Regulatory Impact Statement for the Final Adoption of New 11 NYCRR 38 (Insurance Regulation 230)

1. Statutory authority: Financial Services Law ("FSL") sections 202, 301, and 302, Insurance Law ("IL") sections 301, 3217-a, 3241, and 4324, and Part II of Chapter 57 of the Laws of 2023 ("Chapter 57").

FSL section 202 establishes the office of the Superintendent of Financial Services ("Superintendent").

FSL sections 301 and 302 and IL section 301, in pertinent part, authorize the Superintendent to prescribe regulations interpreting the IL and to effectuate any power granted to the Superintendent in the IL, FSL, or any other law.

IL section 3217-a sets forth disclosure requirements for all comprehensive, expense-reimbursed health insurance contracts, managed care health insurance contracts, and any other health insurance contract for which the Superintendent deems such disclosure appropriate.

IL section 3241 requires an insurer, a corporation organized pursuant to IL Article 43, a municipal cooperative health benefit plan certified pursuant to IL Article 47, and a student health plan established or maintained pursuant to IL section 1124 (collectively, "health care plans"), that issues a health insurance policy or contract with a network of health care providers to ensure that the network is adequate to meet the health care needs of insureds and provide for an appropriate choice of providers sufficient to render the services covered under the policy or contract.

IL section 4324 sets forth disclosure requirements for all comprehensive, expense-reimbursed health insurance contracts, managed care health products, and any other contract or product for which the Superintendent deems such disclosure appropriate.

Chapter 57 amended the Insurance Law to require the Superintendent, in consultation with the commissioners of the Department of Health, the Office of Mental Health ("OMH"), and the Office of Addiction Services and Supports ("OASAS"), to propose regulations setting forth standards for network adequacy for behavioral health treatment services.

2. Legislative objectives: To effectuate the statutory intent of Chapter 57 to increase access to behavioral health services in this State by establishing provider network standards. The regulation strengthens network adequacy requirements for behavioral health services, requires health plans to establish internal protocols for monitoring access and utilization of these services, assists insureds in finding timely access to providers, and takes certain actions to ensure the accuracy of provider directories. Together, these requirements will make it easier and faster for consumers to access behavioral health services.

3. Needs and benefits: The regulation implements Chapter 57, which requires the Department of Financial Services ("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. Ensuring meaningful access to behavioral health care is vital to addressing New York's behavioral health crisis.

A key component of access is the availability of an adequate number of appropriate providers within a health care plan's network. The regulation sets forth appointment wait time standards for behavioral health services. If an insured cannot access behavioral health services from an in-network provider who can treat the insured's behavioral health condition and is available within the appointment wait time standards, the regulation gives the health care plan three business days from receipt of an access complaint to provide the insured or the insured's designee with the contact information for an in-network provider who can treat the insured's behavioral health condition and is available within the appointment wait time standards. If the insured requests an in-person visit rather than a telehealth visit, the in-network provider also must be located within a reasonable distance.

If no such in-network provider is available within the appointment wait time standards, the regulation requires the health care plan to provide the insured with a referral to an out-of-network provider at the in-network cost-sharing, if the out-of-network provider can treat the insured's behavioral health condition, is able to meet the appointment wait time standards, is located within a reasonable distance from the insured, and charges rates that are not excessive or unreasonable. The regulation requires the referral to remain in effect until the behavioral

health services are no longer medically necessary or the health care plan locates an in-network provider that can treat the insured's behavioral health condition, is able to meet the appointment wait time standards, is located within a reasonable distance if an in-person appointment is requested, and the insured's treatment can be transitioned to the in-network provider, unless the health care plan determines, in consultation with the insured's treating provider, as appropriate, that such transition would be harmful to the insured.

The regulation requires health care plans to verify information in their provider directories and to include information in the directories on any restrictions concerning the conditions or ages treated by network providers, languages spoken by a health care professional, whether the provider offers services via telehealth, and, if the provider is a facility, the level of care offered by the facility.

The regulation requires health care plans to review claims activity twice each year to identify behavioral health providers who have not submitted claims and to verify their participation status and confirm whether they are accepting new patients. Additionally, the regulation requires health care plans to post certain information on a publicly accessible area of their websites, including a method for insureds, providers, and other persons to report provider directory errors, a description of the appointment wait time standards, and the process for submitting an access complaint.

The regulation requires a health care plan to have an access plan that establishes a protocol for monitoring and ensuring access to behavioral health services, including assessing the ability of the health care plan's network of behavioral health providers to meet the cultural and linguistic needs of the health care plan's insured population. The regulation also requires health care plans to submit to the Superintendent an annual certification of compliance that includes the number of access complaints received by the health care plan and a description of how the access complaints were resolved.

4. Costs: A health care plan may incur compliance costs to: file new insurance policy and contract forms and premium rates with the Department; develop a process to monitor and evaluate access to its network

providers; recruit additional behavioral health providers for its networks or pay for out-of-network providers; modify on-line provider directories to ensure that they are searchable and filterable; provide training to staff on the requirements for responding to access complaints; update its website with required information; and submit an annual compliance certification. Some of the compliance costs may impact premium rates charged to insureds; however, certain costs should be minimal because health care plans submit insurance policy or contract form and premium rate filings as a part of the normal course of business and should already have compliance procedures in place.

