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300 SW TENTH AVENUE ▪ SUITE 24-E ▪ TOPEKA, KS 66612 ▪ (785) 296-2321

## MEMORANDUM

To: House Standing Committee on Insurance

From: Office of the Revisor of Statutes

Date: February 10, 2020

Subject: Bill Brief for HB 2459

House Bill 2459 limits utilization review conducted by health plans under certain circumstances involving the treatment of mental illness or substance abuse disorder. The amendments to the sections in the bill are named the Kristi L. Bennett mental health parity act.

Section 1 amends K.S.A. 40-2,105a, pertaining to large group and individual health benefit plans. Current law requires any group health insurance policy that provides medical, surgical or hospital expense coverage to include coverage for diagnosis and treatment of mental illnesses and alcoholism, drug abuse or other substance use disorders. The bill would require any health insurer that offers a health benefit plan that provides medical, surgical or hospital expense coverage to include coverage for diagnosis and treatment of mental illness or substance use disorder. Such coverage is required to include treatment and services for inpatient or outpatient care. Further, such coverage shall not be subject to deductibles, copayments, coinsurance, out-of-pocket expenses, treatment limitations and other limitations that are more strict or limiting than those that apply to other covered services.

The bill specifies that for patients who have substance use disorder, are afflicted with suicidal ideation or are actively suicidal, health insurers shall provide coverage without the imposition of prior authorization, concurrent review, retrospective review or other form of utilization review for the first 14 days of medically necessary inpatient treatment and services provided in-network and the first 180 days of medically necessary outpatient treatment and services provided in-network. Medical necessity is determined by the treating provider in consultation with the patient and noted in the patient's medical record. For any inpatient treatment, if there is no in-network facility immediately available for a covered person, a health insurer shall provide all necessary network exceptions to ensure that the patient is admitted to a treatment facility within 24 hours. Treating providers cannot require prepayment of medical expenses in excess of any applicable copayment, deductible or coinsurance under the health benefit plan during the applicable first 14 days or first 180 days of treatment.

Section 2 amends K.S.A. 40-2,105, pertaining to small group health plans. Current law requires any insurer that issues any group policy of accident and sickness insurance to a small employer that provides medical, surgical or hospital expense coverage for other than specific diseases or accidents only and that provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility must provide for reimbursement or indemnity under such small employer group policy that shall be limited to not less than 45 days per year for in-patient treatment of mental illness in a medical care facility and not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or substance use disorders in a treatment facility. The bill would add the same provisions added to K.S.A. 40-2,105a discussed above.

The bill would take effect upon publication in the Kansas register.