HBXX

XXXXXX-1

By Representative \_\_\_\_\_\_\_\_

RFD: Insurance

First Read: XX-JAN-19

PFD:

XXXXXXX-1:n:01/XX/2019:XXX/xx LRS2019-XXXX

Synopsis: Under existing law, there is no requirement that no requirement

that insurers or other issuers of individual or group health benefit plans that provide mental health or substance abuse benefits demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008

 This bill would require the insurers or other issuers of individual or group health benefit plans that provide mental health or substance abuse benefits to submit an annual report demonstrating compliance with the Mental Health Parity and Addiction Equity Act of 2008.

A BILL

TO BE ENTITLED

AN ACT

 To amend section 27-54-4 of the Code of Alabama 1975, relating to reporting requirements for insurers or other issuers of individual or group health benefit plans that provide mental health or substance abuse benefits about compliance with the Mental Health Parity and Addiction Equity Act of 2008 and requirements of the Commissioner of Insurance specific to the Mental Health Parity and Addiction Equity Act of 2008.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

 Section 1: Section 27-54-4, Code of Alabama 1975, is amended to read as follows:

 §27-44-4.

 “(a) All group health benefit plans shall offer to provide, at a minimum, additional benefits according to this chapter for a person receiving medical treatment for any of the following mental illnesses diagnosed by an appropriately licensed provider.

 “(1) Schizophrenia, schizophrenia form disorder, schizo affective disorder.

“(2) Bipolar disorder.

“(3) Panic disorder.

“(4) Obsessive-compulsive disorder.

“(5) Major depressive disorder.

“(6) Anxiety disorders.

“(7) Mood disorders.

“(8) Any condition or disorder involving mental illness or alcohol and substance abuse, ~~excluding alcohol and substance abuse,~~ that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised.

“(b) All group health benefit plans, policies, contracts, and certificates executed, delivered, issued for delivery, continue, or renewed in this state on or after January 1, 2001, shall offer, at the time of proposal, sale, or renewal of a policy subject to this chapter, to provide additional mental health benefits which meet the requirements of this chapter. For purposes of this subsection, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

“(1) ~~The~~ Any individual or group health benefit plan ~~shall offer to~~ that provides benefits for the treatment and diagnosis of mental illnesses or alcohol and substance abuse shall provide those benefits under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses and shall comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), found at 42 U.S.C. § 300gg-26, and its implementing and related regulations found at 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

“(2) At the request of a reimbursing group health benefit plan, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the insurer or other issuer of the group health benefit plan shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the contract.

~~“(3) This chapter does not apply to group health benefit plans covering employers with 50 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust, or to another entity~~.

~~“(4) This chapter does not require and shall not be construed to require coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in subsection (a).~~

~~“(5)~~ (3) This chapter does not require and shall not be construed to require the coverage of services of providers who are not designated as covered providers, or who are not selected as a participating provider, by a group health benefit plan or issuer having a participating network of service providers. Provided, however, reasonable effort shall be made to include a sufficient number of qualified providers to insure reasonable access to services.

~~“(6)~~ (4) Insurers and other issuers of limited or restricted mental health provider networks shall continue to be able to establish and apply selection criteria and utilization protocols for mental health providers including the designation of types of providers for which coverage is provided as well as credentialing criteria used in the selection of providers.

~~“(7)~~ (5) Provided further, employer sponsors of group health benefit plans are not required to purchase additional coverage for mental health services that are offered pursuant to this chapter.

“(c) All insurers or other issuers of individual or group health benefit plans that provide benefits for the treatment and diagnosis of mental illnesses or alcohol and substance abuse shall submit an annual report to the Commissioner of Insurance on or before June 30th that contains the following information:

“(1) A description of the process used to develop or select the medical necessity criteria for mental health or alcohol 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 or alcohol 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 or alcohol 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 or alcohol 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 use 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.

“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 individual or group health benefit plans that the results of the analyses above indicate that the insurer or other issuer of individual or group health benefit plans is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which include 45 CFR 146.136, 45 CFR 147.160, 45 CFR 156.115(a)(3).

“(d) 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), and this section, which includes:

“(1) Proactively ensuring compliance by insurers or other issuers of individual or group health benefit plans that provide benefits for the treatment and diagnosis of mental illnesses or alcohol and substance abuse.

“(2) Evaluating all consumer or provider complaints regarding benefits for the treatment and diagnosis of mental illnesses or alcohol and substance abuse for possible parity violations.

“(3) Performing parity compliance market conduct examinations of insurers or other issuers of individual or group health benefit plans that provide benefits for the treatment and diagnosis of mental illnesses or alcohol and substance abuse, as authorized under section 27-2-7 of this title, 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 or other issuers of individual or group health benefit plans that provide benefits for the treatment and diagnosis of mental illnesses or alcohol and substance abuse 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 illness or alcohol 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, as authorized under section 27-2-17 of this title, 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.

“(e) Not later than January 31st, 2020, the Commissioner shall issue a report and an educational presentation to the Legislature; such report and presentation shall:

“(1) Cover the methodology the Commissioner is using to check for compliance with this section, 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 this section and MHPAEA and summarize the results of such market conduct examinations.

“(3) Detail any educational or corrective actions the Commissioner has taken to ensure insurer compliance with MHPAEA and relevant section(s) of state law.

“(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 website of the Department of Insurance.”

“(f) Any individual or group health benefit plan that provides prescription drug benefits for the treatment of alcohol and 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 alcohol and substance abuse.

“(g) Any individual or group health benefit plan that provides prescription drug benefits for the treatment of alcohol and substance abuse shall not impose any step therapy requirements before the health benefit plan will authorize coverage for a prescription medication approved by the FDA for the treatment of alcohol and substance abuse.

“(h) Any individual or group health benefit plan that provides prescription drug benefits for the treatment of alcohol and substance abuse shall place all prescription medications approved by the FDA for the treatment of alcohol and substance abuse on the lowest tier of the drug formulary developed and maintained by the health benefit plan.

“(i) Any individual or group health benefit plan that provides prescription drug benefits for the treatment of alcohol and substance abuse shall not exclude coverage for any prescription medication approved by the FDA for the treatment of alcohol and substance abuse and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.”

Section 2. This act shall become effective on the first day of the third month following its passage and approval by the Governor, or its otherwise becoming law.