LEGISLATURE OF NEBRASKA

ONE HUNDRED SIXTH LEGISLATURE

 FIRST SESSION

**LEGISLATIVE BILL XXX**

Introduced by \_\_\_\_\_\_\_\_\_

Read first time \_\_\_\_\_\_\_\_\_

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to insurance; to provide definitions; to provide requirements for parity transparency.

Be it enacted by the people of the State of Nebraska,

 Section 1. (1) For the purposes of this section:

 (a) Director shall mean the Director of Insurance;

 (b) Classification of benefits means inpatient in-network benefits,

inpatient out-of-network benefits, outpatient in-network benefits, outpatient

out-of-network benefits, prescription drug benefits, and emergency care

benefits. These classifications of benefits are the only classifications that may

be used except that there may be sub-classifications within both outpatient

classifications differentiating office visits from other outpatient items and

services, including outpatient surgery, facility charges for day treatment

centers, laboratory charges, and other medical items;

(c) Health insurance plan means (a) any individual or group sickness and accident insurance policy, individual or group health maintenance organization contract, or individual or group subscriber contract delivered, issued for delivery, or renewed in this state and (b) any self-funded employee benefit plan to the extent not preempted by federal law; health insurance plan includes any group policy, group contract, or group plan offered or administered by the state or its political subdivisions; health insurance plan does not include group policies providing coverage for a specified disease, accident-only coverage, hospital indemnity coverage, disability income coverage, Medicare supplement coverage, long-term care coverage, or other limited-benefit coverage;

 (d) Mental health and alcohol or substance abuse benefits mean benefits for the diagnosis and treatment of any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and

 (e) Nonquantitative treatment limitations mean limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment.

Sec. 2. (1) All insurers that deliver, issue, or renew any health insurance plan that provides coverage of mental health and alcohol or substance abuse benefits shall submit an annual report to the Director on or before March 31st that contains the following information:

 (a) A description of the process used to develop or select the medical necessity criteria for mental health and alcohol or substance abuse benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(b) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and alcohol or substance abuse benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health and alcohol or substance abuse benefits but do not apply to medical and surgical benefits within any classification of benefits;

(c) The results of an analysis that demonstrates that for the medical necessity criteria described in item (a) and for each NQTL identified in item (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental health and alcohol or substance abuse benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(i) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

(ii) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL;

(iii) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to mental health and alcohol or substance abuse disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

(iv) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health and alcohol or substance abuse benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

(v) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the insurer is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).