Mental Health and Substance Use Disorder Parity Report Act

Instructions for Reporting

Reporting Periods:

January 1, 2019 through December 31, 2019
January 1, 2020 through December 31, 2020

Introduction

Insurance Law § 343 established the mental health and substance use disorder parity report act. This law is intended to ensure compliance with state and federal requirements for mental health and substance use disorder parity laws. It requires entities subject to its provisions to provide a variety of information related to their administration of mental health and substance use disorder benefits in comparison to their administration of medical and surgical benefits.

Applicability

The data reporting applies to individual, group and blanket policies or contracts that provide comprehensive-type coverage, including coverage provided through the Child Health Plus program, and that are issued by insurers authorized to write accident and health insurance in New York State, corporations organized pursuant to Article 43 of the Insurance Law, and managed care organizations certified pursuant to Article 44 of the Public Health Law* ("insurers"). The legislation requires such insurers to provide the requested information for the preceding two calendar years to the Superintendent of the Department of Financial Services ("DFS") beginning July 1, 2019 and every two years thereafter.

*Prepaid Health Services Plans ("PHSPs") are required to report data related to plans offered in the commercial individual market for the specified reporting periods.

Report Submission

Due Date for Submission: July 1, 2021.

The following are the guidelines regarding report submission:

- Submit Report in Microsoft Excel Format using the data template provided.

- Insurers may not consolidate information from multiple NAIC numbers into one report. ***Submit one completed worksheet per NAIC number for each reporting period***.
- Data should not include information related to the following types of coverage:
    - Self-funded;
    - Medicaid:
    - Essential Plan;
    - Managed Long-Term Care,
    - Policies situs outside of New York,
    - Article 47 municipal cooperative health benefit plans,
    - Medicare,
    - Federal Employee Insurance; and
    - Dental and vision benefits.

Data Publication

The requested data will be posted on the DFS website.

Data Review

DFS will review the submitted data to ensure compliance with MHPAEA. As such, DFS may request additional information from an insurer in order to demonstrate its compliance with MHPAEA requirements related to quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs). The additional information requested by DFS may include the completion of quantitative test worksheets and/or an NQTL comparative analysis.

Data Template

The data template includes the following:

- Demographic information
- Utilization Review – Retrospective
- Utilization Review - Prior Authorization
- Utilization Review – Concurrent
- Rate of 1st Level Appeals
- Percentage of Claims Paid
- Number of Behavioral Health Representatives
- Cost Share Comparison – Utilization Review (Schedule 1)
- Cost Share Comparison – Individual Market
- Cost Share Comparison – Small Group Market
- Cost Share Comparison – Large Group Market
- Participating Providers

- External Appeals
- Attestation and Contact Information (attached separately)

Demographic Information

Provide information regarding the total number of insureds[1] who received medical/surgical services and the number of claims for medical/surgical services as directed in the report template. Provide the same information for mental health/substance use disorder benefits.

- Name of Insurer – Enter the name of the reporting insurer. Once entered on the initial tab of the worksheet this information should carry over to the remaining worksheet tabs.
- NAIC # - Enter the NAIC number associated with the reporting insurer. For PHSPs, enter the number assigned by DFS. Once entered on the initial tab of the worksheet this information should carry over to the remaining worksheet tabs.
- Reporting Period – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of Insureds Who Received Services – Provide the number of insureds who actually received services during the reporting period for each treatment category and claim type. This should be based on the date of service.
- Total # of Claims – Provide the total number of claims for each treatment category and claim type during the reporting period. This should be based on the date on which the insurer received the claim.
- Total Number of Insureds Who Have Accessed Services – Provide the total number of insureds who have received at least one service during the reporting period for each claim type (medical/surgical, mental health, and substance use disorder).
- Total Number of Insureds Across All Claim Types – Provide the total number of insureds covered by individual, group, and blanket policies or contracts that provide comprehensive-type coverage.

