S T A T E O F N E W Y O R K

S. 7912 A. 10164

S E N A T E - A S S E M B L Y

June 17, 2014

IN SENATE -- Introduced by Sens. SEWARD, HANNON, MARTINS, RITCHIE -- (at request of the Governor) -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

IN ASSEMBLY -- Introduced by COMMITTEE ON RULES -- (at request of M. of A. Cusick) -- (at request of the Governor) -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the public health law, in relation to requiring health insurance coverage for substance use disorder treatment services and creating a workgroup to study and make recommendations

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding two new paragraphs 30 and 31 to read as follows:

(30)(A) EVERY POLICY THAT PROVIDES HOSPITAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE COVERAGE MUST PROVIDE INPATIENT COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF SUBSTANCE USE DISORDER, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES. SUCH COVERAGE SHALL NOT APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO INPATIENT SUBSTANCE USE DISORDER BENEFITS THAT ARE MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS COVERED BY THE POLICY. FURTHER, SUCH COVERAGE SHALL BE PROVIDED CONSISTENT WITH THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (29 U.S.C. S 1185A).

(B) COVERAGE PROVIDED UNDER THIS PARAGRAPH MAY BE LIMITED TO FACILITIES IN NEW YORK STATE WHICH ARE CERTIFIED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND, IN OTHER STATES, TO THOSE WHICH ARE ACCREDITED BY THE JOINT COMMISSION AS ALCOHOLISM, SUBSTANCE ABUSE, OR CHEMICAL DEPENDENCE TREATMENT PROGRAMS.

(C) COVERAGE PROVIDED UNDER THIS PARAGRAPH MAY BE SUBJECT TO ANNUAL DEDUCTIBLES AND CO-INSURANCE AS DEEMED APPROPRIATE BY THE SUPERINTENDENT

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD12108-01-4

AND THAT ARE CONSISTENT WITH THOSE IMPOSED ON OTHER BENEFITS WITHIN A GIVEN POLICY.

(31) (A) EVERY POLICY THAT PROVIDES MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE MUST PROVIDE OUTPATIENT COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF SUBSTANCE USE DISORDER, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES. SUCH COVERAGE SHALL NOT APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO OUTPATIENT SUBSTANCE USE DISORDER BENEFITS THAT ARE MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS COVERED BY THE POLICY. FURTHER, SUCH COVERAGE SHALL BE PROVIDED CONSISTENT WITH THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (29 U.S.C. S 1185A).

(B) COVERAGE UNDER THIS PARAGRAPH MAY BE LIMITED TO FACILITIES IN NEW YORK STATE CERTIFIED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES OR LICENSED BY SUCH OFFICE AS OUTPATIENT CLINICS OR MEDICALLY SUPERVISED AMBULATORY SUBSTANCE ABUSE PROGRAMS AND, IN OTHER STATES, TO THOSE WHICH ARE ACCREDITED BY THE JOINT COMMISSION AS ALCOHOLISM OR CHEMICAL DEPENDENCE SUBSTANCE ABUSE TREATMENT PROGRAMS.

(C) COVERAGE PROVIDED UNDER THIS PARAGRAPH MAY BE SUBJECT TO ANNUAL DEDUCTIBLES AND CO-INSURANCE AS DEEMED APPROPRIATE BY THE SUPERINTENDENT AND THAT ARE CONSISTENT WITH THOSE IMPOSED ON OTHER BENEFITS WITHIN A GIVEN POLICY.

