ARIZONA STATE SENATE

Fifty-Fourth Legislature, Second Regular Session

ENACTED

AMENDED

FACT SHEET FOR S.B. 1523/H.B. 2764

mental health omnibus

Purpose

Directs health care insurers to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and outlines related requirements. Grants the Department of Insurance and Financial Institutions (DIFI) compliance enforcement authority. Establishes the Suicide Mortality Review Team (Team) and the Mental Health Parity Advisory Committee (Advisory Committee). Establishes and appropriates $8,000,000 to the Children's Behavioral Health Services Fund (CBH Fund) to pay for eligible behavioral health services.

Background

MHPAEA generally precludes health care insurers that provide mental health or substance use disorder (MH/SUD) benefits from imposing limitations on MH/SUD benefits that are more stringent or less favorable than those imposed on medical and surgical benefits. State insurance authorities and the U.S. Department of Health and Human Services have jurisdiction over applicable public sector group health plans while the U.S. Department of Labor (U.S. DOL) and the U.S. Department of the Treasury have jurisdiction over applicable private sector group health plans (MHPAEA).

MHPAEA specifies that a group health plan or health insurance coverage that includes medical and surgical benefits as well as MH/SUD benefits cannot apply financial requirements, such as deductibles and co-payments, or treatment limitations, such as coverage days, to MH/SUD benefits that are more restrictive than the financial requirements or treatment limitations that apply to medical and surgical benefits. Additionally, if a group health plan or health insurance coverage that includes medical and surgical benefits and MH/SUD benefits provides for out-of-network medical and surgical benefits, the plan or coverage is required to also provide out-of-network MH/SUD benefits (U.S. DOL).

Further, MHPAEA regulations establish a distinction between quantitative treatment limitations (QTLs), such as visit days, and nonquantitative treatment limitations (NQTLs). Examples of NQTLs include medical management, step therapy and pre-authorization. As such, a group health plan or health insurance coverage cannot apply an NQTL to MH/SUD benefits unless the processes and factors used in applying the NQTL are comparable to those used in applying the same NQTL to corresponding medical and surgical benefits.

S.B. 1523 appropriates $8,000,000 from the state General Fund (state GF) to the CBH Fund to pay for eligible behavioral health services and appropriates $250,000 from the state GF to DIFI.

Provisions

Health Care Insurers

1. Directs health care insurers (insurers) that issue plans in Arizona to comply with MHPAEA.

2. Precludes an insurer that issues a health plan in Arizona that includes MH/SUD benefits from denying any claim for such benefits for a minor solely because the MH/SUD service was provided in a school or other educational setting, or court ordered and provided by an in-network provider or permissible out-of-network provider.

3. States that an insurer is not required to approve a claim or provide reimbursement for a MH/SUD service provided by an out-of-network provider except as otherwise required or allowed by a health plan.

4. Permits an insurer to require that any MH/SUD service offered by a mental health provider in an educational setting be provided in a location that is appropriate for the service and in a manner that complies with applicable laws for privacy, parental consent and the provision of health care services.

5. Requires that claims for MH/SUD services provided by an out-of-network provider and not covered by the insured's health plan solely because of the provider's out-of-network status be paid with monies from the CBH Fund.

Insurer Reporting Requirements

6. Requires, after January 1, 2020, on a date determined by the DIFI Director, each insurer to submit a report to DIFI for each fully insured product network type issued by the insurer.

7. Requires that reports subsequently be filed every three years.

8. Requires each report to:
   a) describe the development and selection process for medical necessity criteria for MH/SUD benefits and medical and surgical benefits;
   b) identify all NQTLs applied to MH/SUD benefits and medical and surgical benefits within each classification of benefits (classification); and
   c) demonstrate through analysis that for any NQTL applied to a MH/SUD benefit within a classification that any specified standard or factor used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and not applied more stringently than, those used for medical and surgical benefits in the classification.

