State of Tennessee

PUBLIC CHAPTER NO. 244

SENATE BILL NO. 151

By Briggs

Substituted for: House Bill No. 360

By Hawk, Whitson, Smith, Clemmons, Tim Hicks

AN ACT to amend Tennessee Code Annotated, Title 8; Title 56; Title 63; Title 68 and Title 71, relative to coverage for mental health, alcoholism, or drug dependency services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-2360, is amended by deleting the section and substituting:

(a)(1) As used in this section:

(A) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit;

(B) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a twelve-month period under a health plan with respect to an individual or other coverage unit;

(C) "Classification of benefits" means:

(i) Inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits; and

(ii) The only classifications that may be used, except that there may be sub-classifications within both outpatient classifications differentiating office visits from other outpatient items and services, including outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items;

(D) "Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit;

(E) "Health benefit plan" means a hospital or medical expense policy, health, hospital, or medical service corporation contract, a policy or agreement entered into by a health insurer or a health maintenance organization contract offered by an employer, other plans administered by the state government, or a certificate issued under the policies, contracts, or plans;

(F) "Health insurance carrier" means an entity subject to this title, or subject to the jurisdiction of the commissioner of commerce and insurance, that contracts with healthcare providers in connection with a plan of health insurance, health benefits, or health services;

(G) "Mental health or alcoholism or drug dependency benefits" means benefits for the treatment of a condition or disorder that involves a mental health condition or substance use disorder that:

(i) Falls under the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease; or

(ii) Is listed in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;

(H) "Non-quantitative treatment limitations" or "NQTLs":

(i) Means limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. For purposes of this subdivision (a)(1)(H), fail-first or step therapy protocols do not include formulary designs that require the prescription, use, and a showing of ineffectiveness of generic drugs prior to approval of payment for the prescription of higher cost drugs; and

(ii) Include:

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

(b) Formulary design for prescription drugs;

(c) Tier design for plans with multiple network tiers, including preferred providers and participating providers, and network tier design;

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

(e) 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, that are also known as fail-first policies or step therapy protocols;

(g) Exclusions based on 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 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; and

(o) Exclusions for services provided by clinical social workers;

(I) "Predominant" means application to more than one-half (1/2) of such type of limit or requirement;

(J) "Substantially all" means application to at least two-thirds (2/3) of all medical or surgical benefits in a classification; and

(K) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(2) In addition to any other requirement of law concerning coverage of mental health or mental illness benefits or alcoholism or drug dependency benefits, including, but not limited to, §§ 56-7-2601 and 56-7-2602, an individual or group health benefit plan issued by a health insurance carrier regulated pursuant to this title shall provide coverage for mental health or alcoholism or drug dependency services in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (42 U.S.C. § 300gg-26) and 45 CFR § 146.136 and 45 CFR § 147.160.

(b) Subsection (a) does not prohibit an employee health benefit plan, or a plan issuer offering an individual or group health plan from utilizing managed care practices for the delivery of benefits required under this section, as long as that for an utilization review or benefit determination for the treatment of alcoholism or drug dependence the clinical review criteria is the most recent Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine or other evidence-based clinical guidelines, such as those referenced by the federal substance abuse and mental health services administration (SAMHSA). Additional criteria, other than in this subsection (b), must not be used during utilization review or benefit determination for treatment of substance use disorders.

(c) The mandate to provide coverage for mental health services does not apply with respect to a group health plan if the application of the mandate to the plan results in an increase in the cost under the plan of more than one percent (1%). Documentation of the increase in cost must be filed with the department after twelve (12) months of experience. If the commissioner determines that the increase in cost is a result of the requirements of this section, then the commissioner or the commissioner's designee shall issue a letter to the issuer of the plan stating that the plan does not have to comply with the mandate set out in this section. The issuer may appeal the letter as final agency action pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(d) The department of commerce and insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, this section, and §§ 56-7-2601 and 56-7-2602, that include:

(1) Ensuring compliance by individual and group health benefit plans;

(2) Detecting possible violations of the law by individual and group health benefit plans;

(3) Accepting, evaluating, and responding to complaints regarding such violations; and

(4) Maintaining and regularly reviewing for possible parity violations a publicly available consumer complaint log regarding mental health or alcoholism or drug dependency coverage as long as individually identifiable information is excluded.

