CHAPTER 15

(HB 50)

AN ACT relating to mental health parity.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔Section 1. KRS 304.17A-660 is amended to read as follows:

As used in KRS 304.17A-660 to 304.17A-669, unless the context requires otherwise:

(1) ***"Classification of benefits" means the classification of benefits set forth in 45 C.F.R. sec. 146.136(c)(2)(ii)(A);***

(2) "Mental health condition" means any condition or disorder that involves mental illness or substance use disorder as defined in KRS 222.005 and that falls under any of the diagnostic categories listed in the ***most recent version of the*** Diagnostic and Statistical Manual of Mental Disorders~~[(Fourth Edition)]~~ or that is listed in the mental disorders section of the ***most recent version of the*** International Classification of Disease~~[, or the most recent subsequent editions]~~;

(3)~~[(2)]~~ ***"Nonquantitative treatment limitation" means any limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment;***

(4) "Terms or conditions" includes day or visit limits, episodes of care, any lifetime or annual payment limits, deductibles, copayments, prescription coverage, coinsurance, out-of-pocket limits, and any other cost-sharing requirements; and

(5)~~[(3)]~~ "Treatment of a mental health condition" includes but is not limited to any necessary outpatient, inpatient, residential, partial hospitalization, day treatment, emergency detoxification, or crisis stabilization services.

➔Section 2. KRS 304.17A-661 is amended to read as follows:

(1) Notwithstanding any other provision of law***:***~~[,]~~

(a) ***1.*** A health benefit plan issued or renewed ***on or*** after ***the effective date of this Act***~~[July 14, 2000]~~, that provides coverage for treatment of a mental health condition shall provide coverage of any treatment ***of***~~[for]~~ a mental health condition under~~[the same]~~ terms or conditions ***that are no more restrictive than the terms or conditions***~~[as]~~ provided for treatment of a physical health condition.

2.~~[(2)]~~ Expenses for mental health and physical health conditions shall be combined for purposes of meeting deductible and out-of-pocket limits required under a health benefit plan.

3.~~[(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 or mental health conditions may provide coverage for treatment of mental health conditions through a managed care organization***;***~~[.~~

~~(4) For the purposes of a health benefit plan issued or renewed on or after July 14, 2000, any mental health condition that is excluded from the standard health benefit plan authorized by KRS 304.17A-250 and in effect on January 1, 2000, may continue as an exclusion under this section.]~~

(b) With respect to mental health condition benefits in any classification of benefits, a health benefit plan required to comply with paragraph (a) of this subsection shall not impose:

1. A nonquantitative treatment limitation that does not apply to medical and surgical benefits in the same classification; and

2. Medical necessity criteria or a nonquantitative treatment limitation unless, under the terms of the plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the criteria or limitation to mental health condition 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 criteria or limitation to medical and surgical benefits in the same classification; and

(c) Paragraph (b) of this subsection shall be construed to require, at a minimum, compliance with the requirements for nonquantitative treatment limitations set forth in the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. sec. 300gg-26, as amended, and any related federal regulations, as amended, including but not limited to 45 C.F.R. sec. 146.136, 45 C.F.R. sec. 147.160, and 45 C.F.R. sec. 156.115(a)(3).

(2) (a) An insurer that issues or renews a health benefit plan that is subject to the provisions of this section shall submit an annual report to the commissioner on or before April 1 of each year following the effective date of this Act that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for both mental health condition benefits and medical and surgical benefits;

2. Identification of all nonquantitative treatment limitations applicable to benefits and services covered under the plan that are applied to both mental health condition benefits and medical and surgical benefits within each classification of benefits;

3. The results of an analysis that demonstrates compliance with subsection (1)(b) and (c) of this section for the medical necessity criteria described in subparagraph 1. of this paragraph and for each nonquantitative treatment limitation identified in subparagraph 2. of this paragraph, as written and in operation. At a minimum, the results of the analysis shall:

a. Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies:

i. Used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to mental health condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits; and

ii. Used to apply each nonquantitative treatment limitation, in operation, for mental health condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

d. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses performed under this subparagraph indicate that the insurer is in compliance with subsection (1)(b) and (c) of this section; and

4. Any additional information that may be prescribed by the commissioner for use in determining compliance with the requirements of this section.

(b) The annual report shall be submitted in a manner and format prescribed by the commissioner through administrative regulation.

(3) ~~[(5)]~~ A ***willful*** violation of this section shall constitute an act of discrimination and shall be an unfair trade practice under this chapter. The remedies provided under Subtitle 12 of this chapter shall apply to conduct in violation of this section.

➔Section 3. KRS 304.17A-669 is amended to read as follows:

(1) Nothing in KRS 304.17A-660 to 304.17A-669 shall be construed as mandating coverage for mental health conditions.

(2) ***A group health benefit plan covering fewer than fifty-one (51) employees that is not otherwise required to provide parity in mental health condition benefits under federal law*** ~~[The following]~~ shall be exempt from the provisions of KRS 304.17A-660 to 304.17A-669~~[:~~

~~(a) A group health benefit plan covering fewer than fifty-one (51) employees;~~

~~(b) An individual health benefit plan; and~~

~~(c) An employer-organized association as defined in KRS 304.17A-005]~~.

➔Section 4. This Act takes effect on January 1, 2022.

Signed by Governor March 12, 2021.