

AN ACT

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To require health insurers offering health benefits plans in the District to comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any guidance or regulations implementing the act, to require the Department of Insurance, Securities, and Banking to enforce the requirements of the act, to impose annual reporting requirements on health insurers and the department, to bar health insurers from imposing non-quantitative treatment limitations on the provision of benefits for mental health conditions or substance use disorders unless certain enumerated requirements are met, to require Medicaid to provide coverage for medication-assisted treatment prescribed for the treatment of substance use disorders, and to authorize the Mayor to issue rules to implement the provisions of the act.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the “Behavioral Health Parity Act of 2018”.

Sec. 2. Definitions.

For the purposes of this act, the term:

(1) “Benefits” means the health care services covered by a health insurer under a health benefits plan.

(2) “Department” means the Department of Insurance, Securities, and Banking.

(3) “Health benefits plan” shall have the same meaning as provided in section 2(4) of the Prompt Pay Act of 2002, effective July 23, 2002 (D.C. Law 14-176; D.C. Official Code § 31-3131(4)).

(4) “Health insurer” shall have the same meaning as provided in section 2(5) of the Prompt Pay Act of 2002, effective July 23, 2002 (D.C. Law 14-176; D.C. Official Code § 31-3131(5)).

(5) “In-network” means providers or health care facilities that have entered into a contract or agreement with a health insurer pursuant to which such entities are obligated to provide benefits to individuals enrolled with the health insurer’s health benefits plan.

(6) “Market conduct examination” means an examination conducted by the Department to evaluate the practices and operations of a health insurer.

(7) “Medicaid” means the medical assistance programs authorized by Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 *et seq.*), and by section 1 of An Act To enable the District of Columbia to receive Federal financial assistance under title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), and administered by the Department of Health Care Finance.

(8) “Medication-assisted treatment” means the use of opioid addiction treatment medication to treat substance use disorders.

(9) “Mental health condition” means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Diseases or that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(10) “MHPAEA” means and includes the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, approved October 3, 2008 (Pub. L. No. 110-343; 122 Stat. 3881), and any federal guidance or regulations implementing MHPAEA, including 45 C.F.R §§ 146.136, 147.136, 147.160, and 156.115(a)(3).

(11) “Non-quantitative treatment limitation” means limitations imposed by a health insurer on the scope or duration of mental health condition and substance use disorder benefits for treatment, including:

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

(B) Formulary design for prescription drugs;

(C) For health benefit plans with multiple network tiers, such as preferred providers and participating providers, network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Health benefits plan methods for determining usual, customary, and reasonable charges;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, including fail-first policies or step therapy protocols;

(G) Exclusions based on the failure to complete a course of treatment;

(H) 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 health benefits plan or coverage;

(I) In and out-of-network geographic limitations;

(J) Standards for providing access to out-of-network providers;

(K) Limitations on inpatient services for situations where the participant is

a threat to self or others;

- (L) Exclusions for court-ordered and involuntary holds;
- (M) Experimental treatment limitations;
- (N) Service coding;
- (O) Exclusions for services provided by clinical social workers; and
- (P) Network adequacy.

(12) “Out-of-network” means providers or health care facilities who have not entered into a contract or agreement with a health insurer pursuant to which such entities are obligated to provide benefits to individuals enrolled with the health insurer’s health benefits plan.

(13) “Prescriber” shall have the same meaning as provided in section 202(3) of the SafeRx Amendment Act of 2008, effective March 26, 2008 (D.C. Law 17-131; D.C. Official Code § 48-841.02(3)).

(14) “Prior authorization” means the process of obtaining prior approval from a health insurer for the provision of prescribed procedures, services, or medications.

(15) “Provider” shall have the same meaning as provided in section 2(7) of the Prompt Pay Act of 2002, effective July 23, 2002 (D.C. Law 14-176; D.C. Official Code § 31-3131(7)).

(16) “Step therapy” shall have the same meaning as provided in section 2(12) of the Specialty Drug Copayment Limitation Act of 2016, effective April 7, 2017 (D.C. Law 21-248; D.C. Official Code § 48-855.01(12)).

