

**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
PROPOSED
11 NYCRR PART 230
(INSURANCE REGULATION 218)**

MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY COMPLIANCE PROGRAM

I, Linda A. Lacewell, Superintendent of Financial Services, pursuant to the authority granted by Sections 202 and 302 of the Financial Services Law and Sections 301, 316, 1124, 3201, 3216, 3217, 3221, and Articles 43 and 47 of the Insurance Law, do hereby promulgate Part 230 of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Insurance Regulation 218), to take effect 90 days after publication of the Notice of Adoption in the State Register, to read as follows:

(ALL MATERIAL IS NEW)

A new Part 230 is added to read as follows:

- Section 230.0 Preamble.
- Section 230.1 Applicability.
- Section 230.2 Definitions.
- Section 230.3 Mental health and substance use disorder parity compliance program.

§ 230.0 Preamble.

The purpose of this Part is to establish mental health and substance use disorder parity compliance program requirements to ensure that insurers are providing comparable coverage for benefits to treat mental health and substance use disorder as required under both state and federal law. This Part requires that such compliance programs establish corporate governance for parity compliance, identify discrepancies in coverage of services for the treatment of mental health conditions and substance use disorder, and ensure appropriate identification and remediation of improper practices.

§ 230.1 Applicability.

This Part shall apply to all insurers offering coverage that is subject to the mental health and substance use disorder requirements under Insurance Law sections 3216, 3221, and 4303.

§ 230.2 Definitions.

As used in this Part:

(a) *Benefit classification* means the following classifications of medical and surgical benefits and mental health and substance use disorder benefits for purposes of complying with the MHPAEA: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs. Provided, however, the outpatient classification includes any subclassification of office visits.

(b) *Comparative analysis means* an analysis of the nonquantitative treatment limitations imposed on mental health or substance use disorder benefits to determine if such limitations are comparable to and applied no more stringently than, both as written and in operation, nonquantitative treatment limitations imposed on medical or surgical benefits within the same benefit classification. Comparative analysis includes the documented identification and assessment of the factors, processes, strategies, and evidentiary standards the insurer relied upon to determine the applicability and design of a nonquantitative treatment limitation and the processes and strategies the insurer used in operationalizing a nonquantitative treatment limitation to illustrate insurer compliance with MHPAEA.

(c) *Compliance program* means a mental health and substance use disorder parity compliance program.

(d) *Financial requirements* means deductibles, copayments, coinsurance, and out-of-pocket maximums.

(e) *Insurer* means an insurer authorized to write accident and health insurance in this State, a corporation organized pursuant to Insurance Law Article 43, student health plans certified pursuant to Insurance Law section 1124, and municipal cooperative health benefit plans certified pursuant to Insurance Law Article 47 and a health maintenance organization certified pursuant to Public Health Law Article 44.

(f) *Latency period* means the period of time that must elapse between the time at which a dose of drug is applied to a biologic system and the time at which a specified pharmacologic effect is produced.

(g) *MHPAEA* means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, codified at 29 U.S.C. section 1185a, and its implementing regulations and sub-regulatory guidance.

(h) *Nonquantitative treatment limitation* means a qualitative limit affecting the scope or duration of benefits 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.

(i) *Provider* means a physician, health care professional, or facility licensed, registered, certified, or otherwise authorized or accredited as required by state law.

(j) *Quantitative treatment limitation* means a numerical limit affecting the scope or duration of benefits.

§ 230.3 Mental health and substance use disorder parity compliance program.

