

STATE OF NEW YORK

7288--B

2023-2024 Regular Sessions

IN SENATE

May 19, 2023

Introduced by Sens. FERNANDEZ, ADDABBO, RYAN -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- recommitted to the Committee on Insurance in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to certain cost sharing fees for treatment of substance use disorder

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

1 Section 1. Subparagraph (E) of paragraph 31 of subsection (i) of
2 section 3216 of the insurance law, as amended by section 6 of subpart A
3 of part BB of chapter 57 of the laws of 2019, is amended and a new
4 subparagraph (K) is added to read as follows:
5 (E) This subparagraph shall apply to facilities in this state that are
6 licensed, certified or otherwise authorized by the office of [~~alcoholism~~
7 ~~and substance abuse~~] addiction services and supports for the provision
8 of outpatient, intensive outpatient, outpatient rehabilitation and
9 opioid treatment that are participating in the insurer's provider
10 network. Coverage provided under this paragraph shall not be subject to
11 preauthorization. Coverage provided under this paragraph shall not be
12 subject to concurrent review for the first four weeks of continuous
13 treatment, not to exceed twenty-eight visits, provided the facility
14 notifies the insurer of both the start of treatment and the initial
15 treatment plan within two business days. The facility shall perform
16 clinical assessment of the patient at each visit, including periodic
17 consultation with the insurer at or just prior to the fourteenth day of
18 treatment to ensure that the facility is using the evidence-based and
19 peer reviewed clinical review tool utilized by the insurer which is
20 designated by the office of [~~alcoholism and substance abuse~~] addiction

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

LBD11569-05-4

1 services and supports and appropriate to the age of the patient, to
2 ensure that the outpatient treatment is medically necessary for the
3 patient. Any utilization review of the treatment provided under this
4 subparagraph may include a review of all services provided during such
5 outpatient treatment, including all services provided during the first
6 four weeks of continuous treatment, not to exceed twenty-eight visits,
7 of such outpatient treatment. Provided, however, the insurer shall only
8 deny coverage for any portion of the initial four weeks of continuous
9 treatment, not to exceed twenty-eight visits, for outpatient treatment
10 on the basis that such treatment was not medically necessary if such
11 outpatient treatment was contrary to the evidence-based and peer
12 reviewed clinical review tool utilized by the insurer which is desig-
13 nated by the office of [~~alcoholism and substance abuse~~] addiction
14 services and supports. An insured shall only have financial responsibil-
15 ities as set out in subparagraph (K) of this paragraph and shall not
16 have any financial obligation to the facility for any treatment under
17 this subparagraph other than any copayment, coinsurance, or deductible
18 otherwise required under the policy.

19 (K) (i) Such coverage may be subject to annual deductibles and coinsu-
20 rance as may be deemed appropriate by the superintendent and as are
21 consistent with those established for other benefits within a given
22 policy; provided however, the total amount that an insured is required
23 to pay out-of-pocket for such services shall be capped at an amount not
24 to exceed five hundred dollars for an episode of care, regardless of the
25 insured's deductible, copayment, coinsurance or any other cost-sharing
26 requirement. If under federal law, application of this requirement would
27 result in health savings account ineligibility under 26 USC 223, this
28 requirement shall apply for health savings account-qualified high deduc-
29 tible health plans with respect to the deductible of such a plan after
30 the insured has satisfied the minimum deductible under 26 USC 223.

31 (ii) An episode of care shall include up to sixty visits with the same
32 treatment provider.

33 § 2. Subparagraphs (C-1) and (E) of paragraph 7 of subsection (1) of
34 section 3221 of the insurance law, subparagraph (C-1) as added by
35 section 16 and subparagraph (E) as amended by section 17 of subpart A of
36 part BB of chapter 57 of the laws of 2019, are amended and a new subpar-
37 agraph (K) is added to read as follows:

38 (C-1) A large group policy that provides coverage under this paragraph
39 shall not impose [~~copayments or~~] coinsurance for outpatient substance
40 use disorder services that exceeds the [~~copayment or~~] coinsurance
41 imposed for a primary care office visit. [~~Provided that no greater than~~
42 ~~one such copayment may be imposed for all services provided in a single~~
43 ~~day by a facility licensed, certified or otherwise authorized by the~~
44 ~~office of alcoholism and substance abuse services to provide outpatient~~
45 ~~substance use disorder services] A large group policy that provides
46 coverage under this paragraph shall not impose copayments for outpatient
47 substance use disorder services.~~

48 (E) This subparagraph shall apply to facilities in this state that are
49 licensed, certified or otherwise authorized by the office of [~~alcoholism~~
50 ~~and substance abuse~~] addiction services and supports for the provision
51 of outpatient, intensive outpatient, outpatient rehabilitation and
52 opioid treatment that are participating in the insurer's provider
53 network. Coverage provided under this paragraph shall not be subject to
54 preauthorization. Coverage provided under this paragraph shall not be
55 subject to concurrent review for the first four weeks of continuous
56 treatment, not to exceed twenty-eight visits, provided the facility

