FIRST REGULAR SESSION

SENATE BILL NO. 507

100TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR HOUGH.

Read 1st time February 28, 2019, and ordered printed.

ADRIANE D. CROUSE, Secretary.

2416S.01I

AN ACT

To amend chapters 191 and 376, RSMo, by adding thereto six new sections relating to health coverage for certain disorders.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Chapters 191 and 376, RSMo, are amended by adding thereto six new sections, to be known as sections 191.1164, 191.1165, 191.1166, 191.1167, 191.1168, and 376.1552, to read as follows:

191.1164. 1. Sections 191.1164 to 191.1168 shall be known and may be cited as the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act".

2. As used in sections 191.1164 to 191.1168, the following terms shall mean:

(1) "ASAM criteria", the American Society of Addiction Medicine (ASAM) national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction; a comprehensive set of guidelines for placement, continued stay, and transfer or discharge of patients with addiction and co-occurring conditions;

(2) "Behavioral therapy", an individual, family, or group therapy designed to help patients engage in the treatment process, modify their attitudes and behaviors related to substance use, and increase healthy life skills;

(3) "Department", the state agency or department that has jurisdiction over the provision of medical care, including substance use disorders;

(4) "Department of insurance", the department that has jurisdiction regulating health insurers;

(5) "Financial requirements", deductibles, co-payments,

coinsurance, or out-of-pocket maximums;

(6) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(7) "Health insurer", any person or entity that issues, offers, delivers, or administers a health insurance plan;

(8) "Health insurance plan", an individual or group plan that provides, or pays the cost of, health care items or services;

(9) "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)", the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 found at 42 U.S.C. 300gg-26 and its implementing and related regulations found at 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115;

(10) "Nonquantitative treatment limitation" or "NQTL", any limitation on the scope or duration of treatment that is not expressed numerically;

(11) "Pharmacologic therapy", a prescribed course of treatment that may include methadone, buprenorphine, naltrexone, or other FDA-approved or evidence-based medications for the treatment of substance use disorder;

(12) "Pharmacy benefits manager", an entity that contracts with pharmacies on behalf of health carriers or any health plan sponsored by the state or a political subdivision of the state;

(13) "Prior authorization", the process by which the health insurer or the pharmacy benefits manager determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service;

(14) "Quantitative treatment limitation" or "QTL", numerical limits on the scope or duration of treatment, which include annual, episode, and lifetime day and visit limits;

(15) "Step therapy", a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized

by a health insurer or prescription drug management company;

(16) "Urgent health care service", a health care service with respect to which the application of the time period for making a non-expedited prior authorization, in the opinion of a physician with knowledge of the enrollee's medical condition:

(a) Could seriously jeopardize the life or health of the subscriber or the ability of the enrollee to regain maximum function; or

(b) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

3. For the purpose of this section, "urgent health care service" shall include services provided for the treatment of substance use disorders.

191.1165. 1. Medication-assisted treatment (MAT) services shall include, but not be limited to, pharmacologic and behavioral therapies. At a minimum, a formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include all current and new formulations and medications approved by the U.S. Food and Drug Administration for the treatment of substance use disorder. Such medications include, but are not limited to:

(1) Buprenorphine;

(2) Methadone;

(3) Naloxone;

(4) Extended-release injectable naltrexone; and

(5) Buprenorphine/naloxone combination.

2. All MAT medications required for compliance in this section shall be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.

3. MAT services provided for in this section shall not be subject to any of the following:

(1) Any annual or lifetime dollar limitations;

(2) Limitations to a predesignated facility, specific number of visits, days of coverage, days in a waiting period, scope or duration of treatment, or other similar limits;

(3) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and

Addiction Equity Act of 2008 (MHPAEA), specifically 45 CFR 146.136(c)(3);

(4) Step therapy or other similar drug utilization strategy or policy when it conflicts or interferes with a prescribed or recommended course of treatment from a licensed health care professional; and

(5) Prior authorization for MAT services as specified in this section, as well as any behavioral, cognitive or mental health services prescribed in conjunction with or supplementary to the MAT services for the purpose of treating a substance use disorder.

4. The health care benefits and MAT services outlined in this section shall apply to all health insurance plans offered to consumers in the state of Missouri.

