The State of Parity in New York State

New York State has long been a national leader in seeking to ensure that individuals have equitable access to insurance coverage for substance use disorder (SUD) and mental health (MH) conditions through enforcement of both the federal Mental Health Parity and Addiction Equity Act (MHPAEA or Parity Act) and New York's own insurance laws.

New York has the opportunity now to continue its record as a parity leader by conducting stronger and more consistent enforcement of parity and related insurance laws, collecting better data to inform equitable access to care, and limiting cost-sharing for a wider range of outpatient MH and SUD services - and the State can feel confident in doing so given new public opinion research affirming New Yorkers overwhelmingly support better insurance access to care. Recent polling commissioned by the Legal Action Center shows that 80% of New Yorkers, including 73% of Republicans, 88% of Democrats, and 74% of Independents, want to see health insurers cover SUD care at levels equal to other health conditions.

Setting the Scene

Building off of a much narrower federal parity law, MHPAEA as we know it was enacted in **2008**, establishing more comprehensive parity standards for both MH and SUD benefits. This was shortly after Timothy's Law was enacted in New York in **2006**, which provided some of the earliest protections nationwide for MH coverage. In **2016**, New York's Attorney General entered into six groundbreaking settlement agreements with insurers for violating parity and other insurance regulations. In **2018**, New York also created a first-in-the-nation ombudsman program, CHAMP, to help residents navigating MH and SUD coverage. That same year, the State required health plans to submit comprehensive parity reports, and then in **2019**, passed the Insurance Parity Reform package of legislation to provide a series of robust insurance protections to New Yorkers seeking SUD and MH care. More recently, New York has enacted additional legislation and regulations to require health plans to have robust parity compliance programs and the creation of (still pending) network adequacy standards. There have also been some recent enforcement actions on both the Medicaid side and commercial side for violations of parity and other insurance protections for MH and SUD care. To learn more about NY's history of parity enforcement actions, view a detailed timeline here.

Federally, new Parity Act regulations for commercial insurance plans were recently finalized by the Departments of Labor, Health and Human Services and Treasury. These new regulations implement changes to MHPAEA that were passed in 2021 and focus on eliminating discriminatory practices by health plans, closing loopholes and enhancing enforcement. Specifically, the new regulations attempt to make clear that consumers should not face greater restrictions on access to MH and SUD coverage compared to medical/surgical benefits. There is also a renewed focus on the identification and monitoring of outcome data to assess the impact of non-quantitative treatment limitations on access to MH and SUD care.

Similarly, the Centers for Medicare and Medicaid Services (CMS) recently released new guidance and templates for comment for Medicaid managed care plans to document compliance with parity. These actions and others demonstrate the federal government's interest in enhancing parity compliance and ensuring equitable access to SUD and MH coverage and care.

Strengthening Parity Enforcement in NYS

Since the federal Parity Act was enacted, New York has undertaken several enforcement actions against plans for discriminatory conduct that resulted in limitations on access to MH and SUD benefits for New Yorkers. For example, in 2021, New York's Department of Financial Services (DFS) secured $3.1million from several plans for parity violations, however, since that time, there has been little public information about enforcement activity. Most recently, on the Medicaid side, Managed Care Organizations (MCOs) conducted a series of focused surveys to assess compliance with a series of laws and regulations regarding behavioral health services, including the Parity Act. The last surveys for parity compliance only collected data through the end of 2020.

Consistent monitoring and enforcement of parity and other insurance law compliance is critical to eliminating barriers to accessing MH and SUD care. Recognizing this, New York created the Parity Compliance Fund in 2019 specifically to make fines collected available for continuing parity monitoring and enforcement. We urge New York regulators to utilize this funding source for its intended purpose to fund staff at New York's Department of Health (DOH) and DFS to engage in compliance monitoring activities.

Comprehensive data collection is necessary to engage in robust monitoring and enforcement efforts. Changes to the **federal Parity Act** in 2021 (and now included in the new final parity regulations) require plans to complete comparative analyses focused on the application of non-quantitative treatment limitations (NQTLs) and, upon request, submit them to federal and/or state regulators. These analyses are intended to compare the application of NQTLs to MH/SUD care with medical/surgical care and demonstrate that the processes, strategies, and evidentiary standards for each are comparable. The particular outcome data points identified in the final parity regulations are important for understanding whether health plans in the state are lawfully providing benefits for MH/SUD care in a non-discriminatory way as required by the Parity Act.

New York's Parity Reporting Act, which requires plans to submit comparative analyses every two years, collects different data that instead looks at the numbers and percentages of NQTLs, like prior authorization and network composition. This data is useful to be sure, but the state would have an even better picture of Parity Act compliance if it used the New York Parity Reporting Act data as a complement to the data identified in the federal regulations.