(D) A POLICY PROVIDING COVERAGE FOR SUBSTANCE USE DISORDER SERVICES PURSUANT TO THIS PARAGRAPH SHALL PROVIDE UP TO TWENTY OUTPATIENT VISITS PER POLICY OR CALENDAR YEAR TO AN INDIVIDUAL WHO IDENTIFIES HIM OR HERSELF AS A FAMILY MEMBER OF A PERSON SUFFERING FROM SUBSTANCE USE DISORDER AND WHO SEEKS TREATMENT AS A FAMILY MEMBER WHO IS OTHERWISE COVERED BY THE APPLICABLE POLICY PURSUANT TO THIS PARAGRAPH. THE COVERAGE REQUIRED BY THIS PARAGRAPH SHALL INCLUDE TREATMENT AS A FAMILY MEMBER PURSUANT TO SUCH FAMILY MEMBER'S OWN POLICY PROVIDED SUCH FAMILY MEMBER:

(I) DOES NOT EXCEED THE ALLOWABLE NUMBER OF FAMILY VISITS PROVIDED BY THE APPLICABLE POLICY PURSUANT TO THIS PARAGRAPH; AND

(II) IS OTHERWISE ENTITLED TO COVERAGE PURSUANT TO THIS PARAGRAPH AND SUCH FAMILY MEMBER'S APPLICABLE POLICY.

S 2. Paragraphs 6 and 7 of subsection (l) of section 3221 of the insurance law, paragraph 6 as amended by chapter 558 of the laws of 1999 and paragraph 7 as amended by chapter 565 of the laws of 2000, are amended to read as follows:

(6) (A) Every [insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery, in this state, which] POLICY THAT provides [coverage for inpatient hospital care] HOSPITAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE COVERAGE must [make available and, if requested by the policyholder,] provide INPATIENT coverage for the diagnosis and treatment of [chemical abuse and chemical dependence, however defined in such policy, provided, however, that the term chemical abuse shall mean and include alcohol and substance abuse and chemical dependence shall mean and include alcoholism and substance dependence, however defined in such policy. Written notice of the availability of such coverage shall be delivered to the policyholder prior to inception of such group policy and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.

(B) Such coverage shall be at least equal to the following:

(i) with respect to benefits for detoxification as a consequence of chemical dependence, inpatient benefits in a hospital or a detoxification facility may not be limited to less than seven days of active treatment in any calendar year; and

(ii) with respect to benefits for rehabilitation services, such benefits may not be limited to less than thirty days of inpatient care in any calendar year.] SUBSTANCE USE DISORDER, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES. SUCH COVERAGE SHALL NOT APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO INPATIENT SUBSTANCE USE DISORDER BENEFITS THAT ARE MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS COVERED BY THE POLICY. FURTHER, SUCH COVERAGE SHALL BE PROVIDED CONSISTENT WITH THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (29 U.S.C. S 1185A).

[(C) Such coverage] (B) COVERAGE PROVIDED UNDER THIS PARAGRAPH may be limited to facilities in New York state which are certified by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission [on accreditation of hospitals] as alcoholism, substance abuse or chemical dependence treatment programs.

[(D) Such coverage shall be made available at the inception of all new policies and with respect to all other policies at any anniversary date of the policy subject to evidence of insurability.

(E) Such coverage] (C) COVERAGE PROVIDED UNDER THIS PARAGRAPH may be subject to annual deductibles and co-insurance as [may be] deemed appropriate by the superintendent and THAT are consistent with those imposed on other benefits within a given policy. [Further, each insurer shall report to the superintendent each year the number of contract holders to whom it has issued policies for the inpatient treatment of chemical dependence, and the approximate number of persons covered by such policies.

(F) Such coverage shall not replace, restrict or eliminate existing coverage provided by the policy.]

(7) (A) Every [insurer delivering a group or school blanket policy or issuing a group or school blanket policy for delivery in this state which] POLICY THAT provides [coverage for inpatient hospital care] MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE must provide OUTPATIENT coverage for [at least sixty outpatient visits in any calendar year for] the diagnosis and treatment of [chemical dependence of which up to twenty may be for family members, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state.] SUBSTANCE USE DISORDER, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES. SUCH COVERAGE SHALL NOT APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO OUTPATIENT SUBSTANCE USE DISORDER BENEFITS THAT ARE MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS COVERED BY THE POLICY. FURTHER, SUCH COVERAGE SHALL BE PROVIDED CONSISTENT WITH THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (29 U.S.C. S 1185A).

