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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2173 Session of 2015

INTRODUCED BY MURT, DAVIDSON, D. MILLER, ACOSTA, BRADFORD, V. BROWN, BULLOCK, D. COSTA, DEAN, DeLUCA, DiGIROLAMO, FRANKEL, FREEMAN, HARPER, KAVULICH, KINSEY, LEWIS, MAHONEY, McNEILL, ROEBUCK, ROZZI, SANTORA, TAYLOR, THOMAS, TRUITT AND WATSON, JUNE 20, 2016

REFERRED TO COMMITTEE ON INSURANCE, JUNE 20, 2016

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in casualty insurance, further providing for mental illness coverage; in benefits for alcohol abuse and dependency, further providing for outpatient alcohol or other drugs services; and, in health insurance coverage parity and nondiscrimination, further providing for adoption for Federal acts, for penalties and for regulations.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 635.1(a) and (c) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, added December 21, 1998 (P.L.1108, No.150), are amended to read:

Section 635.1. Mental Illness Coverage.--(a) As used in

this section:

(1) ["Serious mental illness"] "Mental illness and alcohol or other drug abuse and dependency" means [any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder and delusional disorder.] any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the current edition of the mental disorders section of the current International Statistical Classification of Diseases and Related Health Problems or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(2) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate issued by an entity subject to one (1) of the following:

(i) This act.

(ii) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(iii) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(3) "Nonquantitative treatment limitations" or "NQTL" means processes, strategies, 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:

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

(ii) Formulary design for prescription drugs.

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

(iv) Standards for provider admission to participate in a network, including reimbursement rates.

(v) Plan methods for determining usual, customary and reasonable charges.

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

(vii) Exclusions based on failure to complete a course of treatment.

(viii) 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.

(ix) In-network and out-of-network geographic limitations.

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

(xi) Exclusions for court-ordered and involuntary holds.

(xii) Experimental treatment limitations.

(xiii) Service coding.

(xiv) Exclusions for services provided by clinical social workers.

(xv) Network adequacy.

(xvi) Provider reimbursement rates, including rates of

reimbursement for mental health and substance use services in primary care.

* * *

(c) Health insurance policies covered under this section shall provide coverage for [serious] mental illnesses and alcohol or other drug abuse and dependency that meet at a minimum the following standards:

(1) coverage for [serious] mental illnesses and alcohol or other drug abuse and dependency shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;

(2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;

(3) there shall be no difference in either the annual or lifetime dollar limits in coverage for [serious] mental illnesses and alcohol or other drug abuse and dependency and any other illnesses;

(4) there shall be no difference in cost-sharing arrangements, including, but not limited to, deductibles and copayments for coverage of [serious] mental illnesses[, shall not prohibit access to care. The department shall set up a method to determine whether any cost-sharing arrangements violate this subsection.] and alcohol or other drug abuse and dependency and for coverage of any other illnesses; and

(5) a health insurance policy may not impose an NQTL with respect to a mental illness or alcohol or other drug abuse and dependency in any classification of benefits unless, under the terms of the policy as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to mental illness or alcohol or other drug

abuse and dependency 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 NQTL with respect to medical or surgical benefits in the same classification.

* * *

Section 2. Section 605-A of the act, amended December 22, 1989 (P.L.755, No.106), is amended to read:

Section 605-A. Outpatient Alcohol or Other Drug Services.--(a) Minimal additional treatment as a covered benefit under this article shall be provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.

(b) The following services shall be covered under this section:

(1) Physician, psychologist, nurse, certified addictions counselor and trained staff services.

(2) Rehabilitation therapy and counseling.

(3) Family counseling and intervention.

(4) Psychiatric, psychological and medical laboratory tests.

(5) Drugs, medicines, equipment use and supplies[.], including coverage for at least one opioid antagonist, including the medication product, administration devices and any pharmacy administration fees related to the dispensing of the opioid antagonist. This coverage must include refills for expired or utilized opioid antagonist.