9. Specifies if the required reportable information varies by provider network, health insurance plan or market size that the insurer must submit a report for each variation.

10. Directs DIFI to analyze the reports and evaluate each health plan's compliance with specified financial and QTL requirements during the review of other form filings prescribed for insurers.

11. Requires DIFI to perform the report-analysis during the review of other form filings prescribed for insurers and allows DIFI to require an insurer to submit additional compliance data.

12. Permits DIFI to collect and analyze data for each insurer's large group health plans through a separate consolidated report.

13. Prohibits a health plan from applying any financial requirement or QTL to a MH/SUD benefit in a classification that is more restrictive than the predominant financial requirement or QTL of that type applied to all medical and surgical benefits in the same classification, with certain exceptions.

14. Prescribes exemptions for multitiered prescription drug benefits, multiple network tiers and subclassifications for specified office visits if certain criteria are met.

15. Requires insurers, in non-reporting years, to file a summary of changes made to the medical necessity criteria and NQTLs along with a written attestation asserting compliance with MHPAEA and permits DIFI to require an insurer to respond to additional questions related to the summary or supply additional data to verify compliance.

16. Permits an insurer, three years after filing, updating or refiling an original report, to either:
    a) file an updated report; or
    b) resubmit the insurer's currently filed report along with a written attestation to DIFI specifying that no changes have been made.

17. Prohibits DIFI from requiring that an insurer submit additional filings or reports if the information required in the prescribed report has been provided in an existing filing or report, with certain exceptions.

18. Specifies that DIFI is not precluded from requesting information or data that is necessary to verify compliance with MHPAEA or related requirements.

19. Requires DIFI to analyze information included in an insurer's previously submitted report or filing to determine compliance with prescribed reporting requirements.

20. Permits DIFI to establish rules related to terms regarding any required resubmittal of information.

21. States that all related documents, reports or other materials provided to the DIFI Director are confidential and not subject to disclosure.

DIFI

22. Directs DIFI to enforce prescribed requirements and prohibitions related to MH/SUD parity and related requirements.

23. Requires, by January 1, 2021, DIFI to develop a webpage that provides the following information in readily understandable language:
    a) consumer-friendly information regarding the scope and applicability of MHPAEA and the mental health parity requirements that apply to insurers in Arizona;
    b) a guide with information explaining how consumers can file appeals or complaints with DIFI concerning violations of MH/SUD parity requirements;

c) a prominently displayed link to the U.S. DOL website, or a related website, that provides information on appeals and complaints by consumers who are covered by self-insured plans that are regulated by the Employee Retirement Income Security Act; and
d) beginning January 1, 2022, an aggregate summary of DIFI's analysis of the prescribed insurer reports, including any conclusions regarding industry compliance with MHPAEA.

24. Prohibits DIFI from posting any information on the webpage that contains proprietary or confidential information or information that enables a person to determine the identity of an insurer.

25. Requires, beginning in 2022, DIFI to include in its annual report a summary of all stakeholder outreach and regulatory activity related to the implementation, oversight and enforcement of MHPAEA and related requirements.

26. Requires, by April 1, 2021, DIFI to adopt rules for standards to determine MHPAEA compliance and standards for associated forms and worksheets.

27. Permits DIFI to allow insurers to demonstrate compliance by alternative means that are at least as comprehensive as outlined reporting criteria.

28. Directs DIFI to conduct workshops and listening sessions to obtain stakeholder input and review the U.S. DOL's MHPAEA self-compliance tool in the development of associated forms and worksheets.

29. Appropriates $250,000 and one full-time equivalent position from the state GF to DIFI in FY 2021 and exempts the appropriation from lapsing.

CBH Fund

30. Establishes the CBH Fund and appropriates $8,000,000 from the state GF in FY 2021 to the CBH Fund to pay contractors for eligible services.

