SECOND REGULAR SESSION

HOUSE BILL NO. 2384

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE BARNES (60).

6177H.01I D. ADAM CRUMBLISS, 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Section A. Section 376.1550, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.1550, to read as follows: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~~**] 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

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.

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 conditions does 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 shall 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 or 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 when 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 or surgical benefits shall 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 **[**~~except for chemical dependency~~**]**;

(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;**

(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~~**] health conditions**. 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.

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