2019 Regular Session

HOUSE BILL NO. XXX

BY REPRESENTATIVE \_\_\_\_\_\_\_\_\_\_\_

INSURANCE/HEALTH: Provides requirements for mental health parity

AN ACT

To enact R.S. 22:1066.1, relative to parity reporting requirements for health insurance issuers; to establish parity reporting requirements for issuers; to establish parity implementation requirements for the commissioner; to establish insurance requirements for substance abuse medications; to provide for definitions.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1066.1 is hereby enacted to read as follows:

§1066.1. Parity reporting requirements

 A. All insurers or other issuers of health coverage plans shall submit an annual report to the commissioner on or before January 31st that contains the following information:

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

(2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and 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 substance abuse benefits but do not apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in item (1) and for each NQTL identified in item (2), 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 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:

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

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

(c) 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 substance abuse 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

(d) 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 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

(e) Disclose the specific findings and conclusions reached by the insurer or other issuer of a health coverage plan that the results of the analyses above indicate that the insurer or other issuer of a health coverage plan 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).

B. The commissioner shall implement and enforce applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any amendments to, and any federal guidance or regulations relevant to, that act, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3), includes:

(1) Proactively ensuring compliance by insurers or other issuers of health coverage plans.

(2) Evaluating all consumer or provider complaints regarding mental health and substance abuse coverage for possible parity violations.

(3) Performing parity compliance market conduct examinations of insurers or other issuers of health coverage plans, particularly market conduct examinations that focus on nonquantitative treatment limitations such as prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, and geographic restrictions, among other nonquantitative treatment limitations.

(4) Requesting that insurers and other issuers of health coverage plans submit comparative analyses during the form review process demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental health and substance abuse benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits.

(5) The Commissioner may adopt rules, under R.S. 22:11, as may be necessary, to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

C. Not later than March 31st, 2020, the commissioner shall issue a report and educational presentation to the Legislature, which shall contain the following:

(1) Cover the methodology the commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and any federal regulations or guidance relating to the compliance and oversight of MHPAEA.

(2) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and substance abuse benefits under state and federal laws and summarize the results of such market conduct examinations.

(3) Detail any educational or corrective actions the commissioner has taken to ensure insurer or other issuers of health coverage plans compliance with MHPAEA.

(4) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the commissioner finds appropriate, posting the report on the Internet website of the Department of Insurance.

D. Each insurer or other issuer of health coverage plans that provides prescription medication benefits for the treatment of substance abuse shall comply with the following requirements:

(1) Each insurer or other issuer of health coverage plans that provides prescription medication benefits for the treatment of substance abuse shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance abuse.

(2) Each insurer or other issuer of health coverage plans that provides prescription medication benefits for the treatment of substance abuse shall not impose any step therapy requirements before the insurer will authorize coverage for a prescription medication approved by the FDA for the treatment of substance abuse.

(3) Each insurer or other issuer of health coverage plans that provides prescription medication benefits for the treatment of substance abuse shall place all prescription medications approved by the FDA for the treatment of substance abuse on the lowest tier of the drug formulary developed and maintained by the insurer.

(4) Each insurer or other issuer of health coverage plans that provides prescription medication benefits for the treatment of substance abuse shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

E. As used in this section:

(1) "Health coverage plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the Office of Group Benefits programs.

(2) “Mental health or substance abuse benefits” means benefits for the 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.

(3) “Nonquantitative treatment limitations” means limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment, as expressed at 45 CFR 146.136(c)(4)(ii).