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National Council of Insurance Legislators (NCOIL)

Mental Health Parity Model Act

Sponsored by Rep. Rachel Roberts (KY)

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Section 1 – Definitions

(a) The following definitions apply for purposes of this Act:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(3) “Mental health and substance use disorders” means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(4) "Mental health and substance use disorder emergency services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services. As used in this subsection, "988 center" means a center operating in this state that participates in the National Suicide Prevention Lifeline network to respond to 988 calls.

(5) "Mental health professional" means any of the following persons engaged in providing mental health services:

(i) A physician or psychiatrist licensed to practice medicine or osteopathy under [xxxxxx];

(ii) A medical officer of the government of the United States;

(iii) A licensed psychologist, licensed psychological practitioner, certified psychologist, or licensed psychological associate, licensed under [xxxxxxxx];

(iv) A certified nurse practitioner or clinical nurse specialist with a psychiatric or mental health population focus licensed to engage in advanced practice nursing under [xxxxxx];

(v) A licensed clinical social worker licensed under [xxxxxxx] or a certified social worker licensed under [xxxxxxx];

(vi) A licensed marriage and family therapist licensed under [xxxxxxxx] or a marriage and family therapist associate holding a permit under [xxxxxxx];

(vii) A licensed professional clinical counselor or licensed professional counselor associate, licensed under [xxxxxxxx];

(viii) A licensed professional art therapist licensed under [xxxxxx] or a licensed professional art therapist associate licensed under [xxxxxxx];

(ix) A [state] licensed pastoral counselor licensed under [xxxxxxxx];

(x) A licensed clinical alcohol and drug counselor, licensed clinical alcohol and drug counselor associate, or certified alcohol and drug counselor, licensed or certified under [xxxxxx]; or

(xi) A physician assistant licensed under [xxxxxxxxx] who meets the criteria for being a qualified mental health professional under [xxxxxxxxx]; and

(6) “Mental health wellness examination" includes but is not limited to:

(i) A behavioral health screening;

(ii) Education and consultation on healthy lifestyle changes;

(iii) Referrals to ongoing treatment, mental health services, and other supports; and

(iv) Discussion of potential options for medication.

(7) “The Mental Health Parity and Addiction Equity Act” means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any amendments to, and any federal guidance or regulations relevant to, that act.

(8) “Utilization review” means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(9) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

Section 2 – Ensuring Mental Health and Substance Use Disorder Medical Necessity Determinations Follow Generally Accepted Standards of Care

(a) Every insurance policy issued, amended, or renewed on or after [insert date], that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders.

(b) An insurer shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

(c) All medical necessity determinations made by the insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of subsections (e) and (f).

(d) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(e) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(f) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(g) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subsection (f), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subsection does not prohibit an insurer from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

> (1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subsection (f), provided the utilization review criteria were developed in accordance with subdivision (e).
>
> (2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (f), provided that the utilization review criteria were developed in accordance with subdivision (e).

(h) An insurer that authorizes mental health or substance use disorder treatment shall not rescind or modify the authorization after the provider renders the health care service in good faith and

pursuant to the authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility.

(i) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(j) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the [relevant section of code], by order, assess a civil penalty not to exceed [xxxx] for each violation, or, if a violation was willful, a civil penalty not to exceed [ten thousand dollars (xxxxx] for each violation.

Section 3 – Ensuring Coverage of Mental Health and Substance Use Disorder Benefits are at Parity with Medical/Surgical Benefits

(a) The commissioner shall implement and enforce the provisions of the Mental Health Parity and Addiction Equity Act by doing, at minimum, all of the following:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental health or substance use disorder benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical or surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental health substance use disorder coverage for possible parity violations;

(3) performing parity compliance market conduct examinations of insurers including, but not limited to, reviews of:

(A) nonquantitative treatment limitations such as prior authorization requirements, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates, geographic restrictions, and any other nonquantitative treatment limitations deemed relevant by the commissioner;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the commissioner.

(4) Adopting rules, as may be necessary, to effectuate any provisions of the Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(b) Not later than [date], and annually thereafter, the commissioner shall issue a report to relevant committees and/or elected officials and provide an educational presentation to said [relevant committees and/or elected officials]. Such report and presentation shall:

(1) Cover the methodology the commissioner is using to determine compliance with the Mental Health Parity and Addiction Equity Act and Section 1 of this Act.

(2) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with the Mental Health Parity and Addiction Equity Act and Section 1 of this Act and summarize the results of such market conduct examinations.

(3) Detail any educational or corrective actions the commissioner has taken to ensure insurer compliance with the Mental Health Parity and Addiction Equity Act and Section 1 of this Act.

(4) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the commissioner finds appropriate, posting the report on the commissioner's website

(c) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the [relevant section of code], by order, assess a civil penalty not to exceed [xxxxxx] for each violation, or, if a violation was willful, a civil penalty not to exceed [xxxxx] for each violation. The civil penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

Section 4 – Increasing Access to Medications to Treat Substance Use Disorders

(a) Notwithstanding any provision of law to the contrary, beginning January 1, 20XX, an insurer that provides prescription drug benefits for the treatment of substance use disorders shall, for prescription medications that are on the insurer's formulary:

(1) Not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders.

(2) Not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(3) Place medications approved by the FDA for the treatment of substance use disorders on lowest tier of the drug formulary developed and maintained by the insurer.

(4) Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

(5) Not refuse to cover such medication based on whether an insured participates in counseling or wraparound services.

Section 5 - Mental Health or Substance Use Disorder Emergency Care Benefits

(a) Mental health or substance use disorder benefits shall be considered emergency care benefits for the purposes of classifications of benefits if they are provided by the following health or substance use disorder emergency services providers:

(1) A crisis stabilization unit;

(2) A 23-hour crisis relief center;

(3) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(4) An agency certified by the department of health to provide crisis services;

(5) An agency certified by the department of health to provide medically managed or medically monitored withdrawal management services; or

(6) A mobile rapid response crisis team that is contracted with a behavioral health administrative services organization to provide crisis response services in the behavioral health administrative services organization's service area.

Section 6 – Coverage of Mental Health Wellness Examinations

(a) To the extent permitted by federal law, all health plans shall provide coverage for an annual mental health wellness examination ~~of at least forty-five (45) minutes~~ that is performed by a mental health professional.

(b) The coverage required by this section shall:

(1) Be no less extensive than the coverage provided for medical and surgical benefits;

(2) Comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. sec. 300gg-26, as amended; and

(3) Not be subject to copayments, coinsurance, deductibles, or any other cost sharing requirements.