Utilization Review - Retrospective

Insurers must provide total number of claims or cases, total number of retrospective utilization reviews performed, total number of claims or cases approved through retrospective utilization review and total number of claims or cases denied through retrospective utilization review for

[1] Reference to "insureds" includes all covered individuals.

medical and surgical claims or cases as well as mental health claims or cases and substance use disorder claims or cases. ***In instances where a claim or case involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the claim or case is reported under mental health services or substance use disorder services.***

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Period – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Reporting Basis – Indicate whether utilization review data is reported based on utilization management cases or on a claim basis. The basis selected must be consistent for Medical/Surgical, Mental Health, and Substance Use Disorder.
- Total # of Claims or Cases- Enter the total number of claims or cases received during the reporting period for each applicable category.
- Total # of Utilization Reviews Performed – Enter the total number of retrospective utilization reviews performed during the reporting period for each applicable category.
- Total # of Claims or Cases Approved Through Utilization Review - Enter the total number of claims or cases approved through retrospective utilization review performed during the reporting period for each applicable category.
- Total # of Claims or Cases Denied Through Utilization Review - Enter the total number of claims or cases denied, in whole or in part, through retrospective utilization review performed during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if the reporting NAIC number does not provide out-of-network benefits under any of its plans), please enter N/A in the designated field.

Utilization Review – Prior Authorization

Insurers must provide total number of prior authorization requests, total number of prior authorization requests approved through utilization review and total number of prior authorization requests denied through utilization review for medical and surgical services as well as mental health services and substance use disorder services. ***In instances where the prior authorization request involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the prior authorization request is reported under mental health services or substance use disorder services.***

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # Prior Authorization Requests- Enter the total number of prior authorization requests received during the reporting period for each applicable category.
- Total # of Prior Authorization Requests Approved - Enter the total number of prior authorization requests approved through utilization review performed during the reporting period for each applicable category.
- Total # of Prior Authorization Requests Denied - Enter the total number of prior authorizations denied, in whole or in part, through utilization review performed during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if the reporting NAIC number does not provide out-of-network benefits under any of its plans), please enter N/A in the designated field.

Utilization Review – Concurrent

Insurers must provide total number of concurrent authorization requests, total number of concurrent authorization requests approved through utilization review and total number of concurrent authorization requests denied through utilization review for medical and surgical

services as well as mental health services and substance use disorder services. ***In instances where the concurrent authorization request involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the concurrent authorization request is reported under mental health services or substance use disorder services.***

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of Concurrent Authorization Requests- Enter the total number of concurrent authorization requests received during the reporting period for each applicable category.
- Total # of Concurrent Authorization Requests Approved - Enter the total number of concurrent authorization requests approved through utilization review performed during the reporting period for each applicable category.
- Total # of Concurrent Authorization Requests Denied - Enter the total number of concurrent authorization requests denied, in whole or in part, through utilization review performed during the reporting period for each applicable category.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if the reporting NAIC number does not provide out-of-network benefits under any of its plans), please enter N/A in the designated field.

Rate of 1st Level Appeals

Insurers must provide the total number of 1st level appeals filed, total number of denials upheld on 1st level appeal, and total number of denials overturned in whole or part on 1st level appeals for medical and surgical services as well as mental health services and substance use disorder

services. ***In instances where a 1st level appeal involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the 1st level appeal is reported under mental health services or substance use disorder services.***

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of 1st Level Appeals Filed – Enter the total number of 1st level appeals filed during the reporting period for each applicable category.
- Total # of 1st Level Appeals Closed – Enter the total number of 1st level appeals closed during the reporting period for each applicable category. The total should include appeals filed prior to January 1st of the reporting period that were closed during the reporting period.
- Total # of Denials Upheld on 1st Level Appeal – Enter the total number of denials upheld based on the 1st level appeal determination during the reporting period.
- Total # of Denials Overturned on 1st Level Appeal – Enter the total number of denials overturned, in whole or in part, based the on 1st level appeal determination during the reporting period.

Notes:

Insurers will enter whole numbers.

If the insurer has no claims or utilization review data to report in a treatment category enter the number 0 in the applicable field.

If a treatment category does not apply (for example, if a health plan does not provide out-of-network benefits), please enter N/A in the designated field.

