

SECOND REGULAR SESSION

HOUSE BILL NO. 2137

100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE NEELY.

4718H.011

DANA RADEMAN MILLER, Chief Clerk

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Section A. Section 376.1550, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.1550, to read as follows:

376.1550. 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 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

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

17 health service delivery entities certified by the department of mental health, or accredited by a
18 nationally recognized organization, or licensed by the state of Missouri;

19 (3) A health benefit plan that does not otherwise provide for management of care under
20 the plan or that does not provide for the same degree of management of care for all health
21 conditions may provide coverage for treatment of mental health conditions through a managed
22 care organization; provided that the managed care organization is in compliance with rules
23 adopted by the department of commerce and insurance that assure that the system for delivery
24 of treatment for mental health conditions does not diminish or negate the purpose of this section.

25 The rules adopted by the director shall assure that:

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

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

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

31 (4) ~~[Coverage for treatment for chemical dependency shall comply with sections 376.779,~~
32 ~~376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term~~
33 ~~"health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to~~
34 ~~376.836, the term "health insurance policy" shall include group coverage.] A health benefit plan~~
35 **shall not impose a nonquantitative treatment limitation with respect to mental health**
36 **condition benefits in any classification unless, under the terms of the plan as written and**
37 **in operation, any processes, strategies, evidentiary standards, or other factors used in**
38 **applying the nonquantitative treatment limitation to mental health condition benefits in**
39 **the classification are comparable to, and are applied no more stringently than, the**
40 **processes, strategies, evidentiary standards, or other factors used in applying the limitation**
41 **with respect to medical and surgical benefits in the classification. Nonquantitative**
42 **treatment limitations include:**

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

46 (b) **Formulary designs for prescription drugs;**

47 (c) **Plans with multiple network tiers including, but not limited to, preferred**
48 **providers and participating providers;**

49 (d) **Standards for provider admission to participate in a network including, but not**
50 **limited to, reimbursement rates;**

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

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

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

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

58 (i) In- and out-of-network geographic limitations;

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

60 (k) Limitations on inpatient services for situations in which the participant is a
61 threat to his or her self or others;

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

63 (m) Experimental treatment limitations;

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

65 (o) Network adequacy and design.

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

67 (1) [~~"Chemical dependency", the psychological or physiological dependence upon and~~
68 ~~abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment~~
69 ~~of social or occupational role functioning or both]~~ **"Classification of benefits", the**
70 **classification under which all mental health condition benefits and medical and surgical**
71 **benefits shall be assigned, including, but not limited to:**

72 (a) **Inpatient in-network;**

73 (b) **Inpatient out-of-network;**

74 (c) **Outpatient in-network;**

75 (d) **Outpatient out-of-network;**

76 (e) **Emergency care; and**

77 (f) **Prescription drugs;**

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

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

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

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

85 (6) **"Nonquantitative treatment limitation", any limitation on the scope or duration**
86 **of treatment that is not expressed numerically;**

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

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

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

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

- 105 (1) Marital, family, educational, or training services unless medically necessary and
106 clinically appropriate;
- 107 (2) Services rendered or billed by a school or halfway house;
- 108 (3) Care that is custodial in nature;
- 109 (4) Services and supplies that are not immediately nor clinically appropriate; or
- 110 (5) Treatments that are considered experimental.

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

122 rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid
123 and void.

