An Act

ENROLLED SENATE
BILL NO. 1718

By: Montgomery and Haste of the Senate

and

Echols, West (Josh), Steagall, Roe and Pittman of the House

An Act relating to health insurance; amending 36 O.S. 2011, Sections 6060.10, 6060.11, 6060.12, and 6060.13, which relate to definitions, benefits required for mental illness, exempted plans, and analysis and report by Insurance Commissioner; modifying definitions; adding definitions; modifying mandated coverage; prohibiting an insurer from imposing more stringent treatment limitations on mental health conditions and substance use disorders than comparable benefits; prohibiting certain treatment limitations; stating exception; requiring all health plans to meet certain requirements; requiring insurers to submit annual report; providing required information for report; requiring Insurance Commissioner to implement and enforce certain law; requiring Commissioner to publicize certain required reports; requiring Commissioner to identify and publicize insurers failing to submit certain report; authorizing the Commissioner to promulgate rules; conforming language; and providing an effective date.

SUBJECT: Health insurance

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 2011, Section 6060.10, is amended to read as follows:

Section 6060.10. As used in this act:

1. "Base period" means the period of coverage pursuant to the issuance or renewal of a health benefit plan that is required to provide benefits pursuant to the provisions of Section 6060.11 of this title;

2. ~~a.~~ "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title~~, except as provided in subparagraph b of this paragraph.~~

~~b. The term "health benefit plan" shall not include individual plans~~;

3. "Insurer" means any entity providing an accident and health insurance policy in this state including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement or any other entity subject to regulation by the Insurance Commissioner;

~~"Severe mental illness" means any of the following biologically based mental illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:~~

~~a. schizophrenia,~~

~~b. bipolar disorder (manic-depressive illness),~~

~~c. major depressive disorder,~~

~~d. panic disorder,~~

~~e. obsessive-compulsive disorder, and~~

~~f. schizoaffective disorder; and~~

4. ~~"Small employer" means any person, firm, corporation, partnership, limited liability company, association, or other legal entity that is actively engaged in business that, on at least fifty~~

~~percent (50%) of its working days during the preceding calendar year, employed no more than fifty (50) employees who work on a full-time basis, which means an employee has a normal work week of twenty-four (24) or more hours~~ "Mental health and substance use disorder" means any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and

5. "Mental health and substance use disorder benefits" means benefits covering items or services for mental health conditions or substance use disorders, as defined under the terms of the health benefit plan and in accordance with applicable federal and state law. Any condition defined by the plan as a mental health condition or not a mental health condition shall be consistent with the definition of that condition included in generally recognized independent standards of current medical practice, including but not limited to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Disease.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 6060.11, is amended to read as follows:

Section 6060.11. A. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders.

B. ~~Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan offered, issued, or issued for delivery in this state on or after the effective date of this act may provide benefits for other forms of mental health or substance abuse disorder benefits.~~

~~C.~~ 1. Benefits for mental health and substance use disorders~~,~~ ~~including, but not limited to those required by subsection A of this section, and for substance abuse disorder as provided in subsection~~

~~B of this section~~ shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders~~,~~ including, but not limited to:

a. coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater,

b. coverage of outpatient services,

c. coverage of medication,

d. maximum lifetime benefits,

e. copayments,

f. coverage of home health visits,

g. individual and family deductibles, and

h. coinsurance.

2. Treatment limitations applicable to mental health or substance ~~abuse~~ use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.

~~D. The provisions of this section shall not apply to coverage provided by a health benefit plan for a small employer~~

C. A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health benefit plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health disorders in the classification are comparable to and applied no more stringently than to medical and surgical benefits in the same classification.

D. All health benefit plans must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

E. Beginning on or after the effective date of this act, each insurer that offers, issues or renews any individual or group health benefit plan providing mental health or substance use disorder benefits shall submit an annual report to the Insurance Commissioner on or before April 1 of each year that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

2. Identification of all nonquantitative treatment limitations applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and

3. The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph 1 of this subsection and for each nonquantitative treatment limitation identified in paragraph 2 of this subsection, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to and are applied no more stringently than to medical and surgical in the same classification of benefits. At a minimum, the results of the analysis shall:

a. identify the factors used to determine that a nonquantitative treatment limitation 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 nonquantitative treatment limitation,

c. provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation 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 nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes or strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits in the same classification of benefits, and

e. disclose the specific findings and conclusions reached by the insurer that the results of the analyses required by this subsection indicate that the insurer is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

F. The Commissioner shall implement and enforce any applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

G. No later than June 1, 2021, and by June 1 of each year thereafter, the Commissioner shall make available to the public the reports submitted by insurers, as required in subsection E of this section, during the most recent annual cycle; provided, however, that any information that is confidential or a trade secret shall be redacted.