Percentage of Claims Paid

Insurers must provide the following information as applicable for medical/surgical claims as well as mental health claims and substance use disorder claims.

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of Claims Received – Enter the total number of claims received during the reporting period for each applicable category. This should be based on the date on which the insurer received the claim.
- Total # of Claims Paid – Enter the total number of claims paid during the reporting period for each applicable category. This should be based on the date on which the insurer paid the claim.

Notes:

Insurers will enter whole numbers.

Approved in-network exceptions should be included in the "In-Network Exception" category. If an in-network exception request is denied and the plan offers out-of-network coverage, the applicable claim should be included in the "Out-of-Network" category.

If the reporting NAIC # does not offer out-of-network coverage for any of its plans the insurer should enter N/A (Not Applicable) in the "Out-of-Network" category.

Number of Behavioral Health Representatives

Insurers must provide the following information as applicable:

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total Number of Behavioral Health Advocates Pursuant to Agreement with the Office of the Attorney General – Insurers that entered into an agreement with the Office of the

Attorney General, enter the total number of Behavioral Health Advocates. Insurers who were not subject to such agreement with the Office of the Attorney General, enter "Not Applicable" in the designated field. *This should be broken out by those employed directly by the insurer and those employed through a third-party vendor.*

- Total Number of Staff Available to Assist Insureds with Mental Health Benefits and Substance Use Disorder Benefits – Enter the total number of staff available to assist insureds with mental health benefits and substance use disorder benefits. If the insurer has no staff available to assist insureds with mental health benefits and substance use disorder benefits, enter the number 0 in the designated field. *This should be broken out by those employed directly by the insurer and those employed through a third-party vendor.*

- Total Number of Staff Available to Assist Insureds with Medical/Surgical Benefits – Enter the total number of staff available to assist insureds with medical/surgical benefits. If the insurer has no staff available to assist insureds with medical/surgical benefits enter the number 0 in the designated field. *This should be broken out by those employed directly by the insurer and those employed through a third-party vendor.*

Cost Share Comparison – Utilization Review (Schedule 1) *

This should be completed when the insurer's internal guidelines on when utilization review will begin is the same across all plans and markets. If the insurer's internal guidelines on when utilization review will begin varies by plan, then the insurer should complete the Cost Share Comparison worksheets by market and plan name.

Insurers should provide the number of services in each treatment category for each claim type that require utilization review. If no services in a treatment category require utilization review, enter N/A in the applicable categories.

Note:

If the insurer does not utilize the outpatient safe harbor benefit classifications (Outpatient Office and Outpatient Other), enter all outpatient information in the "Outpatient Other" category and enter N/A in the "Outpatient Office" category.

Cost Share Comparison – Individual Market

Insurers must provide the following information as applicable for a specific plan offered in the individual market in New York State under the reporting NAIC number. The insurer should

submit one cost sharing comparison per plan name until the insurer has provided such cost sharing comparisons for at least 75% of the insurer's total insureds in the individual market. *Where more than one co-payment, co-insurance, limitation on scope, limitation on duration or utilization review requirement exists in a treatment category, please use Schedule 2 to provide* ***service specific detail*** *(for example, Outpatient In-Network: Physical Therapy, Chiropractic Services, etc.) and enter "See Schedule 2" in the applicable field on this worksheet.:*

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Line of Business – Select the applicable line of business for the plan (ex. HMO, EPO, etc.) from the drop-down box.
- Product Name (Optional) – Enter the product name.
- Plan Name – Enter the name of the specific plan.
- # of Insureds for this plan as of December 31st – Enter the number of individuals enrolled in the specified plan as of the last date of the reporting period.
- # of Insureds for all plans as of December 31st – Enter the number of individuals enrolled in all plans offered in the individual market as of the last day of the reporting period.
- Co-Payment – Enter the co-payment for the applicable treatment category. If there is no co-payment for the applicable treatment category, enter N/A in the designated field.
- Co-Insurance – Enter the co-insurance percentage for the applicable treatment category. Report co-insurance as the percentage that the insured is responsible for paying. If no co-insurance is applied to the treatment category, enter N/A in the designated field.
- Limitations on Scope – Report any requirements imposed on insureds or providers before the benefit is covered (for example, referrals, prior authorization, step-therapy, etc.). If there are no limitations on scope for the applicable treatment category, enter the word N/A in the designated field.
- Limitations on Duration*****- Enter visit limits and dollar limits for the applicable treatment category. If there are no visit limits for the applicable treatment category, enter the word None in the designated field. If a visit limit applied, specify whether the visit limit is per condition or per plan year (for example, if the treatment category has a duration

