H.101

Introduced by Representatives Donahue of Northfield, Gage of Rutland City, Poirier of Barre City, and Woodward of Johnson

Referred to Committee on

Date:

Subject: Health insurance; mental health; benefit management; prior authorization

Statement of purpose of bill as introduced: This bill proposes to prohibit management of mental health insurance benefits separately from other health care benefits. It also prohibits prior authorization requirements for mental health care that differ from medical or surgical prior authorization requirements.

An act relating to mental health insurance benefits

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4089b is amended to read:

§ 4089b. HEALTH INSURANCE COVERAGE, MENTAL HEALTH, AND SUBSTANCE ABUSE

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(b) As used in this section:

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(3) "Rate, term, or condition" means any lifetime or annual payment limits, deductibles, ~~copayments~~ co-payments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of health insurance coverage that affects the insured.

(c) A health insurance plan shall provide coverage for treatment of a mental condition and shall:

(1) not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition than for access to treatment for other health conditions, including no greater co-payment for primary mental health care or services than the co-payment applicable to care or services provided by a primary care provider under an insured's policy and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under an insured's policy;

(2) not exclude from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer; ~~and~~

(3) make any deductible or out-of-pocket limits required under a health insurance plan comprehensive for coverage of both mental and physical health conditions; and

(4) not establish a prior authorization requirement for mental health care that differs from prior authorization requirements used in the management of medical or surgical care, unless the health insurance plan can demonstrate that the requirement is necessary to provide timely and appropriate mental health care, as supported by evidence-based clinical standards.

(d)(1)(A) A health insurance plan that ~~does not otherwise provide~~ provides 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 conditions through a managed care organization, provided that the managed care organization is in compliance with the rules adopted by the Commissioner that ensure that the system for delivery of treatment for mental conditions does not diminish or negate the purpose of this section. In reviewing rates and forms pursuant to section 4062 of this title, the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall consider the compliance of the policy with the provisions of this section~~ shall ensure that one organization manages care for all health conditions, including mental conditions, and that the organization provides the same degree of management of care for mental conditions as for other health conditions. The "same degree of management" means that mental

health care shall not be limited or managed differently from the care of other health conditions, unless the organization can demonstrate that the limitation or differentiation is necessary to provide timely and appropriate mental health care, as supported by evidence-based clinical standards. In reviewing rates and forms pursuant to section 4062 of this title, the Commissioner and the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall consider whether a health insurance policy is in compliance with the provisions of this section.

(B) The rules adopted by the Commissioner shall ensure that:

(i) timely and appropriate access to mental health care is available and at least as accessible as care for other health conditions;

(ii) the quantity, location, and specialty distribution of health care providers is adequate;

(iii) administrative or clinical protocols do not serve to reduce access to medically necessary mental health treatment for any insured or create burdens on health care providers or members that differ from or are greater than administrative or clinical requirements required for other health conditions;

(iv) utilization review and other administrative and clinical protocols do not deter timely and appropriate mental health care, including emergency hospital admissions, or create burdens on health care providers or

members that differ from or are greater than administrative or clinical requirements required for other health conditions;

(v) in the case of a managed care organization ~~which~~ that contracts with a health insurer to administer the insurer's ~~mental health~~ benefits, the portion of a health insurer's premium rate attributable to the coverage of mental health benefits is reviewed under section 4062, 4513, 4584, or 5104 of this title to determine whether it is excessive, inadequate, unfairly discriminatory, unjust, unfair, inequitable, misleading, or contrary to the laws of ~~this~~ the State;

(vi) the health insurance plan is consistent with the Blueprint for Health with respect to mental conditions, as determined by the Commissioner under 18 V.S.A. § 9414(b)(2);

(vii) a quality improvement project is completed annually as a joint project between the health insurance plan and its ~~mental health~~ managed care organization to implement policies and incentives to increase collaboration among providers that will facilitate clinical integration of services for medical and mental conditions, including:

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(C) Prior to the adoption of rules pursuant to this subdivision, the Commissioner shall consult with the Commissioner of Mental Health ~~and the task force established pursuant to subsection (h) of this section~~ concerning:

* * *

(2) A managed care organization providing or administering coverage for treatment of ~~mental~~ conditions on behalf of a health insurance plan shall comply with this section, sections 4089a and 4724 of this title, and 18 V.S.A. § 9414, with rules adopted pursuant to those provisions of law, and with all other obligations, under Title 18 and under this title, of the health insurance plan and the health insurer on behalf of which the review agent is providing or administering coverage. A violation of any provision of this section shall constitute an unfair act or practice in the business of insurance in violation of section 4723 of this title.

(3) A health insurer that contracts with a managed care organization to provide or administer coverage for treatment of ~~mental~~ conditions is fully responsible for the acts and omissions of the managed care organization, including any violations of this section or a rule adopted pursuant to this section.

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(g) On or before July 15 of each year, ~~health insurance companies~~ a health insurance company doing business in Vermont whose individual share of the commercially insured Vermont market, as measured by covered lives, comprises at least five percent of the commercially insured Vermont market,

shall file with the Commissioner, in accordance with standards, procedures, and forms approved by the Commissioner:

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(2) The health insurance plan's revenue loss and expense ratio relating to the care and treatment of mental conditions covered under the health insurance plan. The expense ratio report shall list amounts paid in claims for services and administrative costs separately. A managed care organization providing or administering coverage for treatment of ~~mental~~ conditions on behalf of a health insurance plan shall comply with the minimum loss ratio requirements pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, applicable to the underlying health insurance plan with which the managed care organization has contracted to provide or administer such services. The health insurance plan shall also bear responsibility for ensuring the managed care organization's compliance with the minimum loss ratio requirement pursuant to this subdivision.

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Sec. 2. EFFECTIVE DATE

This act shall take effect on July 1, 2015.