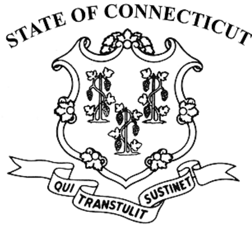

House of Representatives

General Assembly **_File No. 343_**

January Session, 2019 Substitute House Bill No. 7125

House of Representatives, April 3, 2019

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2019*) (a) For the purposes of
2 this section:

3 (1) "Health carrier" has the same meaning as provided in section
4 38a-1080 of the general statutes;

5 (2) "Mental health and substance use disorder benefits" means all
6 benefits for the treatment of a mental health condition or a substance
7 use disorder that (A) falls under one or more of the diagnostic
8 categories listed in the chapter concerning mental disorders in the
9 most recent edition of the International Classification of Diseases, or
10 (B) is a mental disorder, as that term is defined in the most recent
11 edition of the American Psychiatric Association's "Diagnostic and
12 Statistical Manual of Mental Disorders"; and

13 (3) "Nonquantitative treatment limitation" means a limitation that
14 cannot be expressed numerically but otherwise limits the scope or
15 duration of a covered benefit.

16 (b) Not later than March 1, 2021, and annually thereafter, each
17 health carrier shall submit a report to the Insurance Commissioner, in a
18 form and manner prescribed by the commissioner, containing the
19 following information for the calendar year immediately preceding:

20 (1) A description of the processes that such health carrier used to
21 develop and select criteria to assess the medical necessity of (A) mental
22 health and substance use disorder benefits, and (B) medical and
23 surgical benefits;

24 (2) A description of all nonquantitative treatment limitations that
25 such health carrier applied to (A) mental health and substance use
26 disorder benefits, and (B) medical and surgical benefits; and

27 (3) The results of an analysis concerning the processes, strategies,
28 evidentiary standards and other factors that such health carrier used in
29 developing and applying the criteria described in subdivision (1) of
30 this subsection and each nonquantitative treatment limitation
31 described in subdivision (2) of this subsection, provided the
32 commissioner shall not disclose such results in a manner that is likely
33 to compromise the financial, competitive or proprietary nature of such
34 results. The results of such analysis shall, at a minimum:

35 (A) Disclose each factor that such health carrier considered,
36 regardless of whether such health carrier rejected such factor, in (i)
37 designing each nonquantitative treatment limitation described in
38 subdivision (2) of this subsection, and (ii) determining whether to
39 apply such nonquantitative treatment limitation;

40 (B) Disclose any and all evidentiary standards, which standards
41 may be qualitative or quantitative in nature, applied under a factor
42 described in subparagraph (A) of this subdivision, and, if no
43 evidentiary standard is applied under such a factor, a clear description

44 of such factor;

45 (C) Provide the comparative analyses, including the results of such
46 analyses, performed to determine that the processes and strategies
47 used to design each nonquantitative treatment limitation, as written,
48 and the processes and strategies used to apply such nonquantitative
49 treatment limitation, as written, to mental health and substance use
50 disorder benefits are comparable to, and applied no more stringently
51 than, the processes and strategies used to design each nonquantitative
52 treatment limitation, as written, and the processes and strategies used
53 to apply such nonquantitative treatment limitation, as written, to
54 medical and surgical benefits;

55 (D) Provide the comparative analyses, including the results of such
56 analyses, performed to determine that the processes and strategies
57 used to apply each nonquantitative treatment limitation, in operation,
58 to mental health and substance use disorder benefits are comparable
59 to, and applied no more stringently than, the processes and strategies
60 used to apply each nonquantitative treatment limitation, in operation,
61 to medical and surgical benefits; and

62 (E) Disclose information that, in the opinion of the Insurance
63 Commissioner, is sufficient to demonstrate that such health carrier (i)
64 equally applied each nonquantitative treatment limitation described in
65 subdivision (2) of this subsection to (I) mental health and substance
66 use disorder benefits, and (II) medical and surgical benefits, and (ii)
67 complied with (I) sections 2 and 3 of this act, (II) sections 38a-488a and
68 38a-514 of the general statutes, and (III) the Paul Wellstone and Pete
69 Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L.
70 110-343, as amended from time to time, and regulations adopted
71 thereunder.

72 (c) Not later than March 15, 2021, and annually thereafter, the
73 Insurance Commissioner shall submit each report that the
74 commissioner received pursuant to subsection (b) of this section for the
75 calendar year immediately preceding to:

76 (1) The joint standing committee of the General Assembly having
77 cognizance of matters relating to insurance, in accordance with section
78 11-4a of the general statutes; and

79 (2) The Attorney General, Healthcare Advocate and executive
80 director of the Office of Health Strategy.