31. Specifies that CBH Fund monies are continuously appropriated and exempt from lapsing until June 30, 2022.

32. Stipulates that that in order to be eligible to receive behavioral health services paid for by the CBH Fund an individual must:
a) meet the legal age requirements for school admission under Title XV of the Social Security Act at the time of admittance and enrollment in school;
b) be uninsured or under insured;
c) be referred for the services by an educational institution;
d) have written parental consent;
e) receive the services by a contracted licensed behavioral health provider; and
f) receive the services on or off school grounds.

33. Authorizes the Arizona Health Care Cost Containment System (AHCCCS) to impose cost sharing requirements on a sliding fee scale for contractor-provided behavioral health services.

34. Renders AHCCCS as the payor of last resort for individuals eligible for behavioral health services paid for by the CBH Fund.

35. Deems a person who receives behavioral health services paid for by the CBH Fund to have assigned AHCCCS all rights to any type of medical benefit to which the person is entitled.

36. Specifies that there is no established entitlement for any person to receive any particular service or established duty on AHCCCS to provide services or spend monies in excess of the CBH Fund.

Schools

37. Directs school district governing boards and charter school governing bodies to adopt policies relating to school-based referrals for behavioral health services, as permitted by the CBH Fund or AHCCCS, before a school or charter school provides referrals to a contracted behavioral health provider.

38. Obligates school district governing boards and charter school governing bodies to vet proposed policies at a public meeting and to consider public comment prior to adopting policies.

39. Requires the inclusion of the adopted policies on each applicable school's website.

40. Stipulates that policies must include a:
    a) process to allow a parent to annually opt-in to the school-based referrals;
    b) process to conduct a survey of parents whose children were referred to and received behavioral health services that includes whether the:
        i. parent opted in to the program;
        ii. parent was notified prior to a referral;
        iii. behavioral health services were appropriate to meet the student's need;
        iv. parent is satisfied with the choice of behavioral health service providers; and
        v. parent intends to opt-in to a program again the subsequent school year; and
    c) requirement that each school's website include a list of contracted behavioral health service providers.

41. Necessitates that each participating school district governing board and charter school governing body report the survey results to AHCCCS.

AHCCCS

42. Requires AHCCCS to enter into agreements with contractors for behavioral health services using CBH Fund monies to pay for behavioral health services for children and establishes that such agreements must require that:
    a) allocated monies are not used for eligible individuals under Title XIX or Title XXI of the Social Security Act;
    b) contractors coordinate benefits with third parties that are legally responsible for the cost of services;
    c) contractors make payments to providers according to contracts or the AHCCCS capped-fee schedule;
    d) contractors submit monthly expenditure reports, as prescribed by the Director of AHCCCS, for the reimbursement of services; and
    e) AHCCCS is not held financially responsible to the contractor for costs incurred in excess of allocated monies.

43. Permits a contract to allow for reimbursements for administering agreements and caps such reimbursements at eight percent of the expenditures for services.

44. Directs AHCCCS to report annually, by December 31, on the survey results received from each participating school district governing board and charter school governing body and utilization data for related behavioral health services.

45. Requires the report to be distributed to the Governor, the presiding officer in each chamber of the Legislature and the Secretary of State.

46. Stipulates that the report must include the number of students served and the types and costs of the provided behavioral health services.

47. Directs AHCCCS to conduct a survey of public schools to obtain information regarding the delivery of behavioral health services to students by contracted behavioral health providers, including:
    a) the types of behavioral health providers delivering services;
    b) the types of settings where the behavioral health services were delivered to students;
    c) the number of students receiving services; and
    d) the most common diagnoses resulting in a need for services.

48. Requires AHCCCS to distribute the results of the survey, by December 31, 2022, to the Governor, the presiding officer in each chamber of the Legislature and the Secretary of State.

49. Repeals the prescribed reporting requirements on July 1, 2023.

Advisory Committee

50. Establishes the Advisory Committee to advise the Directors of DIFI and the Department of Health Services (DHS) on mental health parity matters, including recommendations regarding case management, discharge planning and review and appeals processes.