(17) “Substance use disorder” means a problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by symptoms identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Sec. 3. Compliance and enforcement.

(a) All health insurers offering health benefits plans, including Medicaid, in the District that provide mental health condition and substance use disorder benefits, shall comply with the requirements of MHPAEA.

(b) The Department shall enforce the requirements of this act by:

- (1) Ensuring compliance by health insurers;
- (2) Detecting, evaluating, and responding to complaints regarding any potential or actual violations of MHPAEA;
- (3) Developing, maintaining, and regularly reviewing a publicly-available consumer complaint log recording any potential or actual violations of MHPAEA; and
- (4) Performing market conduct examinations of health insurers health benefits plans, including a review of any non-quantitative treatment limitations.

Sec. 4. Reporting requirements.

(a) Beginning October 1, 2019, and on an annual basis thereafter, health insurers shall submit a report to the Department containing the following information:

(1)(A) The frequency with which the health insurers health benefits plan required:

(i) Prior authorization for all prescribed procedures, services, or medications for mental health condition and substance use disorder benefits during the prior calendar year; and

(ii) Prior authorization for all prescribed procedures, services, or medications for medical and surgical benefits during the prior calendar year.

(B) Health insurers shall submit the information required pursuant to paragraph (1)(A) of this subsection separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient 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 the 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 and select medical necessity criteria for mental health condition and substance use disorder benefits;

(3) An identification of all non-quantitative treatment limitations that are applied to benefits provided for mental health conditions and substance use disorders;

(4) An analysis of the medical necessity criteria described in paragraph (2) of this subsection, and each non-quantitative treatment limitation identified pursuant to paragraph (3) of this subsection, that shall include:

(A) An identification of the factors used to determine whether a non-quantitative treatment limitation shall apply to the provision of a benefit, including any factors that were considered but rejected;

(B) An identification of the specific evidentiary standards that were relied upon and used to design any non-quantitative treatment limitations;

(C) An identification and description of the methodology used to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, for mental health condition and substance use disorder benefits are comparable to and no more stringent than the processes and strategies used to design each non-quantitative treatment limitation, as written, for medical and surgical benefits;

(D) An identification and description of the methodology used to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for mental health condition and substance use disorder benefits are comparable to and no more stringent than the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) A disclosure of the specific findings and conclusions reached by the health insurer indicating that it is in compliance with the requirements of this act.

(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 condition and substance use disorder benefits during the prior 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 prior calendar year;

(6) A certification that the health insurer has completed a comprehensive review of the administrative practices of its health benefits plan for the prior calendar year to verify compliance with the requirements of this act; and

(7) Any other information requested by the Commissioner of the Department.

(b) By October 1, 2019, and annually thereafter, the Department shall issue a report to the Council in non-technical, readily understandable language, that shall:

(1) Specify the methodologies used by the Department to verify compliance with the requirements of the act;

(2) Identify the market conduct examinations conducted by the Department during the preceding year, including:

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

(B) The benefit classifications assessed by each market conduct examination;

(C) The subject matter of each market conduct examination; and

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

(3) A description of any educational or corrective actions the Department took to ensure health insurer compliance with the requirements of this act; and

(4) A description of the Department's efforts to educate the public regarding mental health condition and substance use disorder protections under MHPAEA and this act.

Sec. 5. Non-quantitative treatment limitations.

A health insurer shall not impose a non-quantitative treatment limitation with respect to a mental health condition or substance use disorder for any classification of benefits unless, under the terms of the health benefits plan, as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder 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 non-quantitative treatment limitation with respect to medical or surgical benefits in the same classification.

Sec. 6. Medicaid coverage for medication-assisted treatment.

Medicaid shall provide coverage for medication -assisted treatment prescribed for the treatment of substance use disorders; provided, that medication assisted treatment covered in accordance with this section shall not be subject to:

- (1) Utilization control, other than those processes specified by the American Society of Addiction Medicine;
- (2) Prior authorization;
- (3) Step therapy; or
- (4) Lifetime restriction limits.

Sec. 7. Rules.

The Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq.*), may issue rules to implement the provisions of this act.

Sec. 8. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 9. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as

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provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia