SENATE BILL NO. 21

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

BY SENATORS DAVIS, Ellis

Introduced: 1/21/09
Referred: Health and Social Services, Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act requiring health care insurers to provide coverage for treatment of mental health, alcoholism, and substance abuse conditions, and requiring parity between health care insurance coverage for mental health, alcoholism, and substance abuse benefits and other medical care benefits; eliminating different treatment for mental health conditions from the minimum benefits of the state health insurance plan; removing an exclusion for mental health services or alcohol or drug abuse from the definition of basic health care services in the law relating to health maintenance organizations; repealing a provision that allows optional insurance coverage for treatment of alcoholism and drug abuse based on the number of employees and the duration of employment; repealing a definition of costs applicable solely to treatment for alcoholism and drug abuse, including a provision that allows the cost for treatment of alcoholism and drug abuse to be determined by the insurance contract or by a contract between the treatment

provider and the health care insurer; repealing a definition of mental health benefits that excludes treatment of substance abuse or chemical dependency; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.42.365(a) is amended to read:

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan [, EXCEPT FOR CATASTROPHIC ILLNESS INSURANCE, PROVIDING COVERAGE FOR FIVE OR MORE EMPLOYEES OF AN EMPLOYER IN THE GROUP MARKET] shall provide a covered employee or the employee's dependent [THE FOLLOWING] coverage for treatment of alcoholism or drug abuse [:

(1) BENEFITS OF AT LEAST $9,600 OVER TWO CONSECUTIVE BENEFIT YEARS; AND

(2) LIFETIME BENEFITS OF AT LEAST $19,200].

*** Sec. 2.** AS 21.42.365(c) is amended to read:

(c) A health care insurer that offers a health care insurance plan providing coverage under this section may not

(1) **establish a rate, term, or condition that places a greater financial burden on an insured for diagnosis or treatment of alcoholism or drug abuse than for other medical care; in this paragraph, "rate, term, or condition" means any lifetime or annual payment limit, deductible, copayment, coinsurance, cost-sharing requirement, out-of-pocket limit, limit on the frequency of treatment, number of visits, days of coverage, or other similar limit on the scope or duration of treatment, or other financial component of health care insurance coverage that affects the insured** [REQUIRE THAT A COVERED EMPLOYEE OR THE EMPLOYEE'S DEPENDENT BE RESPONSIBLE FOR A DEDUCTIBLE OR COPAYMENT THAT IS DIFFERENT FOR THE DETERMINATION OF BENEFITS RELATING TO TREATING ALCOHOLISM OR DRUG ABUSE THAN FOR THE DETERMINATION OF BENEFITS FOR TREATING ANOTHER COVERED ILLNESS];

(2) use a different claim payment **method to determine** [METHODOLOGY IN DETERMINING] the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for **other medical care** [TREATING ANOTHER COVERED ILLNESS];

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other **medical care** [COVERED MAJOR ILLNESSES];

(4) limit coverage by provisions of the insurance contract that are not applicable to other **medical care** [COVERED MAJOR ILLNESSES], including provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

*** Sec. 3.** AS 21.42.365(e) is amended by adding new paragraphs to read:

(6) "health care insurance plan" means, notwithstanding AS 21.54.500, a health care insurance policy or contract provided by a health care insurer;

(7) "health care insurer" means, notwithstanding AS 21.54.500, a person transacting the business of health care insurance, as defined in AS 21.12.050(b).

*** Sec. 4.** AS 21.54.151 is repealed and reenacted to read:

Sec. 21.54.151. Mental health benefits. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan to an employer or individual, on a group or individual basis, shall provide coverage for treatment of a mental health condition.

(b) A health care insurance plan may not establish a rate, term, or condition that places a greater financial burden on an insured for diagnosis or treatment of a mental health condition than for other medical care. In this subsection, "rate, term, or

condition" means any lifetime or annual payment limit, deductible, copayment, coinsurance, cost sharing requirement, out-of-pocket limit, limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, or other financial component of health care insurance coverage that affects the insured.