(a) Every insurer shall adopt and implement a compliance program that shall include, at a minimum:

(1) designation of an appropriately experienced individual who shall:

(i) be responsible for assessing, monitoring, and managing parity compliance;

(ii) report directly to the insurer's chief executive officer or other senior manager; and

(iii) report no less than annually to the insurer's board of directors or other governing body, or the appropriate committee thereof, on the activities of the compliance program;

(2) written policies and procedures that implement the compliance program, and describe how the insurer's parity compliance is assessed, monitored, and managed, including:

(i) a system for assigning each benefit to the defined benefit classifications as required by MHPAEA;

(ii) methodologies for the identification and testing of all financial requirements and quantitative treatment limitations; and

(iii) methodologies for the identification and testing, including a comparative analysis, of all non-quantitative treatment limitations that are imposed on mental health or substance use disorder benefits;

(3) methodologies for the identification and remediation of improper practices, as described in paragraph (1) of subdivision (b) of this section;

(4) a system for the ongoing assessment of parity compliance, which shall include:

(i) review of a statistically valid sample of preauthorization, concurrent, and retrospective review denials for mental health and substance use disorder benefits to ensure such determinations were consistent with the clinical review criteria approved by the commissioner of mental health or designated by the commissioner of addiction services and supports, in consultation with the superintendent and commissioner of health, and that such criteria have been applied comparably to and no more stringently than criteria applied to medical or surgical benefits;

(ii) review of the comparability of coverage within each benefit classification for mental health and substance use disorder benefits to ensure that coverage for a comparable continuum of services is available for mental health and substance use disorder benefits as is available for medical or surgical benefits, including residential and outpatient rehabilitation services;

(iii) review of the percentage of services provided by out-of-network providers for mental health and substance use disorder benefits where no in-network provider was available compared to the percentage of services provided by out-of-network providers for medical and surgical benefits where no in-network provider was available, to ensure that the processes and strategies for the recruitment and retention of mental health or substance use disorder providers are effective in reducing disparities in out-of-network use;

(iv) review of provider credentialing policies and procedures to ensure that the documentation and qualifications required for credentialing mental health and substance use disorder providers are comparable to and applied no more stringently than the documentation and qualifications required for credentialing medical or surgical providers;

(v) review of the average length of time to negotiate provider agreements and negotiated reimbursement rates with network providers and methods for the determination of usual, customary and reasonable charges, to ensure that reimbursement rates for mental health and substance use disorder benefits are established using standards that are comparable to and applied no more stringently than the standards used for medical or surgical benefits;

(vi) review of insurer policies for the automatic or systematic non-payment or down-coding of Current Procedural Terminology codes used for mental health and substance use disorder benefits to ensure that they are comparable to and applied no more than stringently than insurer policies for the automatic or systematic non-payment or down-coding of Current Procedural Terminology codes used for medical or surgical benefits;

(vii) review of all mental health and substance use disorder medications subject to nonquantitative treatment limitations, including step-therapy protocols or other preauthorization requirements, to ensure that the factors, such as cost and latency periods, processes, strategies, and evidentiary standards the insurer relied upon to determine whether to apply the nonquantitative treatment limitation were comparable to and applied no more stringently than the factors, processes, strategies, and evidentiary standards the insurer relied upon to determine whether to apply nonquantitative treatment limitations, including step therapy or other preauthorization requirements, to medications to treat medical or surgical conditions;

(viii) review of any fail-first requirements applicable to mental health or substance use disorder benefits to ensure that they are comparable to and applied no more stringently than any fail-first requirements applicable to medical or surgical benefits; and

(ix) review of any restrictions based on geographic location, facility type, provider specialty, or other criteria applicable to mental health or substance use disorder benefits to ensure that any such restriction is comparable to and applied no more stringently than any restriction applicable to medical or surgical benefits;

(5) a process for the actuarial certification, in compliance with actuarial standards of practice, of the data used for, and the outcome of, the analyses of the financial requirements and quantitative treatment limitations applicable to mental health and substance use disorder benefits to ensure that they are no more restrictive than the predominant financial requirements and quantitative treatment limitations applied to substantially all the medical and surgical benefits;

(6) training and education for all employees, directors or other governing body members, agents, and other representatives engaged in functions that are subject to federal or state mental health and substance use disorder parity requirements or involved in analysis as a part of the compliance program; provided that such training shall occur at least annually and shall be made a part of the orientation for such new employees, directors or other governing body members, agents, and other representatives;

(7) the methods by which employees, directors or other governing body members, agents, and other representatives may report parity compliance issues to the individual responsible for compliance, as described in

paragraph one of this subdivision; provided that such methods shall include a method for anonymous and confidential reporting of potential compliance issues as they are identified; and

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including reporting and investigating potential issues and reporting to appropriate officials as provided in Labor Law sections 740 and 741.

