STATE OF NEW YORK

8426

2025-2026 Regular Sessions

IN SENATE

June 10, 2025

Introduced by Sen. BROUK -- read twice and ordered printed, and when printed to be committed to the Committee on Rules

AN ACT to amend the insurance law, in relation to requiring health insurance policies conform to the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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

Section 1. Section 3221 of the insurance law is amended by adding a new subsection (v) to read as follows:

(v) (1) Every insurer issuing a policy delivered or issued for delivery in this state that provides coverage for any mental health or substance use disorder services shall:

(A) comply with the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations; and

(B) not discriminate in its plan benefit design or application against individuals because of their history of, present, or predicted mental health or substance use disorder.

(2) The provisions published at 89 Federal Register 77586 et seq. on September twenty-third, two thousand twenty-three, are incorporated into this subsection in their entirety and shall apply as state law. Such incorporation shall remain in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(3) Data collected pursuant to section three hundred forty-three of this chapter, and any other data requested by the superintendent, may be used to assess compliance with the requirements of this subsection.

(4) If an insurer provides any benefits for a mental health or substance use disorder in any classification of benefits, it shall provide meaningful benefits for that mental health or substance use

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

LBD13343-01-5

disorder in every classification in which medical or surgical benefits are provided. "Core treatments" means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health or substance use disorder care. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the insurer provides benefits for one or more medical conditions or surgical procedures. An insurer shall not be deemed to provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the insurer provides benefits for core treatments for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health or substance use disorder with respect to a classification, the insurer is not required to provide benefits for core treatments for such condition or disorder in that classification, but shall provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(5) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, an insurer shall not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits.

(6) A nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification shall not, in operation, be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical/surgical benefits in the classification. To test compliance with this paragraph, an insurer shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health or substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the plan's evaluation. As part of its evaluation, the insurer may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits in a classification, such differences will be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation per examiner contributes per examined to material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits in a classification, the insurer shall take reasonable action, as necessary, to address the material differences to ensure compliance, in operation, and shall document the actions that have been or are being taken by the insurer to address material differ-

ences in access to mental health or substance use disorder benefits, as compared to medical/surgical benefits.

(7) An insurer providing coverage for mental health or substance use disorder benefits shall submit an annual report beginning January first, two thousand twenty-six and annually thereafter, that contains the information described in 29 U.S.C. § 1185a(a)(8)(A) or 42 U.S.C. § 300gg-26(a)(8)(A), as applicable, and any other information determined necessary to assess compliance with this subsection. Such report shall be posted on a publicly available website whose web address is prominently displayed in plan informational and marketing materials.

(8) If a health care provider or a current or prospective enrollee or an employer requests, one or more nonquantitative treatment limitation parity compliance analyses that the insurer is required to have completed by this subsection, the insurer shall provide the requested analyses free of charge within thirty days. The insurer shall include in each of their health plan policies and mental health and substance use disorder provider contracts a notification of the right to request nonquantitative treatment limitation analyses free of charge. The notification shall include information on how to request the analyses. In addition to any other action authorized under this chapter, failure by an insurer to provide the full requested analyses shall result in a penalty of one hundred ten dollars per day. If the request under this paragraph is made in connection with an adverse benefit determination and the insurer fails to provide the requested analyses as required by this subsection, the adverse benefit determination is automatically reversed.

(9) The superintendent may adopt rules or guidance as necessary to implement and administer this subsection, and such rules or guidance shall have the force of law, including:

(A) specifying data testing requirements to determine plan design and application parity and nondiscrimination compliance using outcomes data;

(B) setting standard definitions; and

(C) establishing specific timelines for insurer compliance with the requirements of this subsection, including the effect of an insurer's lack of sufficient comparative analyses or other required information necessary to demonstrate compliance.

§ 2. Section 4303 of the insurance law is amended by adding a new subsection (ww) to read as follows:

(ww) (1) Every corporation issuing a contract delivered or issued for delivery in this state that provides coverage for any mental health or substance use disorder services shall:

(A) comply with the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations; and

(B) not discriminate in its contract benefit design or application against individuals because of their history of, present, or predicted mental health or substance use disorder.

(2) The provisions published at 89 Federal Register 77586 et seq. on September twenty-third two thousand twenty-three, are incorporated into this section in their entirety and shall apply as state law. Such incorporation shall remain in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(3) Data collected pursuant to section three hundred forty-three of this chapter, and any other data requested by the superintendent, may be used to assess compliance with the requirements of this subsection.

(4) If a corporation provides any benefits for a mental health or substance use disorder in any classification of benefits, it shall provide meaningful benefits for that mental health or substance use disorder in every classification in which medical or surgical benefits are provided. "Core treatments" means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health or substance use disorder care. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the corporation provides benefits for one or more medical conditions or surgical procedures. A corporation shall not be deemed to provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the corporation provides benefits for core treatments for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health or substance use disorder with respect to a classification, the corporation is not required to provide benefits for core treatments for such condition or disorder in that classification, but shall provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(5) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, a corporation shall not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical or surgical benefits.

(6) A nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification shall not, in operation, be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical or surgical benefits in the classification. To test compliance with this paragraph, a corporation shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health or substance use disorder benefits and medical or surgical benefits, and carefully consider the impact as part of the contract's evaluation. As part of its evaluation, the corporation may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health or substance use disorder benefits as compared to medical or surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits as compared to medical or surgical benefits in a classification, such differences shall be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits, the corporation shall take reasonable

action, as necessary, to address such differences to ensure operational compliance, and shall document the actions taken to do so.