[Such coverage] (B) COVERAGE UNDER THIS PARAGRAPH may be limited to facilities in New York state certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clin-

ics or medically supervised ambulatory substance abuse programs and, in other states, to those which are accredited by the joint commission [on accreditation of hospitals] as alcoholism or chemical dependence treatment programs.

[Such coverage] (C) COVERAGE PROVIDED UNDER THIS PARAGRAPH may be subject to annual deductibles and co-insurance as [may be] deemed appropriate by the superintendent and THAT are consistent with those imposed on other benefits within a given policy. [Such coverage shall not replace, restrict, or eliminate existing coverage provided by the policy. Except as otherwise provided in the applicable policy or contract, no insurer delivering a group or school blanket policy or issuing a group or school blanket policy providing coverage for alcoholism or substance abuse services pursuant to this section shall deny coverage to a family member]

(D) A POLICY PROVIDING COVERAGE FOR SUBSTANCE USE DISORDER SERVICES PURSUANT TO THIS PARAGRAPH SHALL PROVIDE UP TO TWENTY OUTPATIENT VISITS PER POLICY OR CALENDAR YEAR TO AN INDIVIDUAL who identifies [themself] HIM OR HERSELF as a family member of a person suffering from [the disease of alcoholism, substance abuse or chemical dependency] SUBSTANCE USE DISORDER and who seeks treatment as a family member who is otherwise covered by the applicable policy [or contract] pursuant to this [section] PARAGRAPH. The coverage required by this paragraph shall include treatment as a family member pursuant to such family [members'] MEMBER'S own policy [or contract] provided such family member:

(i) does not exceed the allowable number of family visits provided by the applicable policy [or contract] pursuant to this [section,] PARAGRAPH; and

(ii) is otherwise entitled to coverage pursuant to this [section] PARAGRAPH and such family [members'] MEMBER'S applicable policy [or contract].

S 3. Subsections (k) and (l) of section 4303 of the insurance law, subsection (k) as amended by chapter 558 of the laws of 1999 and subsection (l) as amended by chapter 565 of the laws of 2000, are amended to read as follows:

(k) [A hospital service corporation or a health service corporation which] (1) EVERY CONTRACT THAT provides [group, group remittance or school blanket coverage for inpatient hospital care] HOSPITAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE COVERAGE must [make available and if requested by the contract holder] provide INPATIENT coverage for the diagnosis and treatment of [chemical abuse and chemical dependence, however defined in such policy, provided, however, that the term chemical abuse shall mean and include alcohol and substance abuse and chemical dependence shall mean and include alcoholism and substance dependence, however defined in such policy, except that this provision shall not apply to a policy which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state. Such coverage shall be at least equal to the following: (1) with respect to benefits for detoxification as a consequence of chemical dependence, inpatient benefits for care in a hospital or detoxification facility may not be limited to less than seven days of active treatment in any calendar year; and (2) with respect to benefits for inpatient rehabilitation services, such benefits may not be limited to less than thirty days of inpatient rehabilitation in a hospital based or free standing chemical dependence facility in any calendar year.] SUBSTANCE USE DISORDER, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES. SUCH COVERAGE

SHALL NOT APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO INPATIENT SUBSTANCE USE DISORDER BENEFITS THAT ARE MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS COVERED BY THE CONTRACT. FURTHER, SUCH COVERAGE SHALL BE PROVIDED CONSISTENT WITH THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (29 U.S.C. S 1185A).

[Such coverage] (2) COVERAGE PROVIDED UNDER THIS SUBSECTION may be limited to facilities in New York state which are certified by the office of alcoholism and substance abuse services and, in other states, to those which are accredited by the joint commission [on accreditation of hospitals] as alcoholism, substance abuse, or chemical dependence treatment programs. [Such coverage shall be made available at the inception of all new policies and with respect to policies issued before the effective date of this subsection at the first annual anniversary date thereafter, without evidence of insurability and at any subsequent annual anniversary date subject to evidence of insurability.

