HOUSE DOCKET, NO. 3145 FILED ON: 1/16/2015

HOUSE . . . . . No. 893

The Commonwealth of Massachusetts

PRESENTED BY:

Kay Khan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act providing for certain standards in health care insurance coverage for eating disorders.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Kay Khan	*11th Middlesex*	*1/16/2015*
Marjorie C. Decker	*25th Middlesex*	*2/3/2015*
Marcos A. Devers	*16th Essex*	*2/3/2015*
Danielle W. Gregoire	*4th Middlesex*	*1/29/2015*
Jonathan Hecht	*29th Middlesex*	*2/2/2015*
Elizabeth A. Malia	*11th Suffolk*	*1/30/2015*
Michael O. Moore	*Second Worcester*	*1/23/2015*
Benjamin Swan	*11th Hampden*	*1/29/2015*
Timothy J. Toomey, Jr.	*26th Middlesex*	*2/4/2015*
Chris Walsh	*6th Middlesex*	*2/3/2015*

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HOUSE . . . . . No. 893

By Ms. Khan of Newton, a petition (accompanied by bill, House, No. 893) of Kay Khan and others relative to requiring that certain health insurance policies include coverage for eating disorders. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *937* OF 2013-2014.]

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act providing for certain standards in health care insurance coverage for eating disorders.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Subsection (d) of Section 22 of Chapter 32A, as so appearing, is hereby stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if utilization review criteria and guidelines for application of medical necessity standards for diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly restricts coverage of medically necessary health care services as determined by the commissioner of insurance.

SECTION 2. Subsection (g) of Section 22 of Chapter 32A, as appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:--

(g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary diagnosis and treatment of mental disorders to take place in a clinically appropriate setting, as determined in accordance with generally accepted principles of professional medical practice. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license. No policy subject to this section shall contain a blanket exclusion of services that qualify as intermediate services for mental disorders covered under this section, including but not limited to residential services. A carrier subject to this section must ensure that its network, including the network of any entity that contracts with the carrier for the provision of mental health, behavioral health or substance abuse services, contains a sufficient number of providers representing the range of services required by

this subsection so that an insured may obtain medically necessary services within a clinically reasonable period of time.

SECTION 3. Subsection (d) of Section 47B of Chapter 175, as appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if utilization review criteria and guidelines for application of medical necessity standards for diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly restricts coverage of medically necessary health care services as determined by the commissioner of insurance.

SECTION 4. Subsection (g) of Section 47B of Chapter 175, as appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:--

(g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary diagnosis and treatment of mental disorders to take place in a clinically appropriate setting, as determined in accordance with generally accepted principles of professional medical practice. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse

facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license. No policy subject to this section shall contain a blanket exclusion of services that qualify as intermediate services for mental disorders covered under this section, including but not limited to residential services. A carrier subject to this section must ensure that its network, including the network of any entity that contracts with the carrier for the provision of mental health, behavioral health or substance abuse services, contains a sufficient number of providers representing the range of services required by this subsection so that an insured may obtain medically necessary services within a clinically reasonable period of time.

SECTION 5. Subsection (d) of Section 8A of Chapter 176A, as so appearing, is hereby stricken and replaced with the following:-- Subsection (d) of Section 47B of Chapter 175, as appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant

with this section if utilization review criteria and guidelines for application of medical necessity standards for diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly restricts coverage of medically necessary health care services as determined by the commissioner of insurance.

SECTION 6. Chapter 176A, as so appearing, is hereby amended by striking out subsection (g) of Section 8A, as so appearing, and inserting in place thereof the following section:--

(g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary diagnosis and treatment of mental disorders to take place in a clinically appropriate setting, as determined in accordance with generally accepted principles of professional medical practice. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license. No policy subject to this section shall contain a blanket exclusion of services that qualify as intermediate services for mental

disorders covered under this section, including but not limited to residential services. A carrier subject to this section must ensure that its network, including the network of any entity that contracts with the carrier for the provision of mental health, behavioral health or substance abuse services, contains a sufficient number of providers representing the range of services required by this subsection so that an insured may obtain medically necessary services within a clinically reasonable period of time.

