Assessment of Public Comments on the Revised Proposed New 11 NYCRR 38 (Insurance Regulation 230)

The New York State Department of Financial Services ("Department") received comments from insurers and associations that represent insurers and health maintenance organizations (collectively, "health care plans"); several associations representing hospitals, community-based behavioral health providers, psychologists, and psychiatrists; and advocates for consumers and children's behavioral healthcare. Most of the comments the Department received on the revised proposal were previously addressed in the assessment of public comments on the proposed rulemaking, which the Department posted on its website on November 20, 2024 at: https://www.dfs.ny.gov/industry_guidance/regulatory_activity/insurance. The Department received the following new comments.

Comment: A commenter suggested that the Department establish measures that define what is meant by ensuring providers are reasonably accessible within the wait time standards. The commenter also recommended that the Department develop measures by which the Department can hold health care plans accountable.

Response: The regulation establishes clear, measurable access requirements by setting forth appointment wait times in section 38.4. The Department monitors health care plan compliance with applicable laws and regulations through existing mechanisms, including reporting requirements and market conduct examinations. The Department would monitor compliance with these regulations through the same mechanisms. Enforcement findings and penalties are publicly available on the Department's website. No changes were made to the regulation.

Comment: A commenter recommended that the Department establish a standard of "network breadth" (minimum % of providers in a service area that participate in the network) and require health care plans to analyze and report network breadth to the Department. The commenter recommended a 70% minimum standard and stated that the standard is similar to a federal requirement for qualified health care plans sold on health insurance exchanges. The commenter stated that there is not a provider shortage, but rather the problem is that health care plans claim their provider networks are full or limit their network capacity. Conversely, other commenters stated

that there is a provider shortage and pointed to findings in a Health Resources and Services Administration Behavioral Health Workforce 2023 Issue Brief.

Response: Insurance Law section 3241(a)(1) already requires that every health care plan ensure that its provider network is adequate to meet the behavioral health needs of its insureds and provide an appropriate choice of providers to render the services covered under its health insurance policies and contracts. The number of providers needed to establish an adequate network may vary by health care plan, as their insured populations and service areas will also vary. While requiring a health care plan to contract with a minimum percentage of providers in its network is a possible approach to establishing network standards, the Department did not pursue this approach. Because there are providers who are unwilling to join health care plan networks, adopting this approach could make it difficult for health care plans to meet the minimum standard. The regulation instead establishes appointment wait times and permits insureds to access out-of-network behavioral health providers when certain requirements are met. No changes were made to the regulation.

Comment: A commenter requested clarification as to why the wait time standard for health care professionals set forth in section 38.4(a)(2) of the regulation excepts a provider "who is not employed by or contracted with an outpatient facility or clinic." The commenter suggests that this appears to be an unnecessary restriction.

Response: Section 38.4(a)(1) sets forth an appointment wait time for an outpatient facility or clinic, while section 38.4(a)(2) establishes an appointment wait time for a health care professional. The phrase, "who is not employed by or contracted with an outpatient facility or clinic," is intended to distinguish those professionals who are in private practice, in an office setting, or otherwise offering appointments not within a facility or clinic. No changes were made to the regulation.

Comment: A commenter urged additional analysis of the costs and likely impact of applying appointment wait times to the large group market prior to implementation. The commenter stated that large employers may achieve significant savings by switching to self-funded coverage, by avoiding state mandates and state premium

taxes, at the expense of significant consumer protections (including some that relate to behavioral health). This commenter also suggested delaying the effective date of the regulation to give providers more time to come into compliance.

Response: Recognizing the importance of access to behavioral health services, and that the need and demand for these services has never been greater, the Legislature enacted chapter 57 of the Laws of 2023 ("Chapter 57") requiring the Department to establish by regulation requirements for provider networks used by health care plans that issue comprehensive health insurance policies or contracts in relation to behavioral health services. The regulation implements the legislative mandate that insureds be able to access the services that are covered under their health insurance policies, and health care plans must ensure that insureds have access to behavioral health services through their networks and that provider directories are accurate.