Such coverage] (3) COVERAGE PROVIDED UNDER THIS SUBSECTION may be subject to annual deductibles and co-insurance as [may be] deemed appropriate by the superintendent and THAT are consistent with those imposed on other benefits within a given [policy] CONTRACT. [Further, each hospital service corporation or health service corporation shall report to the superintendent each year the number of contract holders to whom it has issued policies for the inpatient treatment of chemical dependence, and the approximate number of persons covered by such policies. Such coverage shall not replace, restrict or eliminate existing coverage provided by the policy. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract and annually thereafter, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.]

(l) [A hospital service corporation or a health service corporation which] (1) EVERY CONTRACT THAT provides [group, group remittance or school blanket coverage for inpatient hospital care] MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE must provide OUTPATIENT coverage for [at least sixty outpatient visits in any calendar year for] the diagnosis and treatment of [chemical dependence of which up to twenty may be for family members, except that this provision shall not apply to a contract issued pursuant to section four thousand three hundred five of this article which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state.] SUBSTANCE USE DISORDER, INCLUDING DETOXIFICATION AND REHABILITATION SERVICES. SUCH COVERAGE SHALL NOT APPLY FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS TO OUTPATIENT SUBSTANCE USE DISORDER BENEFITS THAT ARE MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS COVERED BY THE CONTRACT. FURTHER, SUCH COVERAGE SHALL BE PROVIDED CONSISTENT WITH THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (29 U.S.C. S 1185A).

[Such coverage] (2) COVERAGE UNDER THIS SUBSECTION may be limited to facilities in New York state certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clin-

ics or medically supervised ambulatory substance abuse programs and, in other states, to those which are accredited by the joint commission [on accreditation of hospitals] as alcoholism or chemical dependence substance abuse treatment programs.

[Such coverage] (3) COVERAGE PROVIDED UNDER THIS SUBSECTION may be subject to annual deductibles and co-insurance as [may be] deemed appropriate by the superintendent and THAT are consistent with those imposed on other benefits within a given [policy] CONTRACT. [Such coverage shall not replace, restrict or eliminate existing coverage provided by the policy. Except as otherwise provided in the applicable policy or contract, no hospital service corporation or health service corporation providing coverage for alcoholism or substance abuse services pursuant to this section shall deny coverage to a family member]

(4) A CONTRACT PROVIDING COVERAGE FOR SUBSTANCE USE DISORDER SERVICES PURSUANT TO THIS SUBSECTION SHALL PROVIDE UP TO TWENTY OUTPATIENT VISITS PER CONTRACT OR CALENDAR YEAR TO AN INDIVIDUAL who identifies [themself] HIM OR HERSELF as a family member of a person suffering from [the disease of alcoholism, substance abuse or chemical dependency] SUBSTANCE USE DISORDER and who seeks treatment as a family member who is otherwise covered by the applicable [policy or] contract pursuant to this [section] SUBSECTION. The coverage required by this subsection shall include treatment as a family member pursuant to such family [members'] MEMBER'S own [policy or] contract provided such family member:

[(i)] (A) does not exceed the allowable number of family visits provided by the applicable [policy or] contract pursuant to this [section,] SUBSECTION; and

[(ii)] (B) is otherwise entitled to coverage pursuant to this [section] SUBSECTION and such family [members'] MEMBER'S applicable [policy or] contract.