SECTION 7. Subsection (d) of Section 4A of Chapter 176B, as appearing in the 2004 Official Edition, is hereby stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if utilization review criteria and guidelines for application of medical necessity standards for diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly restricts coverage of medically necessary health care services as determined by the commissioner of insurance.

SECTION 8. Subsection (g) of Section 4A of Chapter 176B, as so appearing, is hereby stricken and replaced with the following:--

(g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary diagnosis and treatment of mental disorders to take place in a clinically appropriate setting, as determined in

accordance with generally accepted principles of professional medical practice. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license. No policy subject to this section shall contain a blanket exclusion of services that qualify as intermediate services for mental disorders covered under this section, including but not limited to residential services. A carrier subject to this section must ensure that its network, including the network of any entity that contracts with the carrier for the provision of mental health, behavioral health or substance abuse services, contains a sufficient number of providers representing the range of services required by this subsection so that an insured may obtain medically necessary services within a clinically reasonable period of time.

SECTION 9. Subsection (d) of Section 4M of Chapter 176G, as so appearing, is hereby stricken and replaced with the following:-- (d) Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said mental

disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions. Notwithstanding the foregoing, a carrier will be deemed to be non-compliant with this section if utilization review criteria and guidelines for application of medical necessity standards for diagnosis and treatment of mental disorders are developed or applied to in a manner that unduly restricts coverage of medically necessary health care services as determined by the commissioner of insurance.

SECTION 10. Subsection (g) of Section 4M of Chapter 176G, as so appearing, is hereby stricken and replaced with the following:--

(g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary diagnosis and treatment of mental disorders to take place in a clinically appropriate setting, as determined in accordance with generally accepted principles of professional medical practice. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health, or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license. No policy subject to this section

shall contain a blanket exclusion of services that qualify as intermediate services for mental disorders covered under this section, including but not limited to residential services. A carrier subject to this section must ensure that its network, including the network of any entity that contracts with the carrier for the provision of mental health, behavioral health or substance abuse services, contains a sufficient number of providers representing the range of services required by this subsection so that an insured may obtain medically necessary services within a clinically reasonable period of time.

SECTION 11. Section 1 of Chapter 176O, as appearing in the 2004 Official Edition, is hereby amended by inserting after “Ambulatory review” the following definition: -- “Attending health care professional”, a health care professional providing health care services to an insured within the scope of said professional’s license, accreditation or certification.

SECTION 12. Section 1 of Chapter 176O, as so appearing, is hereby amended by striking out the definition of “Second opinion” and replacing it with the following: -- “Second opinion", an opportunity or requirement to obtain a clinical evaluation by a health care professional other than the health care professional who made the original recommendation for a proposed health service, to assess the clinical appropriateness of the initial proposed health service.

SECTION 13. Section 1 of Chapter 176O, as so appearing, is hereby amended by striking out the definition of “Utilization review” and replacing it with the following: -- "Utilization review", a set of formal techniques designed to evaluate the clinical appropriateness or efficacy of health care services, procedures or settings. Such techniques may include, but are

not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

SECTION 14. Subsection (h) of Section 2 of Chapter 176O, as so appearing, is hereby amended by inserting after the second sentence the following: -- Satisfaction by a carrier of the minimum standards for accreditation set forth in subsection (a) of this section shall not excuse a carrier, or any entity with which the carrier contracts to perform functions governed by this chapter, from fulfilling all other obligations set forth in this chapter.

SECTION 15. Subsection (a)(9) of Section 6 of Chapter 176O, as so appearing, is hereby amended by striking out, in line 1, the word “summary” and by inserting after the word “carrier” in line 1 the following: -- in sufficient detail that the average insured adult could reasonably be expected to understand the impact of such programs on the scope of health care services to be provided,

SECTION 16. Section 6 of Chapter 176O, as so appearing, is hereby amended by inserting after subsection (a)(14) the following: -- (15) instructions on how to obtain additional information on any of the areas required to be included in the evidence of coverage by this subsection (a).