81 (d) Not later than April 1, 2021, and annually thereafter, the joint
82 standing committee of the General Assembly having cognizance of
83 matters relating to insurance shall hold a public hearing concerning the
84 reports that such committee received pursuant to subsection (c) of this
85 section for the calendar year immediately preceding. The Insurance
86 Commissioner, or the commissioner's designee, shall attend the public
87 hearing and inform the committee whether, in the commissioner's
88 opinion, each health carrier, for the calendar year immediately
89 preceding, (1) submitted a report pursuant to subsection (b) of this
90 section that satisfies the requirements established in said subsection,
91 and (2) complied with (A) sections 2 and 3 of this act, (B) sections 38a-
92 488a and 38a-514 of the general statutes, and (C) the Paul Wellstone
93 and Pete Domenici Mental Health Parity and Addiction Equity Act of
94 2008, P.L. 110-343, as amended from time to time, and regulations
95 adopted thereunder.

96 (e) The Insurance Commissioner may adopt regulations, in
97 accordance with chapter 54 of the general statutes, to implement the
98 provisions of this section.

99 Sec. 2. (NEW) (*Effective January 1, 2020*) No individual health
100 insurance policy providing coverage of the type specified in
101 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
102 statutes delivered, issued for delivery, renewed, amended or
103 continued in this state on or after January 1, 2020, shall apply a
104 nonquantitative treatment limitation to mental health and substance
105 use disorder benefits unless such policy also applies the
106 nonquantitative treatment limitation to medical and surgical benefits.
107 For the purposes of this section, "nonquantitative treatment limitation"
108 and "mental health and substance use disorder benefits" have the same

109 meaning as provided in section 1 of this act.

110 Sec. 3. (NEW) (*Effective January 1, 2020*) No group health insurance
111 policy providing coverage of the type specified in subdivisions (1), (2),
112 (4), (11) and (12) of section 38a-469 of the general statutes delivered,
113 issued for delivery, renewed, amended or continued in this state on or
114 after January 1, 2020, shall apply a nonquantitative treatment
115 limitation to mental health and substance use disorder benefits unless
116 such policy also applies the nonquantitative treatment limitation to
117 medical and surgical benefits. For the purposes of this section,
118 "nonquantitative treatment limitation" and "mental health and
119 substance use disorder benefits" have the same meaning as provided in
120 section 1 of this act.

121 Sec. 4. (NEW) (*Effective January 1, 2020*) (a) Each individual health
122 insurance policy providing coverage of the type specified in
123 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
124 general statutes delivered, issued for delivery, renewed, amended or
125 continued in this state on or after January 1, 2020, that provides
126 coverage for prescription drugs shall provide coverage for each
127 prescription drug that is prescribed to an individual covered under
128 such policy for the treatment of a substance use disorder, provided use
129 of such drug for such treatment is in compliance with approved
130 federal Food and Drug Administration indications.

131 (b) If an individual health insurance policy described in subsection
132 (a) of this section includes multiple cost-sharing tiers for prescription
133 drugs, the policy shall place each prescription drug that such policy is
134 required to cover pursuant to said subsection in such policy's lowest
135 cost-sharing tier for prescription drugs.

136 (c) No individual health insurance policy described in subsection (a)
137 of this section shall refuse to cover a prescription drug that such policy
138 is required to cover pursuant to said subsection solely because such
139 drug was prescribed pursuant to an order issued by a court of
140 competent jurisdiction.

141 Sec. 5. (NEW) (*Effective January 1, 2020*) (a) Each group health
142 insurance policy providing coverage of the type specified in
143 subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the
144 general statutes delivered, issued for delivery, renewed, amended or
145 continued in this state on or after January 1, 2020, that provides
146 coverage for prescription drugs shall provide coverage for each
147 prescription drug that is prescribed to an individual covered under
148 such policy for the treatment of a substance use disorder, provided use
149 of such drug for such treatment is in compliance with approved
150 federal Food and Drug Administration indications.

151 (b) If a group health insurance policy described in subsection (a) of
152 this section includes multiple cost-sharing tiers for prescription drugs,
153 the policy shall place each prescription drug that such policy is
154 required to cover pursuant to said subsection in such policy's lowest
155 cost-sharing tier for prescription drugs.

156 (c) No group health insurance policy described in subsection (a) of
157 this section shall refuse to cover a prescription drug that such policy is
158 required to cover pursuant to said subsection solely because such drug
159 was prescribed pursuant to an order issued by a court of competent
160 jurisdiction.