(b) Improper practices prohibited.

(1) The following shall be considered improper practices related to mental health and substance use disorder benefits:

(i) implementing a utilization review policy that uses different standards to determine the level of documentation required for utilization review of mental health or substance use disorder benefits versus the level of documentation required for the utilization review of medical or surgical conditions, including the submission of medical records, treatment plans, or evidence of patient involvement or motivation in care or patient response to treatment;

(ii) requiring preauthorization, concurrent, or retrospective utilization review for a higher percentage of mental health or substance use disorder benefits in the absence of defined clinical or quality triggers, as compared to medical or surgical benefits;

(iii) implementing a methodology for developing and applying provider reimbursement rates for mental health or substance use disorder benefits that is not comparable to or is applied more stringently than the methodology for developing and applying provider reimbursement rates for medical or surgical benefits; and

(iv) implementing claim edits or system configurations that provide for higher rates of approval through auto-adjudication for claims for inpatient medical or surgical benefits than for inpatient mental health or substance use disorder benefits.

(2) An insurer shall monitor for and detect improper practices as described in paragraph one of this subdivision and remediate or develop a plan to remediate any improper practices as soon as practicable, but in no event later than 60 days after discovery.

(3) An insurer shall provide written notification to affected insureds and the superintendent and conspicuously post on the insurer's website notice regarding any identified improper practice described in paragraph (1) of this subdivision, including a description of the insurer's efforts to remediate the improper practice or its plan for remediation, within 60 days of discovery.

(c) An insurer shall be responsible for and coordinate parity compliance monitoring activities with any agents and other representatives providing benefit management services or performing utilization review activities on behalf of the insurer.

(d) Annual certification.

(1) By December 31, 2021 and annually thereafter, each insurer shall electronically submit a written certification to the superintendent that the insurer satisfactorily meets the requirements of this section.

(2) Such certification shall be in a form prescribed by the superintendent and signed by the insurer's chief executive officer or the individual responsible for assessing, monitoring, and managing the compliance program attesting to the best of his or her knowledge and belief that the information contained therein is true and that a copy of this certification has been provided to the insurer's board of directors or other governing body, or the appropriate committee thereof.

(e) Exemptions from electronic filing and submission requirements.

(1) An insurer required to make an electronic filing or a submission pursuant to this Part may apply to the superintendent for an exemption from the requirement that the filing or submission be electronic by submitting a written request to the superintendent for approval at least 30 days before the insurer shall submit to the superintendent the particular filing or submission that is the subject of the request.

(2) The request for an exemption shall:

(i) set forth the insurer's NAIC number, if applicable;

(ii) identify the specific filing or submission for which the insurer is applying for the exemption;

(iii) specify whether the insurer is making the request for an exemption based upon undue hardship, impracticability, or good cause, and set forth a detailed explanation as to the reason that the superintendent should approve the request; and

(iv) specify whether the request for an exemption extends to future filings or submissions, in addition to the specific filing or submission identified in paragraph (2) of this subdivision.

(3) The insurer requesting an exemption shall submit, upon the superintendent's request, any additional information necessary for the superintendent to evaluate the insurer's request for an exemption.

(4) The insurer shall be exempt from the electronic filing or submission requirement upon the superintendent's written determination so exempting the insurer, where the determination specifies the basis upon which the superintendent is granting or denying the request and to which filings or submissions the exemption applies.

(5) If the superintendent approves an insurer's request for an exemption from the electronic filing or submission requirement, then the insurer shall make a physical filing in a form acceptable to the superintendent.