SECTION 17. Subsection (a)(15) of Section 6 of Chapter 176O, as so appearing, is hereby amended by renumbering said subsection “(a)(16)”.

SECTION 18. Subsection (a)(3) of Section 7 of Chapter 176O, as so appearing, is hereby amended by striking out the word “summary” and by inserting after the word “developed” the following: -- that is sufficiently detailed for the average adult insured to reasonably be expected to understand the impact of said programs on the scope of health care services to be provided.

SECTION 19. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby amended by inserting at the end of the first paragraph the following: -- The documentation of utilization review required by this paragraph shall be made available, upon request, to an insured and the attending health care professional.

SECTION 20. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby amended by inserting after the first sentence of the second paragraph the following: -- To the extent that another entity conducts utilization review for the carrier, the carrier shall be responsible for said entity's full compliance with this section.

SECTION 21. Subsection (a) of Section 12 of Chapter 176O, as so appearing, is hereby amended by inserting at the end of the second paragraph the following: -- A carrier or utilization review organization shall apply utilization review criteria in a manner that permits an individualized medical assessment based on specific medical data. To the extent that no independent evidence-based standards exist for the use of a treatment in a specific case, the carrier or utilization review organization shall not deny coverage on the basis that the treatment does not meet an evidence-based standard.

SECTION 22. Subsection (b) of Section 12 of Chapter 176O, as so, is amended by inserting after the second full sentence the following – A carrier or utilization review organization shall not be deemed to have obtained all necessary information within the meaning of this section if it has not made reasonable efforts to obtain all relevant clinical documentation from the attending health care professional.

SECTION 23. Subsection (d) of Section 12 of Chapter 176O, as so appearing i, is hereby stricken and replaced with the following: -- (d) The written notification of an adverse

determination shall be in clear, understandable language and shall include a substantive clinical justification for said determination, which is consistent with generally accepted principles of professional medical practice. The notification shall, at a minimum: (1) identify the specific information and factual bases upon which the adverse determination was based; (2) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) specify any alternative treatment option offered by the carrier, if any; (4) reference and include applicable clinical practice guidelines and review criteria, including, but not limited to, internal rules, guidelines, protocols and other similar criteria, relied upon in making the adverse determination; (5) provide for the identification of medical experts whose advice was obtained by the carrier or utilization review organization in connection with the benefit determination, whether or not said advice was relied on in making the ultimate adverse determination; and (6) include the name, contact information and qualifying credentials of the clinical reviewer or reviewers that made the adverse determination. The notification must be sufficiently specific to enable the insured and the attending health care professional to make an informed decision about whether to appeal the adverse determination and to determine the issues to address in the appeal. A notification shall not be in compliance with this subsection if it states only, in generalized language, without identifying information and analysis specific to the insured's claim, that a requested treatment is not medically necessary.

SECTION 24. Section 12 of Chapter 176O, as so appearing, is amended by inserting after subsection (e) the following: – (f) A carrier or utilization review organization shall orally inform the attending health care professional of all relevant utilization review requirements and of the medical necessity criteria and guidelines to be used in making a claim determination. The carrier

or utilization review organization shall provide upon request and free of charge to the insured and, if requested, to the attending health care professional, copies of all documents, records and other information relevant to the claim. Relevant documents shall mean any documents submitted, considered or generated in the course of making the determination, including any statements of policy or guidance concerning the denied treatment for the insured's diagnosis, whether or not such documents were relied upon in making the ultimate adverse determination.

SECTION 25. Section 13 of Chapter 176O, as so appearing, is amended by inserting after subsection (c) the following: – (d) The internal grievance process provided by a carrier or utilization review organization pursuant to this section shall provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an independent clinical peer reviewer that is neither the individual who made the adverse benefit determination that is the subject of the grievance nor the subordinate of such individual.

