STATE OF NEW YORK

8426--A

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 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law, in relation to preventing discrimination by insurers based on an individual's mental health or substance use disorder

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

Section 1. 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 the requirements of the 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 commissioner of mental health shall promulgate rules and regulations to incorporate the regulatory requirements related to the Mental Health Parity and Addiction Equity Act at 89 Fed. Reg. 77735 through 89 Fed. Reg. 77751, as found on September twenty-third, two thousand twenty-four, in their entirety, in relation to the provisions of this subsection.

(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 paragraph one of this subsection.

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

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(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 such 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 paragraph, whether the benefits provided are considered "meaningful benefits" shall be determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and shall require, 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 does not 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 shall not be 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 and 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 and 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 and surgical benefits. To the extent the relevant data evaluated suggests 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 as compared to medical and 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 differences in access to mental health or substance use disorder benefits, as compared to medical and surgical benefits.

(7) An insurer providing coverage for mental health or substance use disorder benefits shall submit an annual report starting on January first, two thousand twenty-six and annually thereafter, that contains the information described in 29 USC 1185a(a)(8)(A) and 42 USC 300gg-26(a)(8)(A). The report required 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, 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 pursuant to 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 300gg-26, 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 dollars per day, which shall be collected by the superintendent and remitted to the requestor. If the request under this paragraph is made in connection with an adverse benefit determination and the insurer fails to provide the required analyses as required by this paragraph, the adverse benefit determination shall be automatically reversed.

(9) The superintendent may adopt rules or guidance as necessary to implement and administer the provisions of paragraphs one through seven of this subsection, and such rules or guidance shall have the force of law and shall include:

(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 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 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 commissioner of mental health shall promulgate rules and regulations to incorporate the regulatory requirements related to the Mental Health Parity and Addiction Equity Act at 89 Fed. Reg. 77735 through 89 Fed. Reg. 77751, as found on September twenty-third, two thousand twen-

ty-four, in their entirety, in relation to the provisions of this subsection.

(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 paragraph one 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 such 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 paragraph, whether the benefits provided are considered "meaningful benefits" shall be determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and shall require, 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 does not 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 shall not be 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 and 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 and 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 and surgical benefits. To the extent the relevant data evaluated suggests 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 classi-

fication, 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 as compared to medical and 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 differences in access to mental health or substance use disorder benefits, as compared to medical and surgical benefits.

(7) An insurer providing coverage for mental health or substance use disorder benefits shall submit an annual report starting on January first, two thousand twenty-six and annually thereafter, that contains the information described in 29 USC 1185a(a)(8)(A) and 42 USC 300gg-26(a)(8)(A). The report required 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, 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 pursuant to 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 300gg-26, 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 dollars per day, which shall be collected by the superintendent and remitted to the requestor. If the request under this paragraph is made in connection with an adverse benefit determination and the insurer fails to provide the required analyses as required by this paragraph, the adverse benefit determination shall be automatically reversed.

(9) The superintendent may adopt rules or guidance as necessary to implement and administer the provisions of paragraphs one through seven of this subsection, and such rules or guidance shall have the force of law and shall include:

(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.

§ 3. 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 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 commissioner of mental health shall promulgate rules and regulations to incorporate the regulatory requirements related to the Mental Health Parity and Addiction Equity Act at 89 Fed. Reg. 77735 through 89 Fed. Reg. 77751, as found on September twenty-third, two thousand twenty-four, in their entirety, in relation to the provisions of this subsection.

(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 paragraph one 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 such 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 paragraph, whether the benefits provided are considered "meaningful benefits" shall be determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and shall require, 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 does not 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 shall not be 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 and 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 and 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 and surgical benefits. To the extent the relevant data evaluated suggests 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 as compared to medical and 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 differences in access to mental health or substance use disorder benefits, as compared to medical and surgical benefits.

(7) An insurer providing coverage for mental health or substance use disorder benefits shall submit an annual report starting on January first, two thousand twenty-six and annually thereafter, that contains the information described in 29 USC 1185a(a)(8)(A) and 42 USC 300gg-26(a)(8)(A). The report required 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, 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 pursuant to 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 300gg-26, 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 dollars per day, which shall be collected by the superintendent and remitted to the requestor. If the request under this paragraph is made in connection with an adverse benefit determination and the insurer fails to provide the required analyses as required by this paragraph, the adverse benefit determination shall be automatically reversed.

(9) The superintendent may adopt rules or guidance as necessary to implement and administer the provisions of paragraphs one through seven of this subsection, and such rules or guidance shall have the force of law and shall include:

(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.

§ 4. This act shall take effect immediately.