161 Sec. 6. (NEW) (*Effective January 1, 2020*) No individual health
162 insurance policy providing coverage of the type specified in
163 subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general
164 statutes that is delivered, issued for delivery, renewed, amended or
165 continued in this state on or after January 1, 2020, shall deny coverage
166 for covered substance abuse services solely because such substance
167 abuse services were provided pursuant to an order issued by a court of
168 competent jurisdiction.

169 Sec. 7. (NEW) (*Effective January 1, 2020*) No group health insurance
170 policy providing coverage of the type specified in subdivisions (1), (2),
171 (4), (11) and (12) of section 38a-469 of the general statutes that is
172 delivered, issued for delivery, renewed, amended or continued in this
173 state on or after January 1, 2020, shall deny coverage for covered

174 substance abuse services solely because such substance abuse services
175 were provided pursuant to an order issued by a court of competent
176 jurisdiction.

177 Sec. 8. Subsection (a) of section 38a-510 of the general statutes is
178 repealed and the following is substituted in lieu thereof (*Effective*
179 *January 1, 2020*):

180 (a) No insurance company, hospital service corporation, medical
181 service corporation, health care center or other entity delivering,
182 issuing for delivery, renewing, amending or continuing an individual
183 health insurance policy or contract that provides coverage for
184 prescription drugs may:

185 (1) Require any person covered under such policy or contract to
186 obtain prescription drugs from a mail order pharmacy as a condition
187 of obtaining benefits for such drugs; or

188 (2) Require, if such insurance company, hospital service corporation,
189 medical service corporation, health care center or other entity uses step
190 therapy for such drugs, the use of step therapy for (A) any prescribed
191 drug for longer than sixty days, or (B) a prescribed drug for cancer
192 treatment for an insured who has been diagnosed with stage IV
193 metastatic cancer<u>, or a prescribed drug for the treatment of a substance</u>
194 <u>use disorder,</u> provided such prescribed drug is in compliance with
195 approved federal Food and Drug Administration indications.

196 (3) At the expiration of the time period specified in subparagraph
197 (A) of subdivision (2) of this subsection or for a prescribed drug
198 described in subparagraph (B) of subdivision (2) of this subsection, an
199 insured's treating health care provider may deem such step therapy
200 drug regimen clinically ineffective for the insured, at which time the
201 insurance company, hospital service corporation, medical service
202 corporation, health care center or other entity shall authorize
203 dispensation of and coverage for the drug prescribed by the insured's
204 treating health care provider, provided such drug is a covered drug
205 under such policy or contract. If such provider does not deem such

206 step therapy drug regimen clinically ineffective or has not requested
207 an override pursuant to subdivision (1) of subsection (b) of this section,
208 such drug regimen may be continued. For purposes of this section,
209 "step therapy" means a protocol or program that establishes the
210 specific sequence in which prescription drugs for a specified medical
211 condition are to be prescribed.

212 Sec. 9. Subsection (a) of section 38a-544 of the general statutes is
213 repealed and the following is substituted in lieu thereof (*Effective*
214 *January 1, 2020*):

215 (a) No insurance company, hospital service corporation, medical
216 service corporation, health care center or other entity delivering,
217 issuing for delivery, renewing, amending or continuing a group health
218 insurance policy or contract that provides coverage for prescription
219 drugs may:

220 (1) Require any person covered under such policy or contract to
221 obtain prescription drugs from a mail order pharmacy as a condition
222 of obtaining benefits for such drugs; or

223 (2) Require, if such insurance company, hospital service corporation,
224 medical service corporation, health care center or other entity uses step
225 therapy for such drugs, the use of step therapy for (A) any prescribed
226 drug for longer than sixty days, or (B) a prescribed drug for cancer
227 treatment for an insured who has been diagnosed with stage IV
228 metastatic cancer, or a prescribed drug for the treatment of a substance
229 use disorder, provided such prescribed drug is in compliance with
230 approved federal Food and Drug Administration indications.

231 (3) At the expiration of the time period specified in subparagraph
232 (A) of subdivision (2) of this subsection or for a prescribed drug
233 described in subparagraph (B) of subdivision (2) of this subsection, an
234 insured's treating health care provider may deem such step therapy
235 drug regimen clinically ineffective for the insured, at which time the
236 insurance company, hospital service corporation, medical service
237 corporation, health care center or other entity shall authorize

238 dispensation of and coverage for the drug prescribed by the insured's
239 treating health care provider, provided such drug is a covered drug
240 under such policy or contract. If such provider does not deem such
241 step therapy drug regimen clinically ineffective or has not requested
242 an override pursuant to subdivision (1) of subsection (b) of this section,
243 such drug regimen may be continued. For purposes of this section,
244 "step therapy" means a protocol or program that establishes the
245 specific sequence in which prescription drugs for a specified medical
246 condition are to be prescribed.