S 3-a. Item (ii) of subparagraph (B) of paragraph 1 of subsection (b) of section 4900 of the insurance law, as amended by chapter 586 of the laws of 1998, is amended and a new subparagraph (C) is added to read as follows:

(ii) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; [and] OR

(C) FOR PURPOSES OF A DETERMINATION INVOLVING SUBSTANCE USE DISORDER TREATMENT:

(I) A PHYSICIAN WHO POSSESSES A CURRENT AND VALID NON-RESTRICTED LICENSE TO PRACTICE MEDICINE AND WHO SPECIALIZES IN BEHAVIORAL HEALTH AND HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE USE DISORDER COURSES OF TREATMENT; OR

(II) A HEALTH CARE PROFESSIONAL OTHER THAN A LICENSED PHYSICIAN WHO SPECIALIZES IN BEHAVIORAL HEALTH AND HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE USE DISORDER COURSES OF TREATMENT AND, WHERE APPLICABLE, POSSESSES A CURRENT AND VALID NON-RESTRICTED LICENSE, CERTIFICATE OR REGISTRATION OR, WHERE NO PROVISION FOR A LICENSE, CERTIFICATE OR REGISTRATION EXISTS, IS CREDENTIALED BY THE NATIONAL ACCREDITING BODY APPROPRIATE TO THE PROFESSION; AND

S 4. Subsection (a) of section 4902 of the insurance law is amended by adding a new paragraph 9 to read as follows:

(9) WHEN CONDUCTING UTILIZATION REVIEW FOR PURPOSES OF DETERMINING HEALTH CARE COVERAGE FOR SUBSTANCE USE DISORDER TREATMENT, A UTILIZATION REVIEW AGENT SHALL UTILIZE RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA THAT IS APPROPRIATE TO THE AGE OF THE PATIENT

AND IS DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT.

THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT SHALL APPROVE A RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA, IN ADDITION TO ANY OTHER APPROVED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA.

S 5. Subsection (c) of section 4903 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(c) (1) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, OR REQUESTS FOR INPATIENT SUBSTANCE USE DISORDER TREATMENT, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday AND EXCEPT, WITH RESPECT TO INPATIENT SUBSTANCE USE DISORDER TREATMENT, WITHIN TWENTY-FOUR HOURS OF RECEIPT OF THE REQUEST FOR SERVICES WHEN THE REQUEST IS SUBMITTED AT LEAST TWENTY-FOUR HOURS PRIOR TO DISCHARGE FROM AN INPATIENT ADMISSION. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(2) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(3) PROVIDED THAT A REQUEST FOR INPATIENT TREATMENT FOR SUBSTANCE USE DISORDER IS SUBMITTED TO THE UTILIZATION REVIEW AGENT AT LEAST TWENTY-FOUR HOURS PRIOR TO DISCHARGE FROM AN INPATIENT ADMISSION PURSUANT TO THIS SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR THE INPATIENT SUBSTANCE USE DISORDER TREATMENT WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT IS PENDING.

S 6. Subsection (b) of section 4904 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this article or (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of

information from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal EXCEPT, WITH RESPECT TO INPATIENT SUBSTANCE USE DISORDER TREATMENT PROVIDED PURSUANT TO PARAGRAPH THREE OF SUBSECTION (C) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTICLE, EXPEDITED APPEALS SHALL BE DETERMINED WITHIN TWENTY-FOUR HOURS OF RECEIPT OF SUCH APPEAL. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. PROVIDED THAT THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER FILES AN EXPEDITED INTERNAL AND EXTERNAL APPEAL WITHIN TWENTY-FOUR HOURS FROM RECEIPT OF AN ADVERSE DETERMINATION FOR INPATIENT SUBSTANCE USE DISORDER TREATMENT FOR WHICH COVERAGE WAS PROVIDED WHILE THE INITIAL UTILIZATION REVIEW DETERMINATION WAS PENDING PURSUANT TO PARAGRAPH THREE OF SUBSECTION (C) OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTICLE, A UTILIZATION REVIEW AGENT SHALL NOT DENY ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION SUCH SUBSTANCE USE DISORDER TREATMENT WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT OR EXTERNAL APPEAL AGENT IS PENDING.

