act, provided that services for a substance use disorder shall be provided by a program licensed, certified or otherwise authorized by the office of alcoholism and substance abuse services.

§ 2. This act shall take effect immediately; provided, however that the amendments to paragraph (r) of subdivision 4 of section 364-j of the social services law made by section one of this act shall not affect the repeal of such section and shall be deemed to be repealed therewith.

SUBPART E

Section 1. Subdivision (b) of schedule I of section 3306 of the public health law is amended by adding nineteen new paragraphs 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75 and 76 to read as follows:

(58) N-(1-phenethylpiperidin-4-y1)-N-phenylbutyramide. Other name: Butyryl Fentanyl.

(59) N-[1-[2-hydroxy-2-(thiophen-2-yl)ethyl]piperidin-4-y1]-N-phenylpropionamide. Other name: Beta-Hydroxythiofentanyl.

(60) N-(1-phenethylpiperidin-4-y1)-N-phenylfuran-2-carboxamide. Other name: Furanyl Fentanyl.

(61) 3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide. Other name: U-47700.

(62) N-(1-phenethylpiperidin-4-y1)-N-phenylacrylamide. Other names: Acryl Fentanyl or Acryloylfentanyl.

(63) N-(4-fluoropheny1)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl.

(64) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: ortho-fluorofentanyl or 2-fluorofentanyl.

(65) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide. Other name: tetrahydrofuranyl fentanyl.

(66) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other name: methoxyacetyl fentanyl.

(67) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide. Other name: cyclopropyl fentanyl.

(68) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide. Other name: Valeryl fentanyl.

(69) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-fluorobutyrylfentanyl.

(70) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide. Other name: para-methoxybutyryl fentanyl.

(71) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide. Other name: para-chloroisobutyryl fentanyl.

(72) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide. Other name: isobutyryl fentanyl.

(73) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide. Other name: cyclopentyl fentanyl.

(74) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl) acetamide. Other name: Ocfentanil.

(75) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine. Other name: MT-45.

(76) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers, esters and ethers.

(i) Fentanyl-related substance means any substance not otherwise listed in this section, that is structurally related to fentanyl by one or more of the following modifications:

(A) Replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle;

(B) Substitution in or on the phenethyl group with alkyl, alkenyl, alkoxyl, hydroxyl, halo, haloalkyl, amino or nitro groups;

(C) Substitution in or on the piperidine ring with alkyl, alkenyl, alkoxyl, ester, ether, hydroxyl, halo, haloalkyl, amino or nitro groups;

(D) Replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle; and/or

(E) Replacement of the N-propionyl group by another acyl group.

§ 2. Section 3308 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. The commissioner may, by regulation, classify as a Schedule I controlled substance in section three thousand three hundred six of this article any substance listed in Schedule I of the federal schedules of controlled substances in 21 USC §812 or 21 CFR §1308.11.

§ 3. This act shall take effect on the ninetieth day after it shall have become a law.

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

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

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

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