HOUSE AMENDMENT 3 TO hb1525.

deleting line 8 of page 1 and substituting the following:

"By: Senators Bradford, Argue, Bearden, Edwards, Everett, Mahony, Ross, Walker, Walters, Boozman, and Roebuck"

AND

by deleting lines 12 and 13 of page 1 and substituting the following:

"THE ARKANSAS MENTAL HEALTH PARITY ACT";

AND

by deleting lines 16 and 17 of page 1 and substituting the following:

"THE ARKANSAS MENTAL HEALTH PARITY ACT";

AND

by deleting sections 1 through 12 of the bill and substituting the following:

"SECTION 1. Short Title.

This act shall be known and may be cited as the "Arkansas Mental Health Parity Act."

SECTION 2. Legislative findings and intent.

It is the intent of this state that insurance coverage for mental illnesses and the mental health treatment of those with developmental disorders shall be as available and at parity with that for other medical illnesses.

SECTION 3. Definitions.

As used in this act:

(1) "Commissioner" means the Insurance Commissioner of the State of Arkansas.

(2) "Financial requirements" means co-payments, deductibles, out-of-network charges, out-of-pocket contributions or fees, annual limits, lifetime aggregate limits imposed on individual patients, and other patient cost sharing amounts.

(3) "Health benefit plan" means any group or blanket plan, policy or contract for health care services issued or delivered in this state by health care insurers, including indemnity and managed care plans, but excluding plans providing health care services to state employees or pursuant to Arkansas Constitution, Article 5, Section 32, as amended, the Workers' Compensation Law, A.C.A. §§ 11-9-101, et seq., and the Public Employees Workers Compensation Act, A.C.A. §§ 21-5-601, et seq.;

(4) "Health care insurer" means any insurance company, hospital and medical services corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to any the following laws:

(A) the Arkansas Insurance Code, A.C.A. §§ 23-60-101, et seq.;

(B) A.C.A. §§ 23-75-101, et seq. pertaining to hospital and medical service corporations;

(C) A.C.A. § 23-76-101, et seq. pertaining to health maintenance organizations; and

(D) any successor law of the foregoing.

(5) "Mental illnesses" and "developmental disorders" mean those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders.

(6) "Carve-out arrangement" means an arrangement in which a health care insurer contracts with a separate person or entity to arrange for the delivery of specific types of health care benefits under a health benefit plan.

(7) "Person" or "entity" means and includes, individually and collectively, any individual, corporation, partnership, firm, trust, association, voluntary organization, or any other form of business enterprise or legal entity.

(8) "Small employer" means any person or entity actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding year, employed no more than fifty (50) eligible employees.

SECTION 4. Parity Requirements.

(a) Except as provided in Section 8, every health benefit plan shall provide medical coverage for the diagnosis and mental health treatment of mental illnesses and the mental health treatment of those with developmental disorders.

(b) A health benefit plan shall provide benefits for diagnosis and mental health treatment of mental illnesses and developmental disorders under the same terms and conditions as provided for covered benefits offered under the health benefit plan for the treatment of other medical illnesses or conditions. There shall be no differences in the health benefit plan in regard to any of the following:

(1) the duration or frequency of coverage;

(2) the dollar amount of coverage; or

(3) financial requirements.

(c) Nothing in this act shall be construed:

(1) as requiring equal coverage between treatments for a mental illness or a developmental disorder with coverage for preventive care.

(2) as prohibiting a health care insurer from:

(A) negotiating separate reimbursement rates and service delivery systems, including, but not limited to, a carve-out arrangement;

(B) managing the provision of mental health benefits for mental illnesses and the mental health treatment of those with developmental disorders by common methods used for other medical conditions, including, but not limited to, pre-admission screening, prior authorization of services, or other mechanisms designed to limit coverage of services for mental illnesses and developmental disorders to those that are deemed medically necessary;

(C) Limiting covered services to those authorized by the health insurance policy, provided that such limitations are made in accordance with this act;

(D) Using separate but equal cost-sharing features for mental illnesses or developmental disorders as for other medical illness; or

(E) Using a single lifetime or annual dollar limit as applicable to other medical illness.

(3) As including a Medicare or Medicaid plan or contract or any privatized risk or demonstration program for Medicare or Medicaid coverage.

SECTION 5. Medical necessity.

This act shall not be construed as prohibiting a health benefit plan from excluding coverage for diagnosis and treatment of mental illnesses and developmental disorders when the diagnosis and treatment are medically unnecessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and regulations.

The term "medical necessity" as applied to benefits for mental illnesses and developmental disorders means:

(1) reasonable and necessary for the diagnosis or treatment of a mental illness, or to improve or to maintain or to prevent deterioration of functioning resulting from such illness or developmental disorder;

(2) furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(3) the most appropriate level or supply of service which can safely be provided; and

(4) could not have been omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered.

SECTION 6. Permitted provisions.

(a) A health care insurer may at the insurer's option provide coverage for a health service, such as intensive case management, community residential treatment programs, or social rehabilitation programs, which is used in the treatment of mental illnesses or developmental disorders, but is generally not used for other injuries, illnesses, and conditions, as long as the other requirements of this act are met.

(b) Health care insurers providing chemical dependency treatment or educational remediation may, but are not required to, comply with to the terms of this act in regard to such treatment or remediation.

(c) A health care insurer may provide coverage for a health service, including, but not limited to, physical rehabilitation or durable medical equipment, which generally is not used in the diagnosis or treatment of serious mental illnesses, but is used for other injuries, illnesses, and conditions, as long as the other requirements of this act are

met.

SECTION 7. Applicability.

(a) On or after the effective date of this act, this act shall apply to health benefit plans on the plans_ anniversary or start date, but in no event later than one (1) year after the effective date of this act.

(b) If a health benefit plan provides coverage or benefits to an Arkansas resident, the plan shall be deemed to be delivered in this state within the meaning of this act, regardless of whether the health care insurer or other entity that provides the coverage is located within or outside of Arkansas.

SECTION 8. Exclusions.

This act shall not apply to:

(1) Dental insurance plans;

(2) Vision insurance plans;

(3) Specified-disease insurance plans;

(4) Accidental injury insurance plans;

(5) Long-term care plans;

(6) Disability income plans;

(7) Individual health benefit plans, provided that health care insurer's shall offer individuals the option of purchasing a plan that, other than being optional, meets all the other requirements of this act;

(8) Health benefit plans for small employers, provided that health care insurer's shall offer purchasers the option of purchasing a plan that, other than being optional, meets all the other requirements of this act; and

(9) Medicare Supplement plans, as subject to Section 1882 (g) (1) of the federal Social Security Act [42 U.S.C. § 1395ss].

SECTION 9. Increased Cost Exemption.

This act shall not apply with respect to a health benefit plan if the application of this act to such plan will result in an increase in the cost under the plan of at least one and one-half (1.5) percent. The commissioner shall develop regulations to implement this exemption, and in doing so, may look for guidance in the regulations promulgated by the federal Department of Health and Human Services in implementing the federal Mental Health Parity Act, P.L. 104-204, Sec. 712(c)(2).

SECTION 10. Regulations.

The commissioner shall enforce this act and shall promulgate necessary rules and regulations for carrying out this act.

SECTION 11. Enforcement.

The commissioner shall have all the powers to enforce this act as are granted to the commissioner elsewhere in the Arkansas Insurance Code, A.C.A. §§ 23-60-101, et seq."