S 6-a. Item (B) of subparagraph (i) of paragraph (a) of subdivision 2 of section 4900 of the public health law, as amended by chapter 586 of the laws of 1998, is amended and a new subparagraph (iii) is added to read as follows:

(B) is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review; [and] OR

(III) FOR PURPOSES OF A DETERMINATION INVOLVING SUBSTANCE USE DISORDER TREATMENT:

(A) A PHYSICIAN WHO POSSESSES A CURRENT AND VALID NON-RESTRICTED LICENSE TO PRACTICE MEDICINE AND WHO SPECIALIZES IN BEHAVIORAL HEALTH AND HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE USE DISORDER COURSES OF TREATMENT; OR

(B) A HEALTH CARE PROFESSIONAL OTHER THAN A LICENSED PHYSICIAN WHO SPECIALIZES IN BEHAVIORAL HEALTH AND HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE USE DISORDER COURSES OF TREATMENT AND, WHERE APPLICABLE, POSSESSES A CURRENT AND VALID NON-RESTRICTED LICENSE, CERTIFICATE OR REGISTRATION OR, WHERE NO PROVISION FOR A LICENSE, CERTIFICATE OR REGISTRATION EXISTS, IS CREDENTIALED BY THE NATIONAL ACCREDITING BODY APPROPRIATE TO THE PROFESSION; AND

S 7. Subdivision 1 of section 4902 of the public health law is amended by adding a new paragraph (i) to read as follows:

(I) WHEN CONDUCTING UTILIZATION REVIEW FOR PURPOSES OF DETERMINING HEALTH CARE COVERAGE FOR SUBSTANCE USE DISORDER TREATMENT, A UTILIZATION REVIEW AGENT SHALL UTILIZE RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA THAT IS APPROPRIATE TO THE AGE OF THE PATIENT AND IS DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER AND THE SUPERINTENDENT OF FINANCIAL SERVICES.

THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER AND THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL

APPROVE A RECOGNIZED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA, IN ADDITION TO ANY OTHER APPROVED EVIDENCE-BASED AND PEER REVIEWED CLINICAL REVIEW CRITERIA.

S 8. Subdivision 3 of section 4903 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

3. (A) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, OR REQUESTS FOR INPATIENT SUBSTANCE USE DISORDER TREATMENT, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday AND EXCEPT, WITH RESPECT TO INPATIENT SUBSTANCE USE DISORDER TREATMENT, WITHIN TWENTY-FOUR HOURS OF RECEIPT OF THE REQUEST FOR SERVICES WHEN THE REQUEST IS SUBMITTED AT LEAST TWENTY-FOUR HOURS PRIOR TO DISCHARGE FROM AN INPATIENT ADMISSION. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.

(B) Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending.

(C) PROVIDED THAT A REQUEST FOR INPATIENT TREATMENT FOR SUBSTANCE USE DISORDER IS SUBMITTED TO THE UTILIZATION REVIEW AGENT AT LEAST TWENTY-FOUR HOURS PRIOR TO DISCHARGE FROM AN INPATIENT ADMISSION PURSUANT TO THIS SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR THE INPATIENT SUBSTANCE USE DISORDER TREATMENT WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT IS PENDING.

S 9. Subdivision 2 of section 4904 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:

(a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section forty-nine hundred three of this article; or

(b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review

agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal EXCEPT, WITH RESPECT TO INPATIENT SUBSTANCE USE DISORDER TREATMENT PROVIDED PURSUANT TO PARAGRAPH (C) OF SUBDIVISION 3 OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTICLE, EXPEDITED APPEALS SHALL BE DETERMINED WITHIN TWENTY-FOUR HOURS OF RECEIPT OF SUCH APPEAL. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. PROVIDED THAT THE ENROLLEE OR THE ENROLLEE'S HEALTH CARE PROVIDER FILES AN EXPEDITED INTERNAL AND EXTERNAL APPEAL WITHIN TWENTY-FOUR HOURS FROM RECEIPT OF AN ADVERSE DETERMINATION FOR INPATIENT SUBSTANCE USE DISORDER TREATMENT FOR WHICH COVERAGE WAS PROVIDED WHILE THE INITIAL UTILIZATION REVIEW DETERMINATION WAS PENDING PURSUANT TO PARAGRAPH (C) OF SUBDIVISION 3 OF SECTION FOUR THOUSAND NINE HUNDRED THREE OF THIS ARTICLE, A UTILIZATION REVIEW AGENT SHALL NOT DENY ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION SUCH SUBSTANCE USE DISORDER TREATMENT WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT OR EXTERNAL APPEAL AGENT IS PENDING.

