STATE OF NEW YORK

1156--A

2017-2018 Regular Sessions

IN SENATE

January 6, 2017

Introduced by Sens. ORTT, BOYLE -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to establishing the mental health and substance use disorder parity report act

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short title. This act shall be known and may be cited as the "mental health and substance use disorder parity report act".

§ 2. Subsection (a) of section 210 of the insurance law, as amended by chapter 579 of the laws of 1998, is amended to read as follows:

(a) The superintendent shall annually publish on or before September first, nineteen hundred ninety-nine, and annually thereafter, a consumer guide to insurers providing managed care products, individual accident and health insurance or group or blanket accident and health insurance and entities licensed pursuant to article forty-four of the public health law providing comprehensive health service plans which includes, in detail, a ranking from best to worst based upon each company's claim processing or medical payments record during the preceding calendar year using criteria available to the department, adjusted for volume of coverage provided. Such ranking shall also take into consideration the corresponding total number or percentage of claims denied which were reversed or compromised after intervention by the department and the department of health, consumer complaints to the department and the department of health, violations of section three thousand two hundred twenty-four-a of this chapter and other pertinent data which would permit the department to objectively determine a company's performance. The department in publishing such consumer guide shall publish one state-wide guide or no more than five regional guides so as to facilitate comparisons among individual insurers and entities within a service

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

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market area. Such rankings shall be printed in a format which ranks all health insurers and all entities certified pursuant to article forty-four of the public health law in one combined list. **The consumer guide on or before September first, two thousand eighteen and annually thereafter, shall include a mental health parity report and a substance uses disorder parity report based upon each company's compliance with mental health parity and substance use disorder parity laws based on each company's record during the preceding calendar year using criteria available to the department, including, but not limited to, information required by this subsection and subsections (b), (c) and (d) of this section. In addition, notwithstanding such requirements and any law to the contrary, the data to be included in the mental health parity report and the substance use disorder parity report and collected by the superintendent and the commissioner of health from insurers and health plans, for such purposes shall include:**

(1) Annual mental health parity and substance use disorder parity compliance reports from each insurer and health plan outlining how it complies with Timothy's law, the insurance law provisions regarding substance use disorder and eating disorders and the Paul Wellstone and Pete Domenici mental health parity and addiction equity act of two thousand eight;

(2) Rates of utilization review for mental health and substance use disorder claims as compared to medical and surgical claims, including rates of approval and denial, categorized by benefits provided under the following classifications, as required under 45 C.F.R. § 146.136, 29 C.F.R. § 2590.712 and 26 C.F.R. § 54.9812-1.: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs;

(3) The number of prior or concurrent authorization requests for mental health services and for substance use disorder services and the number of denials for such requests, compared with the number of prior or concurrent authorization requests for medical and surgical services and the number of denials for such requests, categorized by the same classifications identified in paragraph two of this subsection which shall also include the rates of internal and external appeals, including rates of appeals upheld and overturned, specifically for mental health benefits and substance use disorder benefits;

(4) The number of prior or concurrent authorization requests for mental health services and substance use disorder services that went to clinical peer review as a result of a disagreement between the service provider and the insurer or health plan and the number that went to clinical peer review for medical and surgical services categorized in the same manner as provided in paragraph two of this subsection;

(5) The list of services that have a prior or concurrent authorization requirement based on a numerical threshold defined by a specific number of visits or days of care for mental health services, substance use disorder services and medical and surgical services and identification of the threshold requirements;

(6) The list of covered medications for the treatment of a substance use disorder on the prescription drug list of the insurer or health plan including tier placement, authorization requirements and all other utilization management requirements;

(7) The percentage of claims paid for in-network mental health services and for substance use disorder services and the percentage of claims paid for in-network medical and surgical services;

(8) The percentage of claims paid for out-of-network mental health services and substance use disorder services compared with the percentage of claims paid for other types of out-of-network medical and surgical services;

