OLR Bill Analysis

sHB 7125

AN ACT CONCERNING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

SUMMARY

This bill requires certain health insurance policies that cover prescription drugs to also cover drugs prescribed to treat substance use disorder, provided the treatment complies with approved federal Food and Drug Administration (FDA) indications. If the policy includes multiple cost sharing tiers, the insurer must place such drugs in the lowest tier. The bill also prohibits certain policies from (1) requiring step therapy for a drug prescribed to treat substance use disorder, provided it was prescribed in compliance with FDA indications; and (2) requiring prior authorization for any drug approved by the FDA to treat substance use disorder.

Additionally, the bill (1) prohibits certain policies from applying nonquantitative treatment limitations (i.e., non-numeric limits on the scope or duration of coverage) to mental health and substance use disorder benefits unless the policy also applies the limitations to medical and surgical benefits and (2) requires health carriers (e.g., insurers) to report annually to the insurance commissioner on how they develop such limitations.

It also prohibits certain policies from denying coverage for substance abuse services and prescribed treatment drugs solely because the services were provided, or the drugs prescribed, under a court order.

EFFECTIVE DATE: January 1, 2020, except for the reporting provisions, which are effective October 1, 2019.

§ 1 — MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND NONQUANTITATIVE TREATMENT LIMITATIONS REPORTING REQUIREMENT

Beginning by March 1, 2021, the bill requires each health carrier (e.g., insurers) to annually report to the insurance commissioner on mental health and substance use disorder benefits and nonquantitative treatment limitations. The report must be in a form and manner he prescribes and contain, for the prior year, certain information.

Descriptions

The report must contain a description of:

1. the health carrier's process to develop and select criteria to assess the medical necessity of (a) mental health and substance use disorder benefits and (b) medical and surgical benefits; and

2. all nonquantitative treatment limitations that the health carrier applied to mental health, substance use disorder, and medical and surgical benefits.

For the bill's purposes, "mental health and substance use disorder benefits" are all benefits used to treat a mental health condition or substance use disorder that is (1) listed as a mental disorder in the International Classification of Diseases or (2) is a mental disorder as defined by the American Psychiatric Association.

Analysis

The report must also contain an analysis of the process, strategies, evidentiary standards, and other factors the health carrier used to develop and apply the medical necessity criteria and nonquantitative treatment limitations contained in the report. The analysis must:

1. disclose each factor the health carrier considered, regardless of whether it was accepted or rejected, in designing and determining whether to apply nonquantitive treatment limitations;

2. disclose all evidentiary standards, whether quantitative or

qualitative, applied under a factor considered above, or provide a clear description of the factor if no evidentiary standard was used;

3. provide the comparative analyses, including their results, that show that the written processes and strategies used to design and apply nonquantitative treatment limitations as written to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used to design and apply nonquantitative treatment limitations as written to medical and surgical benefits;

4. provide the comparative analyses that show the processes and strategies used to apply nonquantitative treatment limitations, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those used to apply nonquantitative treatment limitations to medical and surgical benefits in operation; and

5. disclose information that, in the commissioner's opinion, sufficiently demonstrates that the carrier (a) equally applied nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits (b) applied nonquantitative treatment limitations equally across mental health, substance use, and medical and surgical benefits, and (c) complied with certain state mental and nervous conditions laws and federal mental health parity laws.

Beginning by March 15, 2021, the commissioner must annually submit any such reports he receives to the Insurance and Real Estate Committee, as well as the attorney general, healthcare advocate, and Office of Health Strategy executive director.

The bill authorizes the insurance commissioner to adopt implementing regulations.

Under the bill, the commissioner is prohibited from disclosing the analysis in a manner that is likely to compromise its financial,

competitive, or proprietary nature.

Public Hearing

Beginning by April 1, 2021, the Insurance and Real Estate Committee must annually hold a public hearing concerning any reports they receive. The commissioner or his designee must attend and inform the committee whether, in his opinion, each health carrier (1) submitted the required reports (2) applied nonquantitative treatment limitations equally across mental health, substance use, and medical and surgical benefits, and (3) complied with certain state mental and nervous conditions laws and federal mental health parity laws.

BILL APPLICABILITY

The nonquantitative limitations (§§ 2 & 3) and court-ordered services (§§ 6 & 7) provisions are applicable to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2020, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan.

In addition to these policies, the substance use disorder prescription drug coverage (§§ 4 & 5) and prior authorization requirements (§§ 10 & 11) provisions also apply to individual or group single service ancillary health coverage, including, dental, vision or prescription drug coverage, that is delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2020.

The step therapy provisions (§§ 8 & 9) apply to all individual and group health insurance policies issued, renewed, amended, or continued in Connecticut.

BACKGROUND

Related Bill

HB 6095, favorably reported by the Insurance and Real Estate Committee, requires insurers to cover a specific list of substance use

disorder treatments.

Step Therapy

Step therapy is a protocol establishing the sequence for prescribing drugs for specific medical conditions that generally requires patients to try less expensive drugs before higher cost drugs.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 20 Nay 0 (03/19/2019)