Chapter 57 did not exempt fully insured large group health insurance policies from the network adequacy requirements, and as a result, the regulation imposes standards for fully insured large group coverage. With any new mandate, there is a risk that a large employer will decide to pursue an option for self-funded coverage. However, if large employers switch to self-funded coverage, such coverage must still comply with the federal parity requirements of the Mental Health Parity and Addition Equity Act, the No Surprises Act, and other consumer protection laws so any potential cost-savings may not be as expected. The suggestion to engage in further study or otherwise delay implementation of the regulation for large groups would only serve to undermine access to important services and undermine the legislative mandate imposed in 2023. Therefore, no changes were made to the regulation although the Department made one non-substantive change to the regulation that revises the effective date from 120 days after publication in the State Register to July 1, 2025. .

Comment: A commenter recommended that health care plans be required to clearly and specifically notify insureds of the option to request an in-person appointment.

Response: The regulation requires a health care plan to post a description of the appointment wait time standards for behavioral health services on a publicly accessible area of its website. Moreover, health insurance

contracts and certificates issued to insureds will be required to include information on these requirements. As a result, no changes were made to the regulation.

Comment: A commenter requested amending section 38.5 of the regulation to ensure that enrollees can complain and seek out-of-network care without additional cost sharing whenever a participating provider is unavailable based on all the standards contained in the Department of Health's managed care organization (MCO) "guidelines." Other commenters also questioned the applicability of the Department of Health's MCO guidelines.

Response: The regulation uses appointment wait times to establish standards for obtaining more timely access to behavioral health services. If a health care plan is unable to locate an in-network provider who can treat the insured's behavioral health condition within three days of receiving an access complaint, the health care plan must inform the insured that the insured may obtain a referral to a non-participating provider who can meet those requirements, at the in-network cost-sharing. The Department of Health's MCO guidelines include many standards that managed care plans and networks must meet, however they go beyond the scope of what the regulation is intended to address. Questions about the Department of Health's MCO guidelines should be directed to the Department of Health. No changes were made to the regulation.

Comment: A commenter recommended that health care plans be required to publish the names and contact information of the health care plan representatives by the areas they cover and that it should be regularly updated to facilitate timely communication, reduce administrative burdens, and streamline the reporting of access issues.

Response: The revised proposed regulation incorporated a change, made in response to prior comments the Department received, mandating that health care plans post the contact information for the department or unit on a publicly accessible area of their website to allow insureds to contact the appropriate designated staff directly. The information required by the revised proposed regulation to be posted on health care plan websites is sufficient to facilitate timely communication with health care plans and avoids any potential confusion created by changes in staffing if specific individuals are required to be named. Accordingly, no changes were made to the regulation.

Comment: Commenters asked whether "reasonable" distance to a provider will continue to be determined by the 30 minute/30 mile guidelines or if the standard will be consistent with federal time and distance requirements. Commenters also asked how the standard might vary in rural areas. Another comment asked whether "reasonable distance" in section 38.5(c) would be the same as in 38.5(b).

Response: Network adequacy time and distance guidelines are currently posted on the Department's website, and they address how standards may vary in rural areas. CMS recently released the final Notice of Benefit and Payment Parameters for 2025 that establishes time and distance standards for network adequacy to be applicable in 2026 for individual and small group qualified health care plans, and the standards are not limited to behavioral health services. The Department is assessing the federal standards in relation to all health care services, not just behavioral health services, and will address separately from this regulation. The term "reasonable distance" in section 38.5(c) would have the same meaning in 38.5(b), and the standards set forth in the guidelines on the Department's website should be used to determine a reasonable distance until such time as any changes are made to the guidelines. No changes were made to the regulation.

Comment: One commenter recommended clarifying that, consistent with the existing out-of-network referral law, if rate negotiations between a health care plan and an out-of-network provider are unsuccessful, the health care plan must pay the provider's rate.

Response: The Insurance Law does not specify the rate that the health care plan must pay to the out-of-network provider when there is not an in-network provider with the appropriate training and experience to meet the health care needs of the insured. Under this regulation, when there is no in-network provider who can meet the appointment wait times, it is the Department's expectation that health care plans will work diligently to reach an agreement with an out-of-network provider on a payment amount. In addition, appointments may be scheduled by telehealth, unless the insured specifically requests an in-person appointment, which may facilitate access to a broader spectrum of providers. No changes were made to the regulation.