(c) Treatment under this section shall be covered as required by this act for a minimum of thirty outpatient, full-session visits or equivalent partial visits per year. Treatment may be subject to a lifetime limit, for any covered individual, of one hundred and twenty outpatient, full-session visits or equivalent partial visits.

(d) In addition, treatment under this section shall be covered as required by this act for a minimum of thirty separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to fifteen additional non-hospital, residential alcohol treatment days.

(e) For any utilization review or benefit determination for the treatment of alcohol or other drug abuse and dependency, including, but not limited to, prior authorization and medical necessity determinations, the clinical review criteria shall be the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. No additional criteria may be used during utilization review or benefit determination for treatment of substance use disorders.

(f) Any Federal Drug Administration-approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered, if such treatment is medically necessary, according to most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

Section 3. Sections 604-B, 605-B(b) and 606-B of the act, added March 22, 2010 (P.L.147, No.14), are amended to read:

Section 604-B. Adoption of and compliance with Federal acts.

(a) General rule.--Insurers shall comply with the Federal acts as contained in sections 2701, 2702, 2705, 2707, 2721, 2753 and 2754 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. §§ 300gg, 300gg-1, 300gg-5, 300gg-7, 300gg-21, 300gg-53 and 300gg-54). Medicaid and the Children's Health Insurance Program will also comply in accordance with the Final Rules for "Medicaid Program; Deadline for Access Monitoring Review Plan Submissions" contained in 42 CFR Pt. 447 (relating to payments for services).

(b) Report.--Each insurer shall submit an annual report to the department on or before March 1 that contains the following information:

(1) The frequency with which the insurer required prior authorization for all prescribed procedures, services or medications for mental health benefits during the previous calendar year, the frequency with which the insurer required prior authorization for all prescribed procedures, services or medications for alcohol or other drug abuse and dependency benefits during the previous calendar year and the frequency with which the insurer required prior authorization for all prescribed procedures, services or medications for medical and surgical benefits during the previous calendar year. Insurers must submit this information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits and prescription drug benefits. Frequency shall be expressed as a percentage, with total prescribed procedures, services or medications within each classification of benefits as the denominator and

the overall number of times prior authorization was required for any prescribed procedures, services or medications within each corresponding classification of benefits as the numerator.

(2) A description of the process used to develop or select the medical necessity criteria for mental health benefits, the process used to develop or select the medical necessity criteria for alcohol or other drug abuse and dependency benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(3) Identification of all NQTLs that are applied to mental health benefits, all NQTLs that are applied to alcohol or other drug abuse and dependency benefits and all NQTLs that are applied to medical and surgical benefits. NQTLs are defined as whichever is more extensive of how they are defined in 45 CFR Pt. 146 (relating to requirements for the group health insurance market) or how they are defined in State law.

(4) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (2) and for each NQTL identified in paragraph (3), 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 alcohol or other drug abuse and dependency 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 insurer 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 service category for mental health benefits, alcohol or other drug abuse and dependency benefits, medical benefits and surgical benefits.

(iv) Disclose the results of the analyses of the specific evidentiary standards in each service category.

(v) Disclose the specific findings of the insurer 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 or alcohol or other drug abuse and dependency 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.

(5) The rates of and reasons for denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs and emergency care mental health 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.

(6) The rates of and reasons for denial of claims for

inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs and emergency care alcohol or other drug abuse and dependency 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.

(7) A certification signed by the insurer's chief executive officer and chief medical officer that states that the insurer has completed a comprehensive review of the administrative practices of the insurer for the prior calendar year for compliance with the necessary provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, 122 Stat. 3881), and any amendments thereto, and Federal guidelines or regulations issued under those acts, including 45 CFR Pts. 146 and 147 (relating to health insurance reform requirements for the group and individual health insurance markets) and 45 CFR 156.115(a)(3) (relating to provision of EHB).

(8) Any other information necessary to clarify data provided in accordance with this section requested by the commissioner, including information that may be proprietary or have commercial value. The commissioner shall not certify any health policy of an insurer that fails to submit all data as required by this section.

(c) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Nonquantitative treatment limitations" or "NQTL." Processes, strategies, evidentiary standards or other factors

that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. The term includes, but is 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) For plans with multiple network tiers, such as preferred providers and participating providers, network tier design.

