FIRST REGULAR SESSION

HOUSE BILL NO. 797

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES LAMPE (Sponsor) AND GRISAMORE (Co-sponsor).

1821L.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 mental health insurance coverage.

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Section A. Section 376.1550, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.1550, to read as follows: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) **Except for the limitations specified in this section which may be applied only when permissible under federal parity requirements,** 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 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**, including but not limited to 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**;**

(5) (a) A health benefit plan shall provide coverage for the diagnosis and treatment of autism spectrum disorders.

(b) To the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by a health benefit plan, the coverage required under this subdivision shall be included in health benefit plans that are delivered, executed, issued, amended, adjusted, or renewed on or after August 28, 2009.

(c) a. coverage provided under this subdivision is limited to treatment that is ordered by the enrollee's treating licensed physician or licensed psychologist under the authority granted under such physician's or psychologist's license and in accordance with a treatment plan.

b. If requested by the health carrier or required under the health benefit plan, the treatment plan shall include all elements necessary to appropriately pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, and goals.

c. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, the health carrier shall have the right to request a review of such treatment not more than once every six months, unless the health carrier and treating

physician or psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be the responsibility of the health carrier.

(d) a. Health benefit plans shall provide coverage for applied behavior analysis for individuals less than twenty-one years of age if the treatment plan indicates that applied behavior analysis is appropriate.

b. If permissible under federal parity requirements, coverage for applied behavior analysis shall be subject to a maximum benefit of seventy-two thousand dollars per year, but shall not be subject to any limits on the number of visits by an individual to an autism service provider for applied behavior analysis. After December 31, 2010, the director of the department of insurance, financial institutions and professional registration shall annually adjust the maximum benefit for applied behavior analysis for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Inflation adjustments shall be announced no later than December first of each year and shall be effective on January first of the following year.

c. Coverage provided under this subdivision for services other than applied behavior analysis shall not be subject to any limits on the number of visits an individual may make to an autism service provider.

d. To the extent any payments or reimbursements are being made for services rendered by a direct implementer for applied behavior analysis, such payments or reimbursements shall be made to:

(i) The person who is supervising the direct implementer who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board; or

(ii) The entity or group for whom such supervising person works or is associated.

e. Payments made by a health carrier on behalf of a covered individual for anything other than applied behavior analysis shall not be applied toward any maximum benefit established under subparagraph b. of this paragraph.

2. As used in this section, the following terms mean:

(1) **"Applied behavior analysis", the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior;**

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri;

(b) Any person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board;

(c) Any person, if not licensed or certified, who shall provide, if requested, documented evidence of equivalent education, professional training, and supervised experience in applied behavior analysis when the treatment provided by the autism service provider is applied behavior analysis; or

(d) A direct implementer;

(3) "Autism spectrum disorders", the same meaning as such term is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) "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;

(5) "Diagnosis of autism spectrum disorders", assessments, evaluations, or tests necessary to diagnose an individual with autism spectrum disorders;

(6) "Direct implementer", any person who provides diagnostic or treatment services for autism spectrum disorders who is not licensed or certified, as described in paragraphs (a) and (b) of subdivision (2) of this subsection, and is supervised by a person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board, whether such analyst supervises as an individual or as an employee or in association with an entity or group;

[(2)**] (7)** "Health benefit plan", the same meaning as such term is defined in section 376.1350;

[(3)**] (8)** "Health carrier", the same meaning as such term is defined in section 376.1350;

[(4)**] (9)** "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)**] (10) "Managed care", the determination of availability of coverage under a health benefit plan through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective concurrent or retrospective basis, sometimes involving case management;**

(11) "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)**] (12)** "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**;**

(13) "Treatment of autism spectrum disorders", care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or psychologist under the authority granted under such physician's or psychologist's license, if the care is determined to be medically necessary, including but not limited to:

(a) Applied behavior analysis as defined in this subsection;

(b) Psychiatric care. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(c) Psychological care. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(d) Habilitative or rehabilitative care. "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore the functioning of an individual;

(e) Therapeutic care. "Therapeutic care" means services provided by licensed speech therapists, occupational therapists, or physical therapists;

(f) Pharmacy care. "Pharmacy care" means medications or nutritional supplements used to address symptoms of an autism spectrum disorder prescribed by a licensed physician and any health-related services necessary to determine the need or effectiveness of the medications or nutritional supplements.

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 **which is not specifically a policy for coverage of a mental health condition**, 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. 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**; except that, applied behavior analysis shall not be considered experimental or educational**.

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, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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.

7. A health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, reissue, or otherwise terminate or restrict coverage on an individual or such individual's dependent solely because such individual or dependent is diagnosed with an autism spectrum disorder. A health carrier shall not deny, delay, or reduce payment for otherwise covered services solely because an individual or an individual's dependent is diagnosed with an autism spectrum disorder.

8. Any violation of this section shall be considered a level two violation under section 374.049, RSMo.

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