REFERENCE TITLE: insurance; mental health coverage; parity

State of Arizona

Senate

Fifty-fourth Legislature

First Regular Session

2019

**SB XXXX**

Introduced by

Senator \_\_\_\_\_\_\_\_\_

AN ACT

AMENDING SECTION 20-2322, ARIZONA REVISED STATUTES; RELATING TO MENTAL HEALTH INSURANCE COVERAGE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

 Section 1. Section 20-2322, Arizona Revised Statutes, is amended to read:

 20-2322. Mental health services and benefits: definitions

 A. Beginning on January 1, 1998, any health benefits plan that is offered by an accountable health plan and that provides services or health benefits that include mental health services or mental health benefits shall comply with this section.

B. If the health benefits plan does not include an aggregate lifetime limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall not impose any aggregate lifetime limit on mental health services or mental health benefits. If the health benefits plan includes an aggregate lifetime limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall either:

1. Apply the applicable lifetime limit to both the health services or health benefits that are not related to mental health services or mental health benefits and to the mental health services or mental health benefits.

2. Not include an aggregate lifetime limit on mental health services or mental health benefits that is less than the applicable lifetime limit for health services or health benefits that are not related to mental health services or mental health benefits.

C. If the health benefits plan does not include an aggregate annual limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall not impose any aggregate annual limit on mental health services or mental health benefits. If the health benefits plan includes an aggregate annual limit on substantially all health services or health benefits that are not related to mental health services or mental health benefits, the health benefits plan shall either:

1. Apply the applicable annual limit to both the health services or health benefits that are not related to mental health services or mental health benefits and to the mental health services or mental health benefits.

2. Not include any aggregate annual limit on mental health services or mental health benefits that is less than the applicable annual limit for health services or health benefits that are not related to mental health services or mental health benefits.

D. ~~Except as provided in subsections A, B and C, this section does not prevent an accountable health plan that offers a health benefits plan that provides mental health services or mental health benefits from imposing terms and conditions, including cost sharing, limits on the number of visits or days of coverage or requirements relating to medical necessity in relation to the amount, duration or scope of coverage for mental health services or mental health benefits under the health benefits plan.~~ AN ACCOUNTABLE HEALTH PLAN THAT OFFERS A HEALTH BENEFITS PLAN THAT PROVIDES MENTAL HEALTH SERVICES OR MENTAL HEALTH BENEFITS SHALL COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 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). Nothing in this section requires an accountable health plan to:

1. Offer a health benefits plan that provides mental health services or mental health benefits.

~~2. Comply with this section in connection with any health benefits plan offered to a small employer.~~

~~3.~~ 2. Comply with this section if that compliance under the health benefits plan offered by the accountable health plan would result in an increase in the cost to the health benefits plan of at least one per cent.

E. The requirements of this section apply separately to each health benefits plan offered by an accountable health plan and shall be consistent with title VII of the health insurance portability and accountability act of 1996 (P.L. 104-204; 110 Stat. 2944) and 45 Code of Federal Regulations part 146.

F. Mental health services or mental health benefits ~~do not~~ include benefits for the treatment of substance abuse or chemical dependency.

G. For the purposes of this section:

1. "Aggregate annual limit" means a dollar limitation on the total amount that may be paid in a twelve month period for benefits or services under a health benefits plan for an individual who is covered under a health benefits plan.

2. "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits or services under a health benefits plan for an individual who is covered under a health benefits plan.

H. Any entity that offers, issues, or otherwise provides an individual or group health benefits plan shall submit an annual report to the director 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 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 entity 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).

I. The director 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), which includes:

1. Proactively ensuring compliance by any entity that offers, issues, or otherwise provides an individual or group health benefits plan.

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 entities that offer, issue, or otherwise provide individual or group health benefits 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 entities 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 director may adopt rules, under insert relevant section of state law, 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.

J. Not later than January 31st, 2020, the director shall issue a report and educational presentation to the Legislature; such report and presentation shall:

1. Cover the methodology the director 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 director has taken to ensure insurer compliance with MHPAEA and this section.

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 director finds appropriate, posting the report on the website of the Department of Insurance.

K. Any health benefits plan that is offered by an accountable health plan and that provides prescription drug benefits for the treatment of substance abuse or chemical dependency 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 or chemical dependency.

L. Any health benefits plan that is offered by an accountable health plan and that provides prescription drug benefits for the treatment of substance abuse or chemical dependency shall not impose any step therapy requirements before the health benefits plan will authorize coverage for a prescription medication approved by the FDA for the treatment of substance abuse or chemical dependency.

M. Any health benefits plan that is offered by an accountable health plan and that provides prescription drug benefits for the treatment of substance abuse or chemical dependency shall place all prescription medications approved by the FDA for the treatment of substance abuse or chemical dependency on the lowest tier of the drug formulary developed and maintained by the health benefits plan.

N. Any health benefits plan that is offered by an accountable health plan and that provides prescription drug benefits for the treatment of substance abuse or chemical dependency shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse or chemical dependency and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.