Comment: One commenter stated that the regulation does not require the health care plan to approve a non-participating provider that charges rates that are “excessive or unreasonable,” but does not define “excessive or unreasonable.” The commenter further stated that the regulation does not provide a recourse for health care plans or their members if rates are unreasonable and there is a lack of alternative providers.

Response: The terms “excessive” and “unreasonable” are commonly defined in Merriam-Webster’s dictionary as “exceeding what is usual, proper, necessary, or normal” and “exceeding the bounds of reason or moderation.” It is expected that health care plans will work with out-of-network providers as they do now when there is not an in-network provider to meet the health care needs of the insured in order to make a referral to an out-of-network provider. It is further expected that a health care plan will ultimately reach an agreement with an out-of-network provider. Appointments may be scheduled by telehealth, unless the insured specifically requests an in-person appointment, which may facilitate access to a broader spectrum of providers. If the out-of-network referral is not resolved to the insured’s satisfaction, the recourse is to submit a complaint to the Department.

Comment: Commenters requested clarification regarding what rates are “excessive and unreasonable,” how such determination would be made, and by whom. Another commenter suggested eliminating or clarifying “excessive or unreasonable” charges, and that it may be a barrier to care.

Response: The rate that a health care plan will pay to an out-of-network provider for covered services is negotiated by the health care plan and provider. The provision in the regulation that requires referrals to an out-of-network provider that charges a rate that is not “excessive or unreasonable” is intended to encourage good faith negotiations by both the health care plan and the provider, while avoiding unnecessary impacts on health insurance premiums.

Comment: A commenter requested clarification of who identifies the out-of-network provider, whether it is the health care plan or the insured, perhaps with the assistance of an ombudsman.

Response: The regulation does not require the health care plan to locate an out-of-network provider since it is unlikely that the health care plan will have information on providers who do not participate with the health

care plan. If the health care plan is unable to locate an in-network provider, section 38.5(c) of the regulation requires the health care plan to notify the insured that the insured may obtain a referral to an out-of-network provider at the in-network cost-sharing and include the contact information for the New York State Behavioral Health Ombudsman Program. No changes were made to the regulation.

Comment: A commenter requested clarification of the required language regarding the New York State Behavioral Health Ombudsman Program.

Response: If the health care plan is unable to locate an in-network provider, section 38.5(c) of the regulation requires the health care plan to notify the insured that the insured may obtain a referral to an out-of-network provider at the in-network cost-sharing and include the contact information for the New York State Behavioral Health Ombudsman Program. The contact information for the New York State Behavioral Health Ombudsman Program is available online and from the New York State Office of Mental Health. No changes were made to the regulation.

Comment: A commenter asked if a referral request is received and there are no providers (either participating or non-participating) located within a reasonable distance, whether the health care plan can suggest an alternate participating provider in response to the referral request.

Response: If there are no providers (in-network or out-of-network) within a reasonable distance who can treat the insured's behavioral health condition within the appointment wait times, the regulation does not prevent the health care plan from providing other assistance to its insureds, such as information on other available in-network providers. Health care plans are strongly encouraged to provide such information and assistance to insureds so insureds can access services they need. Appointments may be scheduled by telehealth, unless the insured specifically requests an in-person appointment, which may facilitate access to a broader spectrum of providers. No changes were made to the regulation.

Comment: A commenter asked what happens if the out-of-network provider cannot meet the appointment wait times or if the wait time for the out-of-network provider is only slightly better than for the in-network provider.

Response: Section 38.5(c)(2) expressly states that a health care plan is only required to approve a referral to an out-of-network provider if that provider "is able to meet the appointment wait times set forth in section 38.4 of this Part." However, the regulation does require the referral to be approved if the out-of-network provider can meet the criteria in section 38.5(c)(2) regardless of whether the appointment wait time is only slightly better than for an in-network provider who cannot meet the appointment wait time. No changes were made to the regulation.