S 10. Section 309 of the insurance law is amended by adding a new subsection (c) to read as follows:

(C) AS PART OF AN EXAMINATION, THE SUPERINTENDENT SHALL REVIEW DETERMINATIONS OF COVERAGE FOR SUBSTANCE USE DISORDER TREATMENT AND SHALL ENSURE THAT SUCH DETERMINATIONS ARE ISSUED IN COMPLIANCE WITH SECTIONS THREE THOUSAND TWO HUNDRED SIXTEEN, THREE THOUSAND TWO HUNDRED TWENTY-ONE, FOUR THOUSAND THREE HUNDRED THREE, AND TITLE ONE OF ARTICLE FORTY-NINE OF THIS CHAPTER.

S 10-a. Subdivision 2 of section 4409 of the public health law, as amended by chapter 805 of the laws of 1984, is amended to read as follows:

2. The superintendent shall examine not less than once every three years into the financial affairs of each health maintenance organization, and transmit his findings to the commissioner. In connection with any such examination, the superintendent shall have convenient access at all reasonable hours to all books, records, files and other documents relating to the affairs of such organization, which are relevant to the examination. The superintendent may exercise the powers set forth in sections three hundred four, three hundred five, three hundred six and three hundred ten of the insurance law in connection with such examinations, and may also require special reports from such health maintenance organizations as specified in section three hundred eight of the insurance law. AS PART OF AN EXAMINATION, THE SUPERINTENDENT SHALL REVIEW DETERMINATIONS OF COVERAGE FOR SUBSTANCE USE DISORDER TREATMENT AND SHALL ENSURE THAT SUCH DETERMINATIONS ARE ISSUED IN COMPLIANCE WITH SECTION FOUR THOUSAND THREE HUNDRED THREE OF THE INSURANCE LAW AND TITLE ONE OF ARTICLE FORTY-NINE OF THIS CHAPTER.

S 11. 1. Within thirty days of the effective date of this act, the commissioner of the office of alcoholism and substance abuse services, superintendent of the department of financial services, and the commissioner of health, shall jointly convene a workgroup to study and make recommendations on improving access to and availability of substance use disorder treatment services in the state. The workgroup shall be co-chaired by such commissioners and superintendent, and shall also include, but not be limited to, representatives of health care provid-

ers, insurers, additional professionals, individuals and families who have been affected by addiction. The workgroup shall include, but not be limited to, a review of the following:

a. Identifying barriers to obtaining necessary substance use disorder treatment services for across the state;

b. Recommendations for increasing access to and availability of substance use disorder treatment services in the state, including underserved areas of the state;

c. Identifying best clinical practices for substance use disorder treatment services;

d. A review of current insurance coverage requirements and recommendations for improving insurance coverage for substance use disorder treatment;

e. Recommendations for improving state agency communication and collaboration relating to substance use disorder treatment services in the state;

f. Resources for affected individuals and families who are having difficulties obtaining necessary substance use disorder treatment services; and

g. Methods for developing quality standards to measure the performance of substance use disorder treatment facilities in the state.

2. The workgroup shall submit a report of its findings and recommendations to the governor, the temporary president of the senate, the speaker of the assembly, the chairs of the senate and assembly insurance committees, and the chairs of the senate and assembly health committees no later than December 31, 2015.

S 12. This act shall take effect immediately; provided, however that sections one, two, three, three-a, four, five, six, six-a, seven, eight and nine of this act shall take effect April 1, 2015 and shall apply to policies and contracts issued, renewed, modified, altered or amended on and after such date.