51. Grants the Directors of DIFI and DHS authority to appoint Advisory Committee members and prescribes advisory Committee membership.

52. Permits the Director of AHCCCS to serve in an advisory capacity upon request of the Director of DIFI or DHS.

53. Terminates the Advisory Committee on July 1, 2028.

Team

54. Establishes the Team, prescribes Team membership and delineates Team duties.

55. Requires that the Team Chairperson, upon request and as necessary to carry out Team duties, be provided access to information and records regarding a Team-reviewed suicide within five days.

56. Allows the Team to request information and records from:
    a) a medical, dental, nursing or mental health care provider;
    b) an insurer; and
    c) Arizona or a political subdivision of Arizona.

57. Allows a law enforcement agency to withhold investigative records requested by the Team if the records may interfere with a pending investigation or prosecution and if approved by the prosecuting attorney.

58. Authorizes the Director of DHS, or their designee, to apply to the superior court for a subpoena to compel the production of records or other evidence related to a person who died by suicide.

59. Exempts law enforcement from producing subpoenaed information if the evidence relates to a pending criminal investigation or prosecution.

60. Obligates the Team to return any record to the agency or organization of origin upon completion of a review.

61. Prohibits the Team from maintaining written reports or records that contain identifying information.

62. Specifies that records and information acquired by the Team are confidential and not subject to subpoena, discovery or introduction into evidence in a civil or criminal proceeding, with certain exceptions.

63. Prohibits Team members, Team meeting attendees and individuals who present information to the Team from being questioned in any civil or criminal proceeding regarding information presented in a Team meeting or opinions formed as a result of a Team meeting.

64. Permits a Team member to contact, interview or obtain information by request or subpoena, as prescribed by Team policy, from a family member of a person who died by suicide, and requires the Team, or local team, to preapprove any contact, interview, request or subpoena.

65. States that Team meetings are closed to the public when the Team is reviewing information on an individual who died by suicide.

66. Classifies violations of Team-related confidentiality requirements as a class 2 misdemeanor.

67. Specifies that Team members are not eligible for compensation; rather, Team members are eligible for reimbursement of expenses as specified.

68. Requires DHS to provide professional and administrative support to the Team.

69. Terminates the Team on July 1, 2028.

Child Fatality Review (CFR) Fund

70. Directs DHS to train and support the Team and to use CFR Fund monies to staff the Team.

71. Appropriates fee revenues in excess of $200,000, rather than $100,000, in any fiscal year from the CFR Fund to the Child Abuse Prevention Fund.

Miscellaneous

72. Requires, beginning January 1, 2022, identification cards that facilitate an individual's access to services or coverage under an individual or group health insurance contract, evidence of coverage or policy issued by a hospital medical service corporation or disability insurer to display the letters *AZDOI* as specified and include a telephone number for customer service.

73. Directs DHS to adopt rules relating to admitting and discharging patients who have attempted suicide or who exhibit suicidal ideation from inpatient care at health care institutions.

74. Requires discharge rules to include protocols for implementation in health care intuitions and provide patients with information on a continuum during the stay, including at admission, before discharge and at discharge.

75. Requires discharge rules to address:
    a) the availability and contact information of age-appropriate crisis services;
    b) information and referrals to the next appropriate level of care after discharge;
    c) information on the DIFI website relating to challenging an adverse decision by an insurer or health plan; and
    d) conducting suicide assessments before discharge.

76. Exempts DHS from rulemaking requirements for 18 months after the effective date of this legislation and prescribes public comment requirements.

77. Defines relevant terms.

78. Names this legislation *Jake's Law*.

79. Makes technical and conforming changes.

80. Becomes effective on the general effective date.

<u>Amendments Adopted by the Health and Human Services Committee</u>

1. Establishes eligibility requirements to receive behavioral health services paid for by the CBH Fund.

2. Permits AHCCCS to impose cost sharing requirements for contractor-provided behavioral health services.

3. Permits insurers to require that MH/SUD services provided in educational settings be provided with parental consent.

4. Eliminates proposed language directing the Arizona Department of Education (ADE) to conduct a research study and eliminates the associated appropriation.