5. Any entity that holds itself out as a treatment program or that applies for licensure by the state to provide clinical treatment services for substance use disorders shall be required to:

(1) Use ASAM criteria or other such nationally recognized, research-validated criteria, for patient placement and review of ongoing need for treatment, and meet or exceed the standards set forth in ASAM or other criteria for the levels of care being provided by such program; and

(2) Disclose the MAT services it provides, as well as which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards.

6. The MO HealthNet program shall cover the MAT medications and services provided for in this section and include those MAT medications in its preferred drug lists for the treatment of substance use disorders and prevention of overdose and death. The preferred drug list shall include all current and new formulations and medications that are approved by the U.S. Food and Drug Administration for the treatment of substance use disorders.

7. The department of corrections and all other state entities responsible for the care of persons detained or incarcerated in jails or prisons shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders. The department of corrections or entity shall make available

the MAT services covered in this section, consistent with a treatment plan developed by the physician, and shall not impose any limitations on the type of medication or other treatment prescribed or the dose or duration of MAT recommended by the physician.

8. Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders. The court or other diversion program shall make available the MAT services covered under this section, consistent with a treatment plan developed by the physician, and shall not impose any limitations on the type of medication or other treatment prescribed or the dose or duration of MAT recommended by the physician.

9. Requirements under this section shall not be subject to a covered person's prior success or failure of the services provided.

191.1166. 1. All health insurers and other payers providing health coverage in the state shall be required to disclose which providers in its network provide MAT services and what level of care is provided pursuant to ASAM criteria or other nationally recognized, research-validated, substance use disorder-specific program standards recognized by the state's applicable licensure body. Such disclosure shall be made in a prominent location in the online and print provider directories.

2. The department of insurance shall require that provider networks meet maximum time and distance standards and minimum wait time standards for providers of MAT services.

(1) Such standards shall be established by the director of the department of insurance and reviewed biannually to ensure patient access to MAT services.

(2) Health insurers must include a description of how their provider networks meet the requirements under this section as part of their access plan or other required network adequacy documentation provided to the department of insurance.

3. A health insurer plan shall have a process to ensure that an enrollee obtains a covered benefit for MAT and related treatment

services at an in-network level of coverage or shall make other arrangements acceptable to the commissioner when:

(1) The health insurance plan has an otherwise sufficient network but does not have an appropriate type of in-network provider available to provide the covered MAT services to the enrollee or it does not have an in-network provider available to provide the covered MAT services to the enrollee without unreasonable travel or delay; or

(2) The health insurance plan has an insufficient number or type of appropriate in-network providers available to provide the covered MAT services to the enrollee without unreasonable travel or delay.

4. For purposes of an enrollee's financial responsibilities when the health insurance plan is deemed inadequate under the requirements of this section, the health insurer shall treat the health care services the enrollee receives from an out-of-network provider pursuant to this section as if the services were provided by an in-network provider, including counting the enrollee's cost-sharing for such services toward the enrollee's deductible and maximum out-of-pocket limit applicable to services obtained from in-network providers under the health insurance plan.

5. A health insurer shall render a determination to a request by an enrollee concerning a covered benefit for MAT services from an out-of-network provider and notify the enrollee and the enrollee's health care provider of that determination within twenty-four hours from the date and time on which the health insurer receives that request.

6. A health insurer shall render a determination concerning urgent care services for MAT and related services and notify the enrollee and the enrollee's health care provider of that determination within twenty-four hours from the date and time on which the health insurer receives that request.

7. The health insurer shall report biannually to the commissioner on the frequency with which the processes outlined in subsections 4, 5, and 6 in this section are used.

8. All payers providing health coverage in the state of Missouri shall submit an annual report to the department of insurance on or before January 1, 2020, that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental health and substance use

disorders and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to mental health and substance use disorder benefits; and

(3) An analysis that demonstrates, for the medical necessity criteria and each NQTL, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental health and substance use disorder benefits within each classification of benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(a) Identify how the factors used to determine that NQTL 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 NQTL;

(c) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each QTL and NQTL, as written, for medical and surgical benefits; and

(d) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, 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 NQTL, in operation, for medical and surgical benefits.

9. The department of insurance shall publicly disclose the specific findings and conclusions reached by the health insurer.