(9) The medical necessity criteria the insurer or health plan uses to make prior authorization or continuing care and discharge determinations, which in conjunction must be conspicuously posted for policyholders and providers to be able to review without making a request on the insurer's or the health plan's website and be made available in hard copy upon request;

(10) The number of behavioral health advocates, pursuant to an agreement with the office of the attorney general if applicable, or staff on hand to assist policyholders with benefits for mental health or substance use disorder;

(11) The network adequacy of insurers and health plans, which in addition to the requirements of subsection (a) of section three thousand two hundred forty-one of this chapter and subsection (c) of this section, shall consist of verifying the mental health and substance use disorder providers listed in an insurer's or health plan's provider directory as in network. Such verification shall be provided by the insurer or health plan, on a semi-annual basis, by providing its list of in-network mental health and substance use disorder providers and the number of claims each provider has submitted within the past six months. The list shall include the name, address and telephone number of all participating in-network providers. For providers that have had no claims in the past six months, the insurer or health plan must provide an attestation that such provider is still part of the network and that the provider is accepting new patients. For qualified health plans offered on New York state of health, the department of health shall review the network adequacy to ensure it is consistent with 45 CFR § 156.230 and the department of health's managed care network adequacy standard including verification of the mental health and substance use disorder providers listed in a qualified health plan's provider directory as in-network. Such verification shall be provided by a qualified health plan, on a semi-annual basis, by providing its list of in-network mental health and substance use disorder providers and the number of claims each provider has submitted within the past six months. The list shall include the name, address and telephone number of all participating providers. For providers that have no claims in the past six months, the qualified health plan must provide an attestation that such provider is still part of the network and that the provider is accepting new patients;

(12) The number of mental health and substance use disorder providers who have left or been removed from the provider network in the past six months and the reason that they have left or been removed; and

(13) Any other data or metric the superintendent or the commissioner of health deems is necessary to measure compliance with mental health parity and substance use disorder parity.

§ 3. Paragraph 2 of subsection (c) of section 210 of the insurance law, as added by chapter 579 of the laws of 1998, is amended to read as follows:

(2) the percentage of primary care physicians who remained participating providers, provided however, that such percentage shall exclude voluntary terminations due to physician retirement, relocation or other similar reasons, and the percentage of mental health professionals, defined as physicians who are licensed pursuant to article one hundred thirty-one of the education law who are diplomats of the American board

of psychiatry and neurology or are eligible to be certified by that board, or are certified by the American osteopathic board of neurology and psychiatry or are eligible to be certified by that board, a social worker licensed pursuant to article one hundred fifty-four of the education law or a psychologist licensed pursuant to article one hundred fifty-three of the education law, who remained as participating providers and the number of claims each type of mental health professional has submitted in the last twelve months and the number of mental health professionals, if any, who have not had any claims in the last twelve months;

§ 4. Subsection (d) of section 210 of the insurance law, as added by chapter 579 of the laws of 1998, is amended to read as follows:

(d) Health insurers and entities certified pursuant to article forty-four of the public health law shall provide annually to the superintendent and the commissioner of health, and the commissioner of health shall provide to the superintendent, all of the information necessary for the superintendent to produce the annual consumer guide, including the mental health parity report and the substance use disorder parity report. In compiling the guide, the superintendent shall make every effort to ensure that the information is presented in a clear, understandable fashion which facilitates comparisons among individual insurers and entities, and in a format which lends itself to the widest possible distribution to consumers. The superintendent shall either include the information from the annual consumer guide in the consumer shopping guide required by subsection (a) of section four thousand three hundred twenty-three of this chapter or combine the two guides as long as consumers in the individual market are provided with the information required by subsection (a) of section four thousand three hundred twenty-three of this chapter.

§ 5. This act shall take effect on the sixtieth day after it shall have become a law, provided, however, effective immediately, the amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized and directed to be made and completed on or before such effective date.