124 **7. Each health carrier that offers or issues health benefit plans that are delivered,**
125 **issued for delivery, continued, or renewed in this state shall submit an annual report to the**
126 **director before February 1, 2021, that contains the following information:**

127 **(1) A description of the process used to develop or select the medical necessity**
128 **criteria for mental health condition benefits and the process used to develop or select the**
129 **medical necessity criteria for medical and surgical benefits;**

130 **(2) An identification of all nonquantitative treatment limitations that are applied**
131 **to both mental health condition benefits and medical and surgical benefits under each**
132 **classification of benefits;**

133 **(3) The results of an analysis that demonstrates that for the medical necessity**
134 **criteria described under subdivision (1) of subsection 7 of this section and for each**
135 **nonquantitative treatment limitation identified under subdivision (2) of subsection 7 of this**
136 **section, as written and in operation, the processes, strategies, evidentiary standards, or**
137 **other factors used in applying the medical necessity criteria and each nonquantitative**
138 **treatment limitation to mental health condition benefits within each classification of**
139 **benefits are comparable to, and are applied no more stringently than, the processes,**
140 **strategies, evidentiary standards, or other factors used in applying the medical necessity**
141 **criteria and each nonquantitative treatment limitation to medical and surgical benefits**
142 **within the corresponding classification of benefits. The results of the analysis shall:**

143 **(a) Identify the factors used to determine that a nonquantitative treatment**
144 **limitation will apply to a benefit, including, but not limited to, factors that are considered**
145 **and rejected;**

146 **(b) Identify and define the specific evidentiary standards used to define the factors**
147 **and any other evidence relied upon in designing each nonquantitative treatment limitation;**

148 **(c) Provide a comparative analysis to determine that the processes and strategies**
149 **used to design each nonquantitative treatment limitation, as written, and the as written**
150 **processes and strategies used to apply the nonquantitative treatment limitation to mental**
151 **health condition benefits are comparable to and applied no more stringently than the**
152 **processes and strategies used to apply the nonquantitative treatment limitation to medical**
153 **and surgical benefits;**

154 **(d) Provide a comparative analysis to determine that the processes and strategies**
155 **used to apply each nonquantitative treatment limitation in operation for mental health**
156 **condition benefits are comparable to, and applied no more stringently than, the processes**
157 **or strategies used to apply each nonquantitative treatment limitation for medical and**
158 **surgical benefits; and**

159 (e) Disclose the specific findings and conclusions reached by the health carrier that
160 the results of the analysis described under subdivision (3) of subsection 7 of this section are
161 in compliance with this section.

162 8. There shall be no separate nonquantitative treatment limitations that apply to
163 mental health condition benefits but do not apply to medical and surgical benefits under
164 any classification of benefits.

165 9. The director shall implement and enforce applicable provisions, and any
166 amendments to, any federal guidance or regulation relevant to the Paul Wellstone and Pete
167 Domenici Mental Health Parity and Addiction Equity Act of 2008 and 45 CFR 146.136, 45
168 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

169 10. In addition, the director shall have the authority to:

170 (1) Ensure that all health carriers that offer or issue health benefit plans that are
171 delivered, issued for delivery, continued, or renewed in this state comply with this section;

172 (2) Evaluate all consumer and provider complaints regarding mental health
173 condition coverage in order to identify possible parity violations;

174 (3) Perform parity compliance market conduct examinations of health carriers that
175 offer or issue health benefit plans that are delivered, issued for delivery, continued, or
176 renewed in this state, particularly market conduct examinations that focus on
177 nonquantitative treatment limitations; and

178 (4) Request that health carriers submit comparative analyses during the form
179 review process demonstrating how the health carriers design and apply nonquantitative
180 treatment limitations, as written and in operation, for medical and surgical benefits.

181 11. Before May 1, 2021, the director shall issue a report and educational
182 presentation to the general assembly that:

183 (1) Identifies the methodology the director is using to check for compliance with the
184 federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act
185 of 2008 and any federal regulations or guidance relating to such compliance;

186 (2) Identifies the methodology the director is using to check for compliance with
187 this section;

188 (3) Identifies market conduct examinations conducted or completed during the
189 preceding twelve month period regarding compliance with parity in mental health
190 condition benefits under the laws of this state; and

191 12. The report required under subsection 11 of this section shall be written in
192 nontechnical, readily understandable language and shall be made available to the public
193 by any method the director deems appropriate, including, but not limited to, posting such
194 report on the department of commerce and insurance website.