limit of 60 visits per condition, enter: 60 visits per condition). ***If the plan does not have limitations on duration for mental health and substance use disorder services, the insurer is not required to list any duration limits for medical and surgical services.***

- Utilization Review – Indicate the number of services in each treatment category for each claim type that require utilization review. If no services in a treatment category require utilization review, enter N/A in the applicable categories. If the internal guidelines for when utilization review begins is the same for all plans and product types, report once under Schedule 1 and enter "See Schedule 1" on this worksheet for each treatment category.

Notes:

Insurers will enter whole numbers.

If the insurer does not utilize the outpatient safe harbor benefit classifications (Outpatient Office and Outpatient Other), enter all outpatient information in the "Outpatient Other" category and enter N/A in the "Outpatient Office" category.

In instances where out-of-network coverage is not available under the plan, the out-of-network treatment categories may be left blank.

Insurers should copy the template and add additional tabs/pages of the Cost Share Comparison – Individual Market worksheet as needed.

Cost Share Comparison – Small Group Market

Insurers must provide the following information as applicable for a specific plan offered in the small group market in New York State under the reporting NAIC number. The insurer should submit one cost sharing comparison per plan name until the insurer has provided such cost sharing comparisons for at least 75% of the insurer's total insureds in the small group market. *Where more than one co-payment, co-insurance, limitation on scope, limitation on duration or utilization review requirement exists in a treatment category, please use Schedule 2 to provide* ***service specific detail*** *(for example, Outpatient In-Network: Physical Therapy, Chiropractic Services, etc.) and enter "See Schedule 2" in the applicable field on this worksheet:*

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.

- Line of Business – Select the applicable line of business for the plan (ex. HMO, EPO, etc.) from the drop-down box.
- Product Name (Optional) – Enter the product name.
- Plan Name – Enter the name of the specific plan.
- # of Insureds for this plan as of December 31st– Enter the number of individuals enrolled in the specified plan as of the last date of the reporting period.
- # of Insureds for all plans as of December 31st—Enter the number of individuals enrolled in all plans offered in the small group market as of the last date of the reporting period.
- Co-Payment – Enter the co-payment for the applicable treatment category. If there is no co-payment for the applicable treatment category, enter the N/A in the designated field.
- Co-Insurance – Enter the co-insurance percentage for the applicable treatment category. Report co-insurance as the percentage that the insured is responsible for paying. If no co-insurance is applied to the treatment category, enter N/A in the designated field.
- Limitations on Scope – Report any requirements imposed on insureds or providers before the benefit is covered (for example, referrals, prior authorization, step-therapy, etc.). If there are no limitations on scope for the applicable treatment category, enter the word N/A in the designated field.
- Limitations on Duration*****- Enter visit limits and dollar limits for the applicable treatment category. If there are no visit limits for the applicable treatment category, enter the word N/A in the designated field. If a visit limit is applied, specify whether the visit limit is per condition or per plan year (for example, if the treatment category has a duration limit of 60 visits per condition, enter: 60 visits per condition). *******If the plan does not have limitations on duration for mental health and substance use disorder services, the insurer is not required to list any duration limits for medical and surgical services.*
- Utilization Review – Indicate the number of services in each treatment category for each claim type that require utilization review. If no services in a treatment category require utilization review, enter N/A in the applicable categories. If the internal guidelines for when utilization review begins is the same for all plans and product types, report once under Schedule 1 and enter "See Schedule 1" on this worksheet for each treatment category.