SECTION 26. Section 14 of Chapter 176O, as so appearing, is amended by striking out subsection (a) and replacing it with the following:-- (a) (i) An insured who remains aggrieved by an adverse determination and has exhausted all remedies available from the formal internal grievance process required pursuant to section 13, may seek further review of the grievance by a review panel established by the office of patient protection pursuant to paragraph (5) of subsection (a) of section 217 of chapter 111. The insured shall pay the first $25 of the cost of the review to said office which may waive the fee in cases of extreme financial hardship. The commonwealth shall assess the carrier for the remainder of the cost of the review pursuant to regulations promulgated by the commissioner of public health in consultation with the commissioner of insurance.

(ii) The office of patient protection shall contract with at least three unrelated and objective review agencies through a bidding process, and refer grievances to one of the review agencies on a random selection basis. The review agencies shall develop review panels appropriate for the given grievance, which shall include qualified clinical decision-makers experienced in the determination of medical necessity, utilization management protocols and grievance resolution, and shall not have any financial relationship with the carrier or utilization review organization making the initial determination. A review panel shall include at least one person who is in the same licensure category and has comparable expertise to the attending health care professional with respect to the health care service that is the subject of the grievance. With respect to an adverse determination that involves a mental health or substance abuse service, the panel shall include at least one licensed physician who is board certified in the relevant specialty to the treatment under review and who is either actively practicing in that specialty or has demonstrated expertise in the particular treatment under review.

(iii) The standard for review of a grievance by a review panel shall be the determination of whether the requested treatment or service is medically necessary, as defined herein, and a covered benefit under the policy or contract. The panel shall consider, but not be limited to considering: (i) written documents submitted by the insured, (ii) additional information from the involved parties or outside sources that the review panel deems necessary or relevant, and (iii) information obtained from any informal meeting held by the panel with the parties. Any documents or information submitted by a party in support of its position shall be shared with the other party or parties. The carrier or utilization review organization shall have the burden of producing substantial, reliable evidence in support of the adverse determination and of demonstrating that, in reaching said determination, it adequately considered the insured's

individual circumstances. A carrier or utilization review organization may not rely in a proceeding before an independent review panel on any basis not stated in its final adverse determination at the conclusion of internal review pursuant to section 13 of this chapter.

(iv) The review panel shall send final written disposition of the grievance, and the reasons therefore, to the insured and the carrier within 60 days of receipt of the request for review, unless the panel determines additional time is necessary to fully and fairly evaluate the grievance and notifies the carrier and the insured of the decision to extend the review beyond 60 days.

(b) If a grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect through completion of the formal internal grievance process. Except when services were not initially authorized by the carrier or are subject to termination based on a specific time or episode-related exclusion in the policy, the external review panel shall order the continued provision of the health care services which are the subject of the grievance during the course of said external review unless the carrier or utilization review organization demonstrates that there will be no harm to the health of the insured absent such continuation.

SECTION 27. Subsection (h) of Section 15 of Chapter 176O, as so appearing, is hereby stricken and replaced with the following:--

(h) A carrier shall provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to insured requiring such services. A carrier shall be deemed not in compliance with this subsection if the carrier’s network lacks sufficient providers so that an insured must wait a clinically inappropriate period

of time to receive medically necessary health care services. A carrier may achieve compliance with this subsection if it provides coverage for treatment by non-network providers when there are insufficient numbers of network providers with appropriate expertise available to an insured within a clinically reasonable period of time.

SECTION 28. Subsection (b) of Section 16 of Chapter 176O, as so appearing, is hereby stricken and replaced with the following:--

(b) A carrier shall be required to pay for health care services ordered by a treating physician if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined herein. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians in the carrier's or utilization review organization's service area; (ii) developed in accordance with the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable.

In applying the medical necessity guidelines, a carrier shall consider the range of health care services and treatments that fall within the professional standard of care for a particular illness, injury or medical condition, in light of the individual health care needs of the insured. In determining medical necessity, a carrier must determine the safety and efficacy of a requested treatment independent of any consideration of cost. A carrier shall determine the effectiveness of a requested treatment based on consideration of evidence in the following order, depending on availability: 1) scientific evidence; 2) professional standards and 3) expert opinion. A carrier

shall give due deference to the opinions and recommendations of the attending health care professional.