Comment: A commenter requested clarification of what is meant by "harmful to the insured" for transitioning care, and who makes the decision. The commenter also inquired whether that decision was subject to Insurance Law Article 49 rights.

Response: The term "harm" generally means something that could cause physical or mental injury. The regulation provides that the decision of whether the transition would be harmful to the insured is made by the health care plan in consultation with the insured's treating provider, as appropriate. Pursuant to the Insurance Law, decisions related to a referral are subject to grievance rights set forth in Insurance Law Article 48, decisions related to medical necessity are subject to the utilization review rights set forth in Article 49, and appeals of out-of-network referral denials are subject to Insurance Law section 4904. No changes were made to the regulation.

Comment: A commenter requested that section 38.5(1) and (2) be revised to make it clear that the determination to transition the insured's care to a participating provider is subject to Insurance Law section 4802 while the determination that services are no longer medically necessary is subject to Insurance Law section 4904.

Response: Pursuant to the Insurance Law, decisions related to a referral are subject to grievance rights set forth in Insurance Law Article 48, decisions related to medical necessity are subject to the utilization review rights set forth in Article 49, and appeals of out-of-network referral denials are subject to Insurance Law section 4904. No changes were made to the regulation.

Comment: A commenter urged the Department to amend section 38.5(d) to provide that only the insured's treating provider has the authority to determine whether transfer to an in-network provider would be clinically appropriate or advisable to ensure that the decision is based solely on patient care needs and not financial concerns.

Response: Currently, when a health care plan approves a referral to an out-of-network provider because the health care plan does not have an in-network provider with the training and experience to meet the health care needs of an insured, the health care plan may require the insured to transition to an in-network provider when one becomes available, unless the insured's health insurance policy generally covers out-of-network services. The regulation primarily addresses situations when in-network providers may be available, but they are unable to meet initial appointment wait times for behavioral health services. The regulation recognizes the unique nature of behavioral health services and provides an enhanced protection to ensure that the transfer of care to an in-network provider cannot be required if it would be harmful to the insured. The regulation balances protections for the insured when transitioning to the care of an in-network provider (who may not have been available within the appointment wait time for an initial appointment) with the benefits provided by an insurance policy that does not generally cover out-of-network services. No changes were made to the regulation.

Comment: A commenter stated that the "transition would be harmful" standard in section 38.5(d)(2) is much too strict and suggests that there should be a standard in which continuity of care and patient choice should be recognized. The commenter stated that, that at a minimum, continuity of care and patient choice should be presumptively controlling, unless the plan can demonstrate that the in-network provider is a more appropriate treatment provider.

Response: In recognition of the unique nature of behavioral health services, the regulation adopts a transition of care standard that is more protective than current referral requirements, which typically permit care to be transitioned when an in-network provider is available, and current continuity of care requirements, which require care to be transitioned after the expiration of either 90 or 60 days. Health insurance policies that do not

include a benefit for out-of-network services are priced with the assumption that most services will be covered in network. The regulation balances protections for the insured when transitioning to the care of an in-network provider (who may not have been available within the appointment wait time for an initial appointment) with the benefits provided by an insurance policy that does not generally cover out-of-network services. No changes were made to the regulation.

Comment: One commenter asked whether the health care plan is the only entity holding providers responsible for maintaining accurate records relating to provider availability, and what recourse a health care plan may have in response to inadequate reporting by providers (other than removing participation status).

Response: Health care plans are responsible for making sure that the services they promise their insureds and cover under their health insurance policies are available. Insurance Law sections 3217-b and 4325 set forth several requirements that health care plans must include in their contracts with providers, including requiring providers to have business processes in place to ensure timely provision of provider directory information to the health care plan. The Insurance Law also requires contracts between health care plans and providers to include a provision requiring providers to reimburse the insured for cost-sharing, with interest, that exceeds the in-network cost-sharing for services when the insured is provided with inaccurate network status by the health care plan. Accordingly, health care plans may seek recourse for a breach by a provider of their contractual obligations. No changes were made to the regulation.

Comment: A commenter recommended requiring residential treatment as an additional level of care that must be listed in section 38.6(a)(3) and noted that it is a distinct level of care that health care plans often fail to distinguish from inpatient treatment.

