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:

Section 1. Subparagraph (E) of paragraph 31 of subsection (i) of section 3216 of the insurance law, as amended by section 6 of subpart A of part BB of chapter 57 of the laws of 2019, is amended and a new subparagraph (K) is added to read as follows:

(E) This subparagraph shall apply to facilities in this state that are licensed, certified or otherwise authorized by the office of [~~alcoholism and substance abuse~~] addiction services and supports for the provision of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the insurer's provider network. Coverage provided under this paragraph shall not be subject to preauthorization. Coverage provided under this paragraph shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the insurer of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is 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

services **and supports** and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**. An insured **shall only have financial responsibilities as set out in subparagraph (K) of this paragraph and** shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

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

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

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

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

notifies the insurer of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the insurer at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this subparagraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the insurer shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the insurer which is designated by the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**. An insured **shall only have financial responsibilities as set out in subparagraph (K) of this paragraph and** shall not have any financial obligation to the facility for any treatment under this subparagraph other than any copayment, coinsurance, or deductible otherwise required under the policy.

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

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

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

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

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

of outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment that are participating in the corporation's provider network. Coverage provided under this subsection shall not be subject to preauthorization. Coverage provided under this subsection shall not be subject to concurrent review for the first four weeks of continuous treatment, not to exceed twenty-eight visits, provided the facility notifies the corporation of both the start of treatment and the initial treatment plan within two business days. The facility shall perform clinical assessment of the patient at each visit, including periodic consultation with the corporation at or just prior to the fourteenth day of treatment to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports** and appropriate to the age of the patient, to ensure that the outpatient treatment is medically necessary for the patient. Any utilization review of the treatment provided under this paragraph may include a review of all services provided during such outpatient treatment, including all services provided during the first four weeks of continuous treatment, not to exceed twenty-eight visits, of such outpatient treatment. Provided, however, the corporation shall only deny coverage for any portion of the initial four weeks of continuous treatment, not to exceed twenty-eight visits, for outpatient treatment on the basis that such treatment was not medically necessary if such outpatient treatment was contrary to the evidence-based and peer reviewed clinical review tool utilized by the corporation which is designated by the office of [~~alcoholism and substance abuse~~] **addiction** services **and supports**. A subscriber **shall only have financial responsibilities as set out in paragraph eleven of this subsection and** shall not have any financial obligation to the facility for any treatment under this paragraph other than any copayment, coinsurance, or deductible otherwise required under the contract.

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

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

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