Notes:

Insurers will enter whole numbers.

If the insurer does not utilize the outpatient safe harbor benefit classifications (Outpatient Office and Outpatient Other), enter all outpatient information in the "Outpatient Other" category and enter N/A in the "Outpatient Office" category.

In instances where out-of-network coverage is not available under the plan, the out-of-network treatment categories may be left blank.

Insurers should copy the template and add additional tabs/pages of the Cost Share Comparison – Small Group Market worksheet as needed.

Cost Share Comparison – Large Group Market

Insurers must provide the following information as applicable for a specific plan offered in the large group market in New York State under the reporting NAIC number. The insurer should submit one cost sharing comparison per plan name until the insurer has provided such cost sharing comparisons for at least 75% of the insurer's total insureds in the large group market. *Where more than one co-payment, co-insurance, limitation on scope, limitation on duration or utilization review requirement exists in a treatment category, please use Schedule 2 to provide* ***service specific detail*** *(for example, Outpatient In-Network: Physical Therapy, Chiropractic Services, etc.) and enter "See Schedule 2" in the applicable field on this worksheet.:*

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Line of Business – Select the applicable line of business for the plan (ex. HMO, EPO, etc.) from the drop-down box.
- Product Name (Optional) – Enter the product name.
- Plan Name – Enter the name of the specific plan.
- # of Insureds for this plan as of December 31st– Enter the number of individuals enrolled in the specified plan as of the last date of the reporting period.
- # of Insureds for all plans as of December 31st—Enter the number of individuals enrolled in all plans offered in the large group market as of the last date of the reporting period.

- Co-Payment – Enter the co-payment for the applicable treatment category. If there is no co-payment for the applicable treatment category, enter the N/A in the designated field.
- Co-Insurance – Enter the co-insurance percentage for the applicable treatment category. Report co-insurance as the percentage that the insured is responsible for paying. If no co-insurance is applied to the treatment category, enter N/A in the designated field.
- Limitations on Scope – Report any requirements imposed on insureds or providers before the benefit is covered (ex., referrals, prior authorization, step-therapy, etc.). If there are no limitations on scope for the applicable treatment category, enter the word N/A in the designated field.
- Limitations on Duration*- Enter visit limits and dollar limits for the applicable treatment category. If there are no visit limits for the applicable treatment category, enter the word N/A in the designated field. If a visit limit applied, please specify whether visit limit is per condition or per plan year (for example, if the treatment category has a duration limit of 60 visits per condition, enter: 60 visits per condition). *If the plan does not have limitations on duration for mental health and substance use disorder services, the insurer is not required to list any duration limits for medical and surgical services.
- Utilization Review – Indicate the number of services in each treatment category for each claim type that require utilization review. If no services in a treatment category require utilization review, enter N/A in the applicable categories. If the internal guidelines for when utilization review begins is the same for all plans and product types, report once under Schedule 1 and enter "See Schedule 1" on this worksheet for each treatment category.

Notes:

Insurers will enter whole numbers.

If the insurer does not utilize the outpatient safe harbor benefit classifications (Outpatient Office and Outpatient Other), enter all outpatient information in the "Outpatient Other" category and enter N/A in the "Outpatient Office" category.

In instances where out-of-network coverage is not available under the plan, the out-of-network treatment categories may be left blank.

Insurers should copy the template and add additional tabs/pages of the Cost Share Comparison – Large Group Market worksheet as needed.

Participating Providers

Insurers must provide the following information regarding participating providers licensed in New York to diagnose and treat mental health conditions as well as participating providers licensed to diagnose and treat substance use disorder.

