HOUSE BILL NO. XXXX

100th GENERAL ASSEMBLY



INTRODUCED BY REPRESENTATIVE \_\_\_\_\_\_\_\_\_ (XX).

 

AN ACT

To repeal section 376.1550, RSMo, and to enact in lieu thereof one new section relating to insurance coverage for mental health conditions.



*Be it enacted by the General Assembly of the state of Missouri, as follows:*

**Section A. Section 376.1550, RSMo, is repealed and a new section enacted in lieu thereof, to be known as section 376.1550, to read as follows:**

376.1550 Mental health coverage, requirements — definitions — exclusions. — 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition as defined in this section, and shall comply with the following provisions:

 (1) A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition.  Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive for coverage of all health conditions, whether mental or physical;

 (2) The coverages set forth [is] in this subsection:

 (a) May be administered pursuant to a managed care program established by the health carrier; and

   (b) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri;

  (3) A health benefit plan **[**that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions**]** may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditionsdoes not diminish or negate the purpose of this section.  The rules adopted by the director shall assure that:

   (a) Timely and appropriate access to care is available;

  (b) The quantity, location, and specialty distribution of health care providers is adequate; and

   (c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

 (4)  **[**Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836\* and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836\*, the term "health insurance policy" shall include group coverage.**]** A health benefit plan may not impose a nonquantitative treatment limitation with respect to mental health condition benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health condition benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. Nonquantitative treatment limitations include:

 (a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(b) Formulary design for prescription drugs;

(c) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(d) Standards for provider admission to participate in a network, including reimbursement rates;

(e) Plan methods for determining usual, customary, and reasonable charges;

(f) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective;

(g) Exclusions based on failure to complete a course of treatment;

(h) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(i) In and out of network geographic limitations;

(j) Standards for providing access to out-of-network providers;

 (k) Limitations on inpatient services for situations where the participant is a threat to self or others;

(l) Exclusions for court-ordered and involuntary holds;

(m) Experimental treatment limitations;

(n) Service coding;

(o) Exclusions for services provided by clinical social workers; and

(p) Network adequacy;

 2.  As used in this section, the following terms mean:

   (1)  **[**"Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both**]** “Classification of benefits”, the classification in which all mental health condition benefits and medical/surgical benefits must be assigned and include:

(a) Inpatient in-network;

(b) Inpatient, out-of-network;

(c) Outpatient, in-network;

(d) Outpatient, out-of-network;

(e) Emergency care; and

(f) Prescription drugs;

   (2)  "Health benefit plan", the same meaning as such term is defined in section 376.1350;

   (3)  "Health carrier", the same meaning as such term is defined in section 376.1350;

   (4)  "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;

   (5)  "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

 (6) “Nonquantitative treatment limitation”, any limitation on the scope or duration of treatment that is not expressed numerically;

   **[**(6)**]** (7)  "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured.

 3.  This section shall not apply to **[**a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836\*,**]** a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

 4.  Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness.  Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

   5.  The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

   (1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

   (2) Services rendered or billed by a school or halfway house;

   (3) Care that is custodial in nature;

   (4) Services and supplies that are not immediately nor clinically appropriate; or

   (5) Treatments that are considered experimental.

  6.  The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder.  The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration.  Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028.  This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

 7. Each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state shall submit an annual report to the director 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 condition 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 condition benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health condition 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 condition 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 condition 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 condition 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

(e) Disclose the specific findings and conclusions reached by the health carrier that the results of the analyses above indicate that the health carrier 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).

8. 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), and this section, which includes:

(1) Proactively ensuring compliance by each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state;

(2) Evaluating all consumer or provider complaints regarding mental health condition coverage for possible parity violations;

(3) Performing parity compliance market conduct examinations of health carriers that offer or issue health benefit plans which are delivered, issued for delivery, continued, or renewed in this state, 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; and

(4) Requesting that health carriers 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 condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits.

9. Not later April 30th, 2020, the Director shall issue a report and educational presentation to the Legislature, which shall contain the following:

(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) Cover the methodology the director is using to check for compliance with this section;

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

(4) Detail any educational or corrective actions the director has taken to ensure health carrier compliance with MHPAEA and this section; and

(5) 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, Financial Institutions, and Professional Registration.

10. Each health carrier that provides prescription drug benefits for the treatment of chemical dependency shall comply with the following requirements:

(1) Each carrier that provides chemical dependency prescription drug benefits shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of chemical dependency;

(2) Each carrier that provides chemical dependency prescription drug benefits shall not impose any step therapy requirements before the carrier will authorize coverage for a prescription medication approved by the FDA for the treatment of chemical dependency;

(3) Each carrier that provides chemical dependency prescription drug benefits shall place all prescription medications approved by the FDA for the treatment of chemical dependency on the lowest tier of the drug formulary developed and maintained by the carrier; and

(4) Each carrier that provides chemical dependency prescription drug benefits shall not exclude coverage for any prescription medication approved by the FDA for the treatment of chemical dependency and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.