5. Requires school district governing boards and charter school governing bodies to adopt policies relating to school-based referrals and outlines minimum requirements including a parent survey and an opt-out process.

6. Directs AHCCCS to compile an annual report, by December 31 of each year, based on the parent survey results and specified utilization data, and outlines additional reporting requirements.

7. Increases the appropriation to DIFI.

8. Requires DIFI to adopt rules by April 2021, rather than January 2022.

9. Requires the DIFI website to include a link to the U.S. DOL website.

10. Expands Advisory Committee membership.

11. Requires the Team to approve requests for information.

12. Makes technical and conforming changes.

Amendments Adopted by the Appropriations Committee

1. Establishes eligibility requirements to receive behavioral health services paid for by the CBH Fund.

2. Permits AHCCCS to impose cost sharing requirements for contractor-provided behavioral health services.

3. Permits insurers to require that MH/SUD services provided in educational settings be provided with parental consent.

4. Eliminates proposed language directing ADE to conduct a research study and eliminates the associated appropriation.

5. Requires school district governing boards and charter school governing bodies to adopt policies relating to school-based referrals and outlines minimum requirements including a parent survey and an opt-in process.

6. Directs AHCCCS to compile an annual report, by December 31 of each year, based on the parent survey results and specified utilization data, and outlines additional reporting requirements.

7. Increases the appropriation to DIFI.

8. Requires DIFI to adopt rules by April 2021, rather than January 2022.

9. Requires the DIFI website to include a link to the U.S. DOL website.

10. Specifies DIFI is not precluded from requesting information or data that is necessary to verify compliance with MHPAEA or related requirements.

11. Expands Advisory Committee membership.

12. Requires the Team to approve requests for information.

13. Makes technical and conforming changes.

Amendments Adopted by Committee of the Whole

1. The Health and Human Services Committee amendment was withdrawn.

2. Establishes eligibility requirements to receive specified behavioral health services that are paid for by the CBH Fund.

3. Exempts CBH Fund monies from lapsing until June 30, 2022.

4. Permits AHCCCS to impose cost sharing requirements for contractor-provided behavioral health services.

5. Permits insurers to require that MH/SUD services provided in educational settings be provided with parental consent.

6. Eliminates proposed language directing ADE to conduct a research study and eliminates the associated appropriation.

7. Requires school district governing boards and charter school governing bodies to adopt policies relating to school-based referrals and outlines minimum requirements including a parent survey and an opt-in process.

8. Directs AHCCCS to compile an annual report, by December 31, based on the parent survey results and specified utilization data, and outlines additional reporting requirements.

9. Repeals the AHCCCS reporting requirement on July 1, 2022.

10. Increases the appropriation to DIFI, from $200,000 to $250,000.

11. Requires DIFI to adopt rules by April 2021, rather than January 2022.

12. Requires the DIFI website to include a link to the U.S. DOL website.

13. Specifies DIFI is not precluded from requesting information or data that is necessary to verify compliance with MHPAEA or related requirements.

14. Expands the Advisory Committee membership.

15. Requires the Team to approve requests for information.

16. Makes technical and conforming changes.

Senate Action

HHS	2/19/20	DPA	8-0-0
APPROP	2/25/20	DPA	9-0-0
3rd Read	3/3/20		30-0-0

House Action

HHS	2/20/20	DPA	9-0-0-0
APPROP	2/24/20	DPA	10-0-0-1
3rd Read	3/3/20		60-0-0

(S.B. 1523 was substituted for H.B. 2764 on 3rd Read)

Signed by the Governor 3/3/20
Chapter 4

Prepared by Senate Research
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