SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 2945

(SENATE AUTHORS: BIGHAM)

DATE	D-PG	OFFICIAL STATUS
03/05/2018		Introduction and first reading Referred to Commerce and Consumer Protection Finance and Policy

A bill for an act

relating to insurance; requiring parity between mental health benefits and other medical benefits; defining mental health and substance use disorder; requiring health plan transparency; requiring accountability from the commissioners of health and commerce; amending Minnesota Statutes 2016, sections 62Q.01, by adding subdivisions; 62Q.47.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2016, section 62Q.01, is amended by adding a subdivision to read:

Subd. 1c. **Classification of benefits.** "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 by a health plan company.

Sec. 2. Minnesota Statutes 2016, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6a. **Mental health conditions and substance use disorders.** "Mental health conditions and substance use disorders" means a 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 most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Substance use disorder does not include caffeine or nicotine use and paraphilic disorders, specific learning disorders, and sexual dysfunctions.

Sec. 3. Minnesota Statutes 2016, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to:

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

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) 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 health plan;

(9) in- and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

Sec. 4. Minnesota Statutes 2016, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan may not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders 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 NQTL with respect to medical/surgical benefits in the same classification.

~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) A health plan that provides coverage for mental health and substance use disorders, or chemical dependency services, must submit an updated annual report to the commissioner on or before March 1 that contains the following information:

(1) a description of the health plan's criteria for mental health and substance use disorders coverage, and how this coverage is compliant with the requirements of section 62Q.53 for medical and surgical benefits;

(2) identification of all NQTLs that are applied to mental health or substance use disorders benefits and medical and surgical benefits;

(3) an analysis that demonstrates that for the medical necessity criteria described in clause (1) and for each NQTL identified in clause (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental health and substance use disorders, benefits are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits; at a minimum, the results of the analysis shall:

(i) identify the specific factors the health plan company used in performing its NQTL analysis;

(ii) identify and define the specific evidentiary standards relied on to evaluate the factors;

(iii) describe how the evidentiary standards are applied to each classification for benefits for mental health and substance use disorders benefits, medical benefits, and surgical benefits;

(iv) disclose the results of the analyses of the specific evidentiary standards in each service category; and

(v) disclose the specific findings of the health plan company in each service category and the conclusions reached with respect to whether the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification;

(4) the rates of and reasons for denial of claims for each classification of benefits for mental health and substance use disorders services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year;

(5) a certification signed by the health plan company's chief executive officer and chief medical officer that states that the health plan company has completed a comprehensive review of the administrative practices of the health plan company for the prior calendar year

for compliance with the necessary provisions of United States Code, title 42, section 18031(j), as amended, and federal guidance or regulations issued under this section, sections 62Q.47 and 62Q.53, Code of Federal Regulations, title 45, parts 146 and 147, and Code of Federal Regulations, title 45, section 156.115(a)(3); and

(6) any other information necessary to clarify data provided in accordance with this section requested by the commissioner of commerce or health including information that may be proprietary or have commercial value.

(g) A health plan company shall provide to the commissioners of commerce and health an update to the annual report on March 1, 2020, and each subsequent year.

(h) The commissioner shall implement and enforce applicable provisions of United States Code, title 42, section 18031(j), as amended, and federal guidance or regulations issued under this section, sections 62Q.47 and 62Q.53, Code of Federal Regulations, title 45, parts 146 and 147, and Code of Federal Regulations, title 45, section 156.115(a)(3), which includes:

(1) ensuring compliance by individual and group health plans;

(2) detecting violations of the law by individual and group health plans;

(3) accepting, evaluating, and responding to complaints regarding such violations; and

(4) evaluating parity compliance for individual and group health plans, including but not limited to reviews of network adequacy, reimbursement rates, denials, and prior authorizations.

(i) The commissioner may request a formal opinion from the attorney general in the event of uncertainty or disagreement with respect to the application, interpretation, implementation, or enforcement of United States Code, title 42, section 18031(j), as amended, and federal guidance or regulations issued under this section, including Code of Federal Regulations, title 45, parts 146 and 147, and Code of Federal Regulations, title 45, section 156.115(a)(3).

(j) Beginning May 1, 2020, and each year thereafter, the commissioner of commerce, in consultation with the commissioner of health, shall issue an updated report to the legislature. The report shall:

(1) describe how the commissioners review health plan compliance with United States Code, title 42, section 18031(j), and any federal regulations or guidance relating to compliance and oversight;

(2) describe how the commissioners review compliance with sections 62Q.47 and 62Q.53;

(3) identify enforcement actions taken during the preceding 12-month period regarding compliance with parity in mental health and substance use disorders benefits under state and federal law and summarize the results of such market conduct examinations. This summary shall include:

(i) the number of formal enforcement actions taken;

(ii) the benefit classifications examined in each enforcement action;

(iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations; and

(iv) how individually identifiable information will be excluded from the reports consistent with state and federal privacy protections;

(4) detail any corrective actions the commissioners have taken to ensure health plan compliance with sections 62Q.47 and 62Q.53 and United States Code, title 42, section 18031(j);

(5) detail their approach relating to informing the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law; and

(6) be written in nontechnical, readily understandable language and shall be made available to the public by, among such other means as they find appropriate, posting the report on department Web sites.