10. The department of insurance shall promote and make prominent on its website a mechanism to explain the requirements of this section or sections and a feedback and complaint process for

subscribers and enrollees, and providers, who have a bona fide complaint that a health insurer is not meeting the requirements of this section.

11. The department of insurance shall promulgate guidelines or regulations as needed to implement and enforce the requirements of this section or sections. Consultation with representatives of the mental health, medical, social work, and other relevant organizations is strongly encouraged.

191.1167. Any contract provision, written policy, or written procedure in violation of this section shall be deemed to be unenforceable and shall be null and void.

191.1168. If any provision of sections 191.1164 to 191.1168 or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of sections 191.1164 to 191.1168 which may be given effect without the invalid provision or application, and to that end the provisions of sections 191.1164 to 191.1168 are severable.

376.1552. 1. In addition to any other requirement of law concerning coverage of mental health, including chemical dependency benefits, including, but not limited to, sections 376.810 to 376.814, and section 376.1550, any health benefit plan issued by a health carrier regulated pursuant to this chapter shall provide coverage for mental health, including chemical dependency benefits, in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Pub. L. No. 110-343) found at 42 U.S.C. 300gg-26, as amended, and its implementing regulations found at 45 CFR 146.136 and 45 CFR 147.160, as amended (collectively, "MHPAEA").

2. The department of insurance, financial institutions and professional registration shall implement and enforce this section, sections 376.810 to 376.814, section 376.1550, and applicable provisions of the MHPAEA.

(1) Ensuring compliance by individual and group health benefit plans;

(2) Detecting possible violations of the law by individual and group health benefit plans;

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

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health or substance use disorder coverage; provided that, individually identifiable information shall be excluded.

3. Not later than September 1, 2020, the department shall issue a report to the general assembly. The report shall:

(1) Discuss the methodology the department is using to check for compliance with this section, sections 376.810 to 376.814, and section 376.1550;

(2) Discuss the methodology the department uses to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136;

(3) Identify market conduct examinations conducted or completed during the preceding twelve-month period regarding compliance with parity in mental health or chemical dependency benefits under state and federal laws and summarize the results of such market conduct examinations. Individually identifiable information shall be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. 290dd-2 and regulations found at 42 CFR 2.1 to 42 CFR 2.67. This discussion shall include:

(a) The number of market conduct examinations initiated and completed;

(b) The benefit classifications examined by each market conduct examination;

(c) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations; and

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

(4) Detail any educational or corrective actions the department of insurance, financial institutions and professional registration has taken to ensure health benefit plan compliance with this section, sections 376.810 to 376.814, section 376.1550, and the MHPAEA;

(5) Detail the department's educational approaches relating to informing the public about mental health or chemical dependency parity protections under state and federal law; and

(6) Describe how the department examines any provider or consumer complaints related to denials or restrictions for possible violations of this section, sections 376.810 to 376.814, section 376.1550, and the MHPAEA, including complaints regarding, but not limited to:

(a) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(b) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(c) Denials of claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(d) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(e) Step therapy requirements imposed before buprenorphine or naltrexone is approved; and

(f) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine.

4. The report issued pursuant to subsection 3 of this section must be written in nontechnical, readily understandable language and shall be made available to the public by posting the report on the department's website and by other means as the department finds appropriate. The name and identity of the health carrier must be given confidential treatment, may not be made public by the department or any other person, and shall not be subject to public inspection pursuant to chapter 610.

5. Coverage for treatment of a mental condition, including chemical dependency, shall not be denied for care for confinement provided in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care, and treatment of psychiatric, mental, or nervous disorders.

6. The health carrier's chief executive officer and chief medical officer shall sign a certification that affirms that the health carrier has completed a comprehensive review of its administrative practices for the prior calendar year for compliance with the provisions of this

section, sections 376.810 to 376.814, section 376.1550, and the MHPAEA.

7. Nothing in this section applies to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or other limited benefit health insurance policies.

8. The director is authorized to promulgate rules to implement this section. 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 under 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, 2019, shall be invalid and void.

9. Nothing in this section shall be construed as requiring the disclosure of any information that would violate 42 U.S.C. 290dd-2 and regulations found at 42 CFR 2.1 through 42 CFR 2.67.

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