The regulation may impose compliance costs on the Department because the Department will need to review amended insurance policy and contract forms and premium rates and review annual compliance certifications. However, any additional costs incurred by the Department should be minimal because existing personnel are already available to review any filings necessitated by the regulation and the Department should be able to absorb the costs in its ordinary budget.

The regulation does not impose any compliance costs on state or local governments or health care providers.

5. Local government mandates: The regulation does not impose any program, service, duty, or responsibility upon a county, city, town, village, school district, fire district, or other special district.

6. Paperwork: Health care plans may need to file new insurance policy forms and premium rates with the Department to comply with the regulation. These include the health insurance contracts and certificates that describe the covered benefits that are reviewed and approved by the Department and then issued to covered individuals. Health care plans also will need to submit an annual certification of compliance to the Superintendent. Health care plans must annually certify that they have an access plan that includes protocols for monitoring and ensuring access to behavioral health services, such as monitoring utilization of those services, numbers and types of providers who are actively providing services, collecting data on provider-to-insured ratios

and appointment wait times, and assessing the ability of their networks' behavioral health providers to meet the cultural and linguistic needs of their insured populations. The access plan must be available to the Department upon request. Health care plans also must certify that they have sufficient providers to meet the appointment wait time standards or otherwise permit insureds to go out-of-network at no additional cost to the insureds and performed the provider directory verification as required by the regulation.

7. Duplication: The regulation does not duplicate, overlap, or conflict with any existing state or federal rules or other legal requirements.

8. Alternatives: The Department consulted with the Department of Health, OMH, and OASAS when drafting the regulation. The Department also met with numerous stakeholders representing providers, consumers, and health care plans. During discussions with various behavioral health provider associations, providers repeatedly stated that there is a state-wide shortage of providers and an increasing demand for behavioral health services. Many providers, including providers who do not participate in health care plan provider networks, expressed concern that they would not be able to meet an appointment wait time standard of ten business days, and many providers indicated that appointment wait times can run up to four weeks or longer. The Department considered requiring health care plans to meet longer appointment wait time standards of 14 to 28 days, instead of ten business days, for initial behavioral health treatment appointments. However, other states and federally run exchanges have a ten business-day timeframe for initial appointments, and the ten business-day timeframe is more protective of consumers than a longer timeframe.

The IL includes a mechanism for an insured to go out of network when there is no provider in a health care plan's network who can perform the services. That process requires the insured to file an internal appeal with a health care plan and an external appeal with independent medical experts. The Department considered the use of that process to assist insureds in finding timely and proximate access to behavioral health services. However, the Department chose to require a more streamlined process for health care plans to assist an insured

in obtaining an appointment with a provider who meets the appointment wait times, which does not necessitate an appeal with independent medical experts.

The Department considered several different timeframes for health care plans to monitor network capacity and provider access, including monthly, quarterly, and annually. The Department added a quarterly timeframe to align with the network adequacy quarterly network submission process.

The Department considered requiring a pre-determined length of time for a referral to an out-of-network provider to be covered, such as 60 or 90 days. However, the interruption of certain behavioral health treatments may cause harm to an insured in some circumstances, while in other situations an insured may be more appropriately transitioned to an in-network provider sooner.

The Department also considered requiring out-of-network referrals to be effective until the completion of an insured's treatment. However, some behavioral health treatments can be very lengthy, lasting years, which would be costly for insurers and increase premiums. In addition, insurers currently can transition insureds to in-network providers in other circumstances where out-of-network referrals are made.

9. Federal standards: The regulation does not conflict with any minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: Health care plans will need to comply with the regulation, effective July 1, 2025, for policies and contracts issued, renewed, modified, or amended on or after such date, and will need to submit their first annual compliance certifications by December 31, 2026.

Statement as to why a revised Regulatory Flexibility Analysis for Small Businesses and Local Governments ("RFA") is not required for the final adoption of new Part 38 to 11 NYCRR (Insurance Regulation 230)

A revised RFA is not required for the final adoption of new Part 38 to 11 NYCRR (Insurance Regulation 230) because the non-substantive revisions to the regulation do not require a change to the previously published RFA.

Statement as to why a revised Rural Area Flexibility Analysis ("RAFA") is not required for the final adoption of new Part 38 to 11 NYCRR (Insurance Regulation 230)

A revised RAFA is not required for the final adoption of new Part 38 to 11 NYCRR (Insurance Regulation 230) because the non-substantive revisions to the regulation do not require a change to the previously published RAFA.

Statement as to why a revised Job Impact Statement ("JIS") is not required for the final adoption of new Part 38 to 11 NYCRR (Insurance Regulation 230)

A revised JIS is not required for the final adoption of new Part 38 to 11 NYCRR (Insurance Regulation 230) because the non-substantive revisions to the regulation do not require a change to the previously published JIS.