1 notifies the insurer of both the start of treatment and the initial
2 treatment plan within two business days. The facility shall perform
3 clinical assessment of the patient at each visit, including periodic
4 consultation with the insurer at or just prior to the fourteenth day of
5 treatment to ensure that the facility is using the evidence-based and
6 peer reviewed clinical review tool utilized by the insurer which is
7 designated by the office of [~~alcoholism and substance abuse~~] addiction
8 services and supports and appropriate to the age of the patient, to
9 ensure that the outpatient treatment is medically necessary for the
10 patient. Any utilization review of the treatment provided under this
11 subparagraph may include a review of all services provided during such
12 outpatient treatment, including all services provided during the first
13 four weeks of continuous treatment, not to exceed twenty-eight visits,
14 of such outpatient treatment. Provided, however, the insurer shall only
15 deny coverage for any portion of the initial four weeks of continuous
16 treatment, not to exceed twenty-eight visits, for outpatient treatment
17 on the basis that such treatment was not medically necessary if such
18 outpatient treatment was contrary to the evidence-based and peer
19 reviewed clinical review tool utilized by the insurer which is desig-
20 nated by the office of [~~alcoholism and substance abuse~~] addiction
21 services and supports. An insured shall only have financial responsibil-
22 ities as set out in subparagraph (K) of this paragraph and shall not
23 have any financial obligation to the facility for any treatment under
24 this subparagraph other than any copayment, coinsurance, or deductible
25 otherwise required under the policy.

26 (K) (i) Such coverage may be subject to annual deductibles and coinsu-
27 rance as may be deemed appropriate by the superintendent and as are
28 consistent with those established for other benefits within a given
29 policy; provided however, the total amount that an insured is required
30 to pay out-of-pocket for such services shall be capped at an amount not
31 to exceed five hundred dollars for an episode of care regardless of the
32 insured's deductible, copayment, coinsurance or any other cost-sharing
33 requirement. If under federal law, application of this requirement would
34 result in health savings account ineligibility under 26 USC 223, this
35 requirement shall apply for health savings account-qualified high deduc-
36 tible health plans with respect to the deductible of such a plan after
37 the insured has satisfied the minimum deductible under 26 USC 223.

38 (ii) An episode of care shall include up to sixty visits with the same
39 treatment provider.

40 § 3. Paragraphs 3-a and 5 of subsection (1) of section 4303 of the
41 insurance law, paragraph 3-a as added by section 27 and paragraph 5 as
42 amended by section 28 of subpart A of part BB of chapter 57 of the laws
43 of 2019, are amended and a new paragraph 11 is added to read as follows:

44 (3-a) A contract that provides large group coverage under this
45 subsection shall not impose [~~copayments or~~] coinsurance for outpatient
46 substance use disorder services that exceed the [~~copayment or~~] coinsu-
47 rance imposed for a primary care office visit. [~~Provided that no greater~~
48 ~~than one such copayment may be imposed for all services provided in a~~
49 ~~single day by a facility licensed, certified or otherwise authorized by~~
50 ~~the office of alcoholism and substance abuse services to provide outpa-~~
51 ~~tient substance use disorder services] A large group policy that
52 provides coverage under this paragraph shall not impose copayments for
53 outpatient substance use disorder services.~~

54 (5) This paragraph shall apply to facilities in this state that are
55 licensed, certified or otherwise authorized by the office of [~~alcoholism~~
56 ~~and substance abuse~~] addiction services and supports for the provision

1 of outpatient, intensive outpatient, outpatient rehabilitation and
2 opioid treatment that are participating in the corporation's provider
3 network. Coverage provided under this subsection shall not be subject to
4 preauthorization. Coverage provided under this subsection shall not be
5 subject to concurrent review for the first four weeks of continuous
6 treatment, not to exceed twenty-eight visits, provided the facility
7 notifies the corporation of both the start of treatment and the initial
8 treatment plan within two business days. The facility shall perform
9 clinical assessment of the patient at each visit, including periodic
10 consultation with the corporation at or just prior to the fourteenth day
11 of treatment to ensure that the facility is using the evidence-based and
12 peer reviewed clinical review tool utilized by the corporation which is
13 designated by the office of [~~alcoholism and substance abuse~~] addiction
14 services and supports and appropriate to the age of the patient, to
15 ensure that the outpatient treatment is medically necessary for the
16 patient. Any utilization review of the treatment provided under this
17 paragraph may include a review of all services provided during such
18 outpatient treatment, including all services provided during the first
19 four weeks of continuous treatment, not to exceed twenty-eight visits,
20 of such outpatient treatment. Provided, however, the corporation shall
21 only deny coverage for any portion of the initial four weeks of contin-
22 uous treatment, not to exceed twenty-eight visits, for outpatient treat-
23 ment on the basis that such treatment was not medically necessary if
24 such outpatient treatment was contrary to the evidence-based and peer
25 reviewed clinical review tool utilized by the corporation which is
26 designated by the office of [~~alcoholism and substance abuse~~] addiction
27 services and supports. A subscriber shall only have financial responsi-
28 bilities as set out in paragraph eleven of this subsection and shall not
29 have any financial obligation to the facility for any treatment under
30 this paragraph other than any copayment, coinsurance, or deductible
31 otherwise required under the contract.

32 (11) (A) Such coverage may be subject to annual deductibles and coin-
33 surance as may be deemed appropriate by the superintendent and as are
34 consistent with those established for other benefits within a given
35 contract; provided however, the total amount that an insured is required
36 to pay out-of-pocket for such services shall be capped at an amount not
37 to exceed five hundred dollars for an episode of care regardless of the
38 insured's deductible, copayment, coinsurance or any other cost-sharing
39 requirement. If under federal law, application of this requirement would
40 result in health savings account ineligibility under 26 USC 223, this
41 requirement shall apply for health savings account-qualified high deduc-
42 tible health plans with respect to the deductible of such a plan after
43 the insured has satisfied the minimum deductible under 26 USC 223.

44 (B) An episode of care shall include up to sixty visits with the same
45 treatment provider.

46 § 4. This act shall take effect on the first of January next succeed-
47 ing the date on which it shall have become a law and shall apply to
48 policies and contracts issued, renewed, modified, altered or amended on
49 and after such date.