(e) Not later than January 31, 2022, and each year thereafter, the department shall issue a report to the general assembly and provide an educational presentation to the general assembly. The department shall request from the United States department of labor and the United States department of health and human services copies of the NQTL analyses submitted to the departments the previous year in compliance with the federal Consolidated Appropriations Act of 2021 (Pub.L. 116–260) and incorporate these analyses into the report. The report and presentation must:

(1) List health plans sold in this state and over which of these plans the department has jurisdiction;

(2) Discuss the methodology the department is using to check for compliance with the MHPAEA, and any federal regulations or guidance relating to the compliance and oversight of the MHPAEA, including 45 CFR 146.136;

(3) Discuss the methodology the department uses to check for compliance with this section and §§ 56-7-2601 and 56-7-2602;

(4) Identify market conduct examinations and full scope examinations conducted or completed during the preceding twelve-month period and summarize

the results of the examinations. Individually identifiable information must be excluded from the reports consistent with federal privacy protections, including, but not limited to, 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67. This discussion must include:

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

(B) The benefit classifications examined by each market conduct examination and full scope examination;

(C) The subject matter of each market conduct examination, including quantitative and non-quantitative treatment limitations;

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

(E) Any examination regarding compliance with parity in mental health or alcoholism or drug dependency benefits under state and federal laws;

(5) Detail educational or corrective actions the department of commerce and insurance has taken to ensure health benefit plan compliance with this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602;

(6) Detail the department's educational approaches relating to informing the public about mental health or alcoholism or drug dependence parity protections under state and federal law; and

(7) Describe how the department examines any provider or consumer complaints related to denials or restrictions for possible violations of this section, the MHPAEA, 42 U.S.C. § 18031(j), and §§ 56-7-2601 and 56-7-2602, including complaints regarding, but not limited to:

(A) Denials of claims for residential treatment or other inpatient treatment on the grounds that such a level of care is not medically necessary;

(B) Claims for residential treatment or other inpatient treatment that were approved but for a fewer number of days than requested;

(C) Denials of requests, authorizations, pre-authorizations, prior authorizations, concurrent reviews, or claims for residential treatment or other inpatient treatment because the beneficiary had not first attempted outpatient treatment, medication, or a combination of outpatient treatment and medication;

(D) Denials of claims for medications such as buprenorphine or naltrexone on the grounds that they are not medically necessary;

(E) Step therapy requirements imposed before buprenorphine or naltrexone are approved;

(F) Prior authorization requirements imposed on claims for buprenorphine or naltrexone, including those imposed because of safety risks associated with buprenorphine; and

(G) Denial of in-network authorization or denials of out-of-network services or claims where there is not an in-network provider within seventy-five (75) miles of the insured patient's home.

(f) The report issued pursuant to subsection (e) must be written in non-technical, readily understandable language and be made available to the public by posting the report on the department's website and by other means as the department finds appropriate. The name and identity of the health insurance carrier must be given confidential treatment, may not be made public by the commissioner or another person, and are not subject to public inspection pursuant to § 10-7-503.

(g) Benefits under this section shall not be denied for care for confinement provided in a hospital owned or operated by this state that is especially intended for use in the diagnosis, care, and treatment of psychiatric, mental, or nervous disorders.

(h) This section does not apply to accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit hospital insurance policies.

(i) The commissioner is authorized to promulgate rules to effectuate the purposes of this section. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(j) This section does not require the disclosure of information that would violate 42 U.S.C. § 290dd-2 and regulations found at 42 CFR § 2.1 through 42 CFR § 2.67.

SECTION 2. This act takes effect upon becoming a law, the public welfare requiring it, and applies to plans entered into, issued, renewed, or amended on or after the effective date of this act.

SENATE BILL NO. 151

PASSED: April 19, 2021

RANDY McNALLY
SPEAKER OF THE SENATE

CAMERON SEXTON, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 28th day of April 2021

BILL LEE, *GOVERNOR*