(7) A corporation providing coverage for mental health or substance use disorder benefits shall submit an annual report beginning January first, two thousand twenty-six and annually thereafter that contains the information described in 29 U.S.C. § 1185a(a)(8)(A) or 42 U.S.C. § 300gg-26(a)(8)(A), as applicable, and any other information determined necessary to assess compliance with this subsection. Such report shall be posted on a publicly available website whose web address is prominently displayed in contract informational and marketing materials.

(8) If a health care provider or a current or prospective enrollee or an employer requests one or more nonquantitative treatment limitation parity compliance analyses that the corporation is required to have completed by this subsection, the corporation shall provide the requested analyses free of charge within thirty days. The corporation shall include in each of its health care contracts and provider agreements for mental health and substance use disorder services a notification of the right to request such analyses free of charge. Such notification shall include information on how to request the analyses. In addition to any other action authorized under this chapter, failure by a corporation to provide the full requested analyses shall result in a penalty of one hundred ten dollars per day. If the request under this paragraph is made in connection with an adverse benefit determination and the corporation fails to provide the requested analyses as required by this subsection, the adverse benefit determination shall be automatically reversed.

(9) The superintendent may adopt rules or guidance as necessary to implement and administer this subsection, and such rules or guidance shall have the force of law, including:

(A) specifying data testing requirements to determine plan design and application parity and nondiscrimination compliance using outcomes data;

(B) setting standard definitions; and

(C) establishing specific timelines for corporation compliance with the requirements of this subsection, including the effect of a corporation's lack of sufficient comparative analyses or other required information necessary to demonstrate compliance.

§ 3. Section 3216 of the insurance law is amended by adding a new subsection (n) to read as follows:

(n) (1) Every insurer issuing a policy delivered or issued for delivery in this state that provides coverage for any mental health or substance use disorder services shall:

(A) comply with all applicable requirements of state and federal law regarding coverage of such services; and

(B) not discriminate in its policy benefit design or administration against individuals because of their history of, present, or predicted mental health or substance use disorder.

(2) The provisions published at 89 Federal Register 77586 et seq. on September twenty-third, two thousand twenty-three, are incorporated into this section in their entirety and shall apply as state law. Such incorporation shall remain in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(3) Data collected pursuant to section three hundred forty-three of this chapter, and any other data requested by the superintendent, may be used to assess compliance with the requirements of this subsection.

(4) If an insurer provides any benefits for a mental health or substance use disorder in any classification of benefits, it shall

provide meaningful benefits for that mental health or substance use disorder in every classification in which medical or surgical benefits are provided. "Core treatments" means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health or substance use disorder care. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the insurer provides benefits for one or more medical conditions or surgical procedures. An insurer shall not be deemed to provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the insurer provides benefits for core treatments for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health or substance use disorder with respect to a classification, the insurer is not required to provide benefits for core treatments for such condition or disorder in that classification, but shall provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(5) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, an insurer shall not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical or surgical benefits.

(6) A nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification shall not, in operation, be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical or surgical benefits in the classification. To test compliance with this paragraph, an insurer shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health or substance use disorder benefits and medical or surgical benefits, and carefully consider the impact as part of the policy's evaluation. As part of its evaluation, the insurer may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health or substance use disorder benefits as compared to medical or surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes per examiner to material differences in access to mental health or substance use disorder benefits as compared to medical or surgical benefits in a classification, such differences shall be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits, the insurer shall take reasonable action, as necessary, to address such differences to ensure operational compliance, and shall document the actions taken to do so.

(7) An insurer providing coverage for mental health or substance use disorder benefits shall submit an annual report beginning January first, two thousand twenty-six and annually thereafter that contains the information described in 29 U.S.C. § 1185a(a)(8)(A) or 42 U.S.C. § 300gg-26(a)(8)(A), as applicable, and any other information determined necessary to assess compliance with this subsection. The report shall be posted on a publicly available website whose web address is prominently displayed in policy informational and marketing materials.

(8) If a health care provider or a current or prospective insured or an employer requests one or more nonquantitative treatment limitation parity compliance analyses that the insurer is required to have completed by this subsection, the insurer shall provide the requested analyses free of charge within thirty days. The insurer shall include in each of its health insurance policies and provider agreements for mental health and substance use disorder services a notification of the right to request such analyses free of charge. Such notification shall include information on how to request the analyses. In addition to any other action authorized under this chapter, failure by an insurer to provide the full requested analyses shall result in a penalty of one hundred ten dollars per day. If the request under this paragraph is made in connection with an adverse benefit determination and the insurer fails to provide the requested analyses as required by this subsection, the adverse benefit determination shall be automatically reversed.

(9) The superintendent may adopt rules or guidance as necessary to implement and administer this subsection, and such rules or guidance shall have the force of law, including:

(A) specifying data testing requirements to determine policy design and application parity and nondiscrimination compliance using outcomes data;

(B) setting standard definitions; and

(C) establishing specific timelines for insurer compliance with the requirements of this section, including the effect of an insurer's lack of sufficient comparative analyses or other required information necessary to demonstrate compliance.

§ 4. This act shall take effect on the one hundred twentieth day after it shall have become a law and shall apply to all policies issued, renewed, modified, altered or amended on or after such date. Effectively immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such date.