(c) In this section,

(1) "health care insurance plan" means, notwithstanding AS 21.54.500, a health care insurance policy or contract provided by a health care insurer;

(2) "health care insurer" means, notwithstanding AS 21.54.500, a person transacting the business of health care insurance, as defined in AS 21.12.050(b);

(3) "mental health condition" means a condition or disorder involving mental illness, including a mental health condition listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

*** Sec. 5.** AS 21.54.500(27) is amended to read:

(27) "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a physical or mental **health** condition that was present before the enrollment date, regardless of whether medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date;

*** Sec. 6.** AS 21.55.110 is amended to read:

Sec. 21.55.110. Minimum benefits of state health insurance plan. Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of $1,000,000 for each individual for usual, customary, reasonable, or prevailing charges or, when applicable, the allowance agreed upon between a provider and the plan administrator for charges. The minimum standard benefits of the plan must cover the following medical services performed for an individual covered by the plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury:

(1) hospital services;

(2) subject to the limitations of AS 21.36.090(d), professional services

that are rendered by a physician or by a registered nurse at the physician's direction, other than services for [MENTAL OR] dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined in regulations of the director [, RENDERED DURING THE YEAR ON OTHER THAN AN INPATIENT BASIS, UP TO A YEARLY MAXIMUM BENEFIT OF $4,000];

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a policy year;

(6) home health agency services up to a maximum of 270 visits in a calendar year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed $200;

(7) hospice services for up to six months in a calendar year;

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

(12) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis;

(13) rental, or purchase if purchase is more **cost-effective** [COST EFFECTIVE] than rental, of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed;

(14) diagnostic x-rays and laboratory tests;

(15) oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth;

(16) services of a licensed physical therapist rendered under the

direction of a physician;

(17) transportation by a local ambulance operated by licensed or certified personnel to the nearest health care institution for treatment of the illness or injury and round trip transportation by air to the nearest health care institution for treatment of the illness or injury if the treatment is not available locally; if the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child may be paid if the attending physician certifies the need for the accompaniment;

(18) confinement in a licensed or certified facility established primarily for the treatment of alcohol or drug abuse, or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year;

(19) alternatives to inpatient services as defined by the association in the state plan benefits;

(20) second surgical opinions;

(21) other services that are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the director.

*** Sec. 7.** AS 21.55.120(b) is amended to read:

(b) A state plan other than a Medicare supplement plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible [AND 50 PERCENT FOR SERVICES DESCRIBED IN AS 21.55.110(3) IN EXCESS OF THE DEDUCTIBLE].

*** Sec. 8.** AS 21.55.120(c) is amended to read:

(c) The sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of $1,500 plus the deductible. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of usual, customary, reasonable, or prevailing charges [, EXCEPT THAT EXPENSES INCURRED FOR TREATMENT OF MENTAL AND NERVOUS CONDITIONS SHALL BE PAID AT THE RATE OF 50 PERCENT].

*** Sec. 9.** AS 21.86.900(3) is amended to read:

(3) "basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services [, BUT DOES NOT

INCLUDE MENTAL HEALTH SERVICES OR SERVICES FOR ALCOHOL OR DRUG ABUSE];

*** Sec. 10.** AS 21.90.900(30) is amended to read:

(30) "medical care" means [AMOUNTS PAID FOR]

(A) diagnosis, care, mitigation, treatment, or prevention of disease [, OR AMOUNTS PAID] for the purpose of affecting any structure or function of the body**, including mental health care or care for an alcoholism or substance abuse disorder**;

(B) transportation primarily for and essential to medical care described in (A) of this paragraph; and

(C) **amounts paid for** insurance covering medical care described in (A) and (B) of this paragraph.

*** Sec. 11.** AS 21.42.365(b), 21.42.365(d), 21.42.365(e)(3), 21.42.365(e)(4); AS 21.54.500(21), and 21.54.500(22) are repealed.

*** Sec. 12.** This Act takes effect July 1, 2009.