1. The Commissioner shall identify insurers that have failed in whole or in part to comply with the full extent of reporting required in this section and shall make a reasonable attempt to obtain missing reports or information by June 1 of the following year.

2. The reports submitted by insurers and the identification by the Commissioner of noncompliant insurers shall be made available to the public by posting on the Internet website of the Insurance Department.

H. The Commissioner shall promulgate rules pursuant to the provisions of this section and any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, that relate to the business of insurance.

SECTION 3. AMENDATORY 36 O.S. 2011, Section 6060.12, is amended to read as follows:

Section 6060.12. ~~A.~~ 1. A health benefit plan that, at the end of its base period, experiences a greater than two percent (2%) increase in premium costs pursuant to providing benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders shall be exempt from the provisions of Section ~~2 of this act~~ 6060.11 of this title.

2. To calculate base-period-premium costs, the health benefit plan shall subtract from premium costs incurred during the base period, both the premium costs incurred during the period immediately preceding the base period and any premium cost increases attributable to factors unrelated to benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders.

3. a. To claim the exemption provided for in subsection A of this section a health benefit plan shall provide to the Insurance Commissioner a written request signed by an actuary stating the reasons and actuarial assumptions upon which the request is based.

b. The Commissioner shall verify the information provided and shall approve or disapprove the request within thirty (30) days of receipt.

c. If, upon investigation, the Commissioner finds that any statement of fact in the request is found to be knowingly false, the health benefit plan may be subject to suspension or loss of license or any other penalty as determined by the Commissioner, or the State Commissioner of Health with regard to health maintenance organizations.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 6060.13, is amended to read as follows:

Section 6060.13. A. The Insurance Commissioner shall analyze any direct incremental impact on premium costs pursuant to the requirements of Section ~~2 of this act~~ 6060.11 of this title. The Commissioner shall submit a report of all preliminary data and findings to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives by May 1, 2000, with subsequent updates submitted by November 1, 2000; May 1, 2001; November 1, 2001; May 1, 2002, and November 1, 2002.

B. 1. The Commissioner shall submit a final report to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives by December 1, 2002, which shall include, but not be limited to, the collection and analysis of data provided by health benefit plans~~,~~ including, but not limited to:

a. a determination of the average premium increase directly attributable to providing benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders pursuant to the provisions of Section ~~2 of this act~~ 6060.11 of this title by health benefit plans in this state incurred during the first

year of implementation of ~~this act~~ Section 6060.10 et seq. of this title, and any additional premium increases incurred during the second and third year of implementation,

b. information on the number of claims filed and the total amount expended on those claims for benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders,

c. information on the utilization of services listed in subsection ~~B~~ C of Section ~~2 of this act~~ 6060.11 of this title, and

d. actuarial assumptions used in determining premium costs for providing the required benefits.

2. The final report shall also include, to the extent possible, an analysis of any other direct or indirect benefit of requiring benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders.

C. 1. All health benefit plans shall provide the data required by this subsection in such form and at such time as the Commissioner shall prescribe.

2. The Commissioner shall compile and report the data provided by the health benefit plans in such a way as to keep individual plan information confidential, unless the plan gives explicit permission to release such identifiable information.

D. If the report required by subsection A of this section shows that the cumulative average premium increase incurred during the first three (3) years of implementation of ~~this act~~ Section 6060.10 et seq. of this title that is directly attributable to the provision of benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders is greater than six percent (6%), the requirements of Section 2 of this act shall terminate May 1, 2003, and any agreement, contract or policy issued after May 1, 2003, shall not be required to provide benefits for treatment of ~~severe~~ mental ~~illness~~ health and substance use disorders.

SECTION 5. This act shall become effective November 1, 2020.

Passed the Senate the 11th day of March, 2020.

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Presiding Officer of the Senate

Passed the House of Representatives the 13th day of May, 2020.

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Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____