(4) Standards for provider admission to participate in a network, including reimbursement rates.

(5) Plan methods for determining usual, customary and reasonable charges.

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

(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 plan or coverage.

(9) In-network and out-of-network geographic limitations.

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

(11) Exclusions for court-ordered and involuntary holds.

(12) Experimental treatment limitations.

(13) Service coding.

(14) Exclusions for services provided by clinical social workers.

(15) Network adequacy.

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

Section 605-B. Penalties.

* * *

[(b) Limitation.--Penalties imposed against a person under this article and under section 5 of the act of June 25, 1997 (P.L.295, No.29), known as the Pennsylvania Health Care Insurance Portability Act, shall not exceed $500,000 in the aggregate during a single calendar year.]

Section 606-B. Regulations and regulatory implementation.

(a) Regulations.--The department may promulgate such regulations as may be necessary or appropriate to carry out this article.

(b) Implementation of Federal act.--The department shall implement and enforce applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, 122 Stat. 3881) and Federal guidelines or regulations issued under those acts, including 45 CFR Pts. 146 (relating to regulations for the group health insurance market) and 147 (relating to health insurance reform regulations for the group and individual health insurance markets) and 45 CFR 156.115(a)(3) (relating to provision of EHB), which include:

(1) Ensuring compliance by individual and group health insurance policies.

(2) Detecting violations of the law by individual and

group health insurance policies.

(3) Accepting, evaluating and responding to complaints regarding such violations.

(4) Maintaining and regularly reviewing, for possible parity violations, a publicly available consumer complaint log regarding mental health and alcohol or other drug abuse and dependency coverage.

(5) Conducting parity compliance market conduct examinations of individual and group health insurance policies, including, but not limited to, reviews of network adequacy, reimbursement rates, denials and prior authorizations.

(c) Report.--Not later than June 30 of each year, the department shall issue a report to the General Assembly and provide an educational presentation to the General Assembly. The report and presentation shall:

(1) Cover the methodology the department is using to check for compliance with the MHPAEA and any Federal regulations or guidelines relating to the compliance and oversight of the MHPAEA and 42 U.S.C. 18031(j) (relating to affordable choices of health benefit plans).

(2) Cover the methodology the department is using to check for compliance with sections 601-A, 602-A, 603-A, 604-A, 605-A, 606-A, 607-A, 608-A and 635.1.

(3) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and alcohol or other drug abuse and dependency benefits under Federal and State laws and summarize the results of such market conduct examinations. This shall include:

(i) The number of market conduct examinations initiated and completed.

(ii) The benefit classifications examined by each market conduct examination.

(iii) The subject matter of each market conduct examination, including quantitative and nonquantitative treatment limitations.

(iv) A summary of the basis for the final decision rendered in each market conduct examination.

(v) Individually identifiable information shall be excluded from the reports consistent with Federal privacy protections.

(4) Detail any educational or corrective actions the regulatory agency has taken to ensure insurer compliance with MHPAEA, 42 U.S.C. 18031(j) and sections 601-A, 602-A, 603-A, 604-A, 605-A, 606-A, 607-A, 608-A, and 635.1.

(5) Detail the department's educational approaches relating to informing the public about mental health and alcohol or other drug abuse and dependency parity protections under Federal and State law.

(6) The report must be written in nontechnical, readily understandable language and shall be made available to the public by, among such other means as the department finds appropriate, posting the report on the department's publicly accessible Internet website.

(d) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Nonquantitative treatment limitations" or "NQTL."

Processes, strategies, evidentiary standards or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. The term includes, but is 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.

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

(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 plan or coverage.

(9) In-network and out-of-network geographic limitations.

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

(11) Exclusions for court-ordered and involuntary holds.

(12) Experimental treatment limitations.

(13) Service coding.

(14) Exclusions for services provided by clinical social workers.

(15) Network adequacy.

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

"Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" or "MHPAEA." The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, 122 Stat. 3881).

Section 4. This act shall take effect immediately.