We are not aware that New York regulators have requested the federally required comparative analyses yet, but we strongly urge New York regulators to utilize both data sets to monitor plans for parity compliance and to amend New York law, so that data is meaningfully collected and analyzed. Additionally, New York – as a leader in parity enforcement – can collect stronger data to properly evaluate parity compliance.

For example, reimbursement rates are evaluated as an NQTL, and low reimbursement rates can be both an indicator of parity violations and a major driver of inadequate networks. The federal regulations offer the example of comparing reimbursement rates to a benchmark rate, which would help to identify whether MH and SUD providers are reimbursed at lower rates compared to the benchmark and medical/surgical providers. However, this comparison fails to account for issues in the underlying benchmark.

For example, CMS has acknowledged in recent years that Medicare fee schedule rates undervalue MH and SUD services, and thus Medicare is an inadequate benchmark if the goal is to truly assess whether the reimbursement rates are sufficient for developing and maintaining a sufficient network. Accordingly, a more meaningful data set for New York should include a comparison of the actual amount reimbursed versus the actual amount billed for MH and SUD services as compared to medical/surgical services, as this would capture the market rate for all services.

Top-down monitoring is the best way to achieve full compliance, especially because individual New Yorkers are likely unaware of their parity rights. However, in some cases, patients are making complaints or filing appeals to DFS or DOH about denials or insurance barriers. It is critical that front line consumer assistance staff at these agencies understand MH and SUD services, how to issue-spot for parity violations, and other best practices to ensure appropriate and lawful coverage.

We encourage regulators to conduct annual trainings for staff on parity red flags and how to elevate complaints to ensure they lead to comprehensive parity compliance assessment and appropriate resolution for consumers.

Utilizing Better Metrics to Advance Health Equity in NYS

Better metrics can be used to identify and incentivize ways to close disparities in New Yorkers' access to MH and SUD care. Evidence consistently shows that access to MH and SUD services, and therefore outcomes, are disproportionately worse for Black and brown individuals, people living in rural communities, and for people speaking languages other than English. Overdose rates are most pronounced among Black individuals statewide.

We are encouraged to see the recent DFS announcement of new regulations to require health plans to collect demographic data to better understand disparities in access to coverage and care, and we urge the State to build on these efforts in other areas.

For example, the newly proposed network adequacy regulations are focused on ensuring shorter wait times for appointments with the hope that insurers will need to establish more robust networks to meet those wait time standards. However, those standards will not necessarily address more equitable access to care unless there are standards and requirements to incentivize more culturally effective providers who can adequately provide services in particular languages, neighborhoods, and that are appropriate to specific racial or ethnic groups' needs. Demographic data about enrollees must be provided both to evaluate network adequacy but also as part of parity compliance reporting to evaluate how particular parity violations may be exacerbating overall inequities in MH and SUD outcomes for already underserved populations.

Additionally, it is important to act creatively to incentivize health plans to strengthen access to MH and SUD care for communities that have traditionally been under-resourced and face worse outcomes. One example is to include rate modifiers to increase reimbursement rates for providers who deliver services in such areas of the state, such as rural communities with lower access to services.

Limiting Cost Sharing for MH and SUD Outpatient Treatment in NYS

Unlike most kinds of medical care, outpatient treatment for MH conditions and SUD can require frequent visits, often daily or weekly, especially early in treatment, but this can be an insurmountable barrier to New Yorkers seeking care. With out-of-pocket costs rising for in-network care for all health conditions, people seeking care for MH and SUD bear the brunt of these cost burdens.

Studies consistently show that the greater the cost-sharing burden, the lower the adherence to treatment in all types of health care. Studies specifically looking at outpatient MH utilization found decreased treatment adherence when co-payments increase. Another study found that even just a one dollar increase in daily out-of-pocket costs for the SUD medication buprenorphine lead to a 12-14% decrease in the odds of retention in treatment.

In 2022, legislation was enacted in New York to totally prohibit co-payments and co-insurance for in-network services provided at an Opioid Treatment Program. Doing so lifted a huge barrier to SUD access – but it didn't go far enough. New York needs to explore expanding limitations on cost-sharing to other MH and SUD services, including all outpatient care and medication co-pays.

In Conclusion, What Can NYS Do?

ADMINISTRATIVE ACTIONS

- **Enforce Parity - actively monitor for violations and hold insurers accountable**
- **Train all front-line staff on Parity Red Flags**
- **Collect better data**

LEGISLATIVE ACTIONS

- **Limit cost-sharing for MH and SUD treatment**
- **Amend the Parity Reporting Act to improve data and collect it more often**

New York has long been a leader among states in working to improve benefits for MH and SUD care by passing key health insurance protections and enforcing the Parity Act. As we enter 2025, we encourage policymakers (regulatory agencies and legislators) to continue this leadership by stepping up enforcement efforts, focusing on better metrics to enhance health equity, and addressing the continuing barrier of high cost-sharing for MH and SUD care.