Response: The regulation was previously revised to provide examples of level of care offered by a facility to be listed in a health care plan's provider directory. No changes were made to the regulation.

Comment: A commenter suggested that health care plans be required to retain records of requests from insureds for lists of behavioral health providers pursuant to section 38.6(c) of the regulation in the insured's file for at least two years to align with the No Surprises Act.

Response: The requirements of the No Surprises Act are currently applicable to health care plans. No changes were made to the regulation.

Comment: One commenter expressed appreciation for the change to 15 days to correct provider directory errors to align with other requirements of the Insurance Law. However, the commenter requested that the language be revised so that the 15-day period begins when the health care plan confirms the error with the provider. Another commenter advised that 15 calendar days is still too long for updating the provider directory and recommends that the timeframe be shortened to five business days.

Response: Insurance Law sections 3217-a and 4324 require a health care plan to update the provider directory on its website within 15 days of the addition or termination of a provider from the health care plan's network or a change in a physician's hospital affiliation. The regulation requires health care plans, within 15 calendar days of receipt of the reported errors, to review such errors and ensure that the provider directory information is accurate, consistent with the 15-day requirement in the Insurance Law for website directory changes. The 15-day period in the regulation aligns with the current statutory requirement. Therefore, no changes were made to the regulation.

Comment: A commenter recommended requiring health care plans to publicly post information related to an insured's right to receive services out-of-network pursuant to section 38.5 and the existing Out-of-Network Referral Law.

Response: Section 38.5(c) of the regulation requires the health care plan to notify the insured that the insured may obtain a referral to a non-participating provider who can meet the appointment wait time requirements, at the same in-network cost-sharing, and to provide contact information for the New York State Behavioral Health Ombudsman Program. In addition, the regulation requires a health care plan to post

information on a publicly accessible area of its website describing the appointment wait time standards for behavioral health services and the process to submit an access complaint. Moreover, health insurance contracts and certificates issued to insureds will be required to include information on these requirements. As a result, no changes were made to the regulation.

Comment: One commenter strongly advised that the regulation's effective date should be no earlier than January 1, 2026, due to significant implementation burdens (re-designing provider directories and creating an access plan) and to assess whether the potential increased cost of allowing insureds to go out of network should be factored into premiums.

Response: Health insurance policies and contracts will need to be updated to include the new requirements, and the requirements will apply to contracts and policies as they are issued, renewed, amended, or modified beginning July 1, 2025. For individual policies and contracts, which renew on a calendar year basis, the requirements will apply beginning January 1, 2026. For group policies, the requirements will apply July 1, 2025, upon issuance or renewal of the group policy. The Department will develop and provide health care plans with updated model contract language.

The Legislature enacted Chapter 57 requiring the Department to establish by regulation requirements for provider networks used by health care plans that issue comprehensive health insurance policies or contracts in relation to behavioral health services. Since then, the Department has engaged in discussions with health care plans about behavioral health provider networks and the development of this regulation. The Department posted the pre-proposed regulation in January of 2024, published the proposed regulation in the State Register on February 21, 2024, and published the revised proposed regulation in the State Register on November 20, 2024. The requirements to include more information in provider directories and to develop behavioral health access plans were included from the beginning, and the health care plans have had plenty of notice and time to begin preparations for such requirements. Therefore, no substantive changes were made to the regulation although the

Department made a non-substantive change that revises the effective date from 120 days after publication in the State Register to July 1, 2025.

Comment: One commenter strongly encouraged the Department to take all actions necessary to ensure that these regulations are adopted as expeditiously as possible, and certainly by mid-August of 2025, given the significant enforcement delays that have already occurred. The commenter further suggested that, if that timeline is missed, it appears that these regulations will be not effective for most plans until January 1, 2027.

Response: The Department recognizes the importance of access to behavioral health services and is moving expeditiously to promulgate and implement these regulations while giving due consideration to the extensive public comments that were submitted. For individual policies and contracts, which are renewed on a calendar year basis, the requirements of the regulation will apply beginning January 1, 2026. For group policies and contracts, the requirements will apply on July 1, 2025, upon issuance or renewal of the group policy.