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- # of Participating Providers Licensed in NY for the Diagnosis and Treatment of Mental Health Conditions as of January 1st of the Reporting Period – Enter the total number of participating providers for the applicable treatment category as of the first day of the reporting period.
- # of New Participating Providers Licensed in NY for the Diagnosis and Treatment of Mental Health Conditions between January 1st and December 31st of the Reporting Period – Enter the total number of participating providers for the applicable treatment category who joined the insurer's provider network during the reporting period.
- # of Participating Providers Licensed in NY for the Diagnosis and Treatment of Mental Health Conditions who left the provider network between January 1st and December 31st of the Reporting Period – Enter the total number of providers for the applicable treatment category who left the insurer's provider network during the reporting period.
- # of Participating Providers Licensed in NY for the Diagnosis and Treatment of Mental Health Conditions as of December 31st of the Reporting Period – Enter the total number of participating providers for the applicable treatment category as of the last day of the reporting period.
- # of Participating Providers Licensed in NY for the Diagnosis and Treatment of Substance Use Disorder as of January 1st of the Reporting Period – Enter the total number of participating providers for the applicable treatment category as of the first day of the reporting period.
- # of New Participating Providers Licensed in NY for the Diagnosis and Treatment of Substance Use Disorder between January 1st and December 31st of the Reporting Period – Enter the total number of participating providers for the applicable treatment category who joined the insurer's provider network during the reporting period.
- # of Participating Providers Licensed in NY for the Diagnosis and Treatment of Substance Use Disorder who left the provider network between January 1st and December 31st of

the Reporting Period – Enter the total number of providers for the applicable treatment category who left the insurer's provider network during the reporting period.

- # of Participating Providers Licensed in NY for the Diagnosis and Treatment of Substance Use Disorder as of December 31st of the Reporting Period – Enter the total number of participating providers for the applicable treatment category as of the last day of the reporting period.

Notes:

If the insurer utilizes more than one network, please complete a separate tab for each network. To create a new tab, right click on the "Par Providers" tab within the worksheet, select "Move or Copy," and then select the "Create a Copy" box.

If applicable, the insurer should add additional types of participating providers licensed to practice in New York for the diagnosis and treatment of mental health conditions and/or substance use disorder where the provider type is not already listed in the template.

External Appeals

Insurers must provide the total number of external appeals filed, total number of denials upheld on external appeal, and total number of denials overturned in whole or part on external appeals for medical and surgical services as well as mental health services and substance use disorder services by benefit classification***. In instances where an external appeal involves both mental health and substance use disorder services, the primary diagnosis code is used to determine whether the external appeal is reported under mental health services or substance use disorder services.***

- Name of Insurer – Enter the name of the reporting insurer if the information has not carried over from the 1st tab of the worksheet.
- NAIC # - Enter the NAIC number associated with the reporting insurer if the information has not carried over from the 1st tab of the worksheet. For PHSPs, enter the number assigned by DFS.
- Reporting Year – Select from the drop-down box the applicable reporting year for the corresponding worksheet.
- Total # of External Appeals Filed – Enter the total number of external appeals filed during the reporting period for each applicable category.
- Total # of External Appeals Closed – Enter the total number of external appeals closed during the reporting period for each applicable category. External appeals received

prior to January 1st of the reporting year that were closed during the reporting period should be included.

- Total # of Denials Upheld on External Appeal – Enter the total number of denials upheld based on the external appeal determination during the reporting period for each applicable category.
- Total # of Denials Overturned on External Appeal – Enter the total number of denials overturned, in whole or in part, based on the external appeal determination during the reporting period for each applicable category.

Attestation & Contact Information

Using the template attestation, attached separately, the chief executive officer (CEO) of the company must attest that the information provided by the insurer is true, accurate, and complete to the best of their knowledge. The insurer must also provide a point of contact for any questions the Department of Financial Services may have regarding this submission. The following information should be provided:

- Name of CEO
- Signature of CEO
- Date Signed
- Name of Insurer – Enter the name of the reporting insurer.
- NAIC # - Enter the NAIC number associated with reporting insurer. For PHSPs, enter the number assigned by DFS.
- Contact Name – Provide the name of an individual who will be the point of contact for answering questions regarding the submission.
- Contact's title – Enter the job title of the person who is the point of contact.
- Contact's Email – Enter the email address of the person who is the point of contact.
- Contact's Phone Number – Enter the phone number of the person who is the point of contact.

Questions

Send questions about the Mental Health and Substance Use Disorder Parity Act data reporting to MentalHealthParity@dfs.ny.gov