247 Sec. 10. Section 38a-510b of the general statutes is repealed and the
248 following is substituted in lieu thereof (*Effective January 1, 2020*):

249 No individual health insurance policy providing coverage of the
250 type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section
251 38a-469 delivered, issued for delivery, renewed, amended or continued
252 in this state on or after January 1, 2020, that provides coverage for
253 prescription drugs **[**and includes on its formulary naloxone**]** shall
254 require prior authorization for the following drugs if such drugs are
255 included on the policy's formulary:

256 (1) Naloxone hydrochloride or any other similarly acting and
257 equally safe drug approved by the federal Food and Drug
258 Administration for the treatment of drug overdose; **[**shall require prior
259 authorization for such drug.**]** and

260 (2) Any drug approved by the federal Food and Drug
261 Administration for the treatment of a substance use disorder.

262 Sec. 11. Section 38a-544b of the general statutes is repealed and the
263 following is substituted in lieu thereof (*Effective January 1, 2020*):

264 No group health insurance policy providing coverage of the type
265 specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-
266 469 delivered, issued for delivery, renewed, amended or continued in
267 this state on or after January 1, 2020, that provides coverage for
268 prescription drugs **[**and includes on its formulary naloxone**]** shall

269 require prior authorization for the following drugs if such drugs are
270 included on the policy's formulary:

271 (1) Naloxone hydrochloride or any other similarly acting and
272 equally safe drug approved by the federal Food and Drug
273 Administration for the treatment of drug overdose; [shall require prior
274 authorization for such drug.] and

275 (2) Any drug approved by the federal Food and Drug
276 Administration for the treatment of a substance use disorder.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2019*	New section
Sec. 2	*January 1, 2020*	New section
Sec. 3	*January 1, 2020*	New section
Sec. 4	*January 1, 2020*	New section
Sec. 5	*January 1, 2020*	New section
Sec. 6	*January 1, 2020*	New section
Sec. 7	*January 1, 2020*	New section
Sec. 8	*January 1, 2020*	38a-510(a)
Sec. 9	*January 1, 2020*	38a-544(a)
Sec. 10	*January 1, 2020*	38a-510b
Sec. 11	*January 1, 2020*	38a-544b

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 20 $	FY 21 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health plan)	GF, TF - Cost	At least $1 million	At least $2 million

Municipal Impact:

Municipalities	Effect	FY 20 $	FY 21 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill will result in a cost to the state employee and retiree health plan and fully insured municipal plans resulting from changes to health coverage requirements for mental health and substance use disorders, as described below.

There is a cost of the state plan of approximately $1 million in FY 20 and $2 million in FY 21 from eliminating medical necessity and prior authorization for certain services which is anticipated to change the utilization of services. In accordance with current law, the state employee and retiree health plan currently provides coverage for inpatient and outpatient mental health and substance use disorder services, using the American Society of Addiction Medicine (ASAM)

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

guidelines to determine the appropriate service intensity and level of care.

In addition, there will be a cost to the state and municipal health plans to the extent services are required to be covered for court ordered services that otherwise would have been excluded. The cost will depend on the mix of services and utilization. Under the state plan, court ordered services that have been ordered as a condition of probation or parole are generally not covered by the plan.

There is an annual cost to the state of approximately $12,000 from requiring all currently covered prescriptions for the treatment of a substance use disorder to be placed in the lowest cost tier. The cost will be greater to the extent the bill is interpreted to require the state to cover all FDA approved prescriptions for substance use disorders. Pursuant to the SEBAC 2017 Agreement the state employee plan has a four tiered structure, with the lowest cost tier requiring a $5 co-pay and the highest cost tier requiring a $40 or 20% coinsurance for nonparticipating retail pharmacies.[2] The state plan does not require step therapy or require prior authorization for prescriptions to treat substance abuse.

The cost to fully insured municipal plans to comply with the provisions of the bill will be reflected in premiums for policy years beginning on and after January 1, 2020. Pursuant to federal law, self-insured plans are exempt from state health insurance mandates.[3]

In addition, many municipal health plans are recognized as “grandfathered” health plans under the Affordable Care Act (ACA).[4] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA.

---

[2] Source: State of Connecticut Prescription Benefit Plan Document (January 1, 2018).

[3] The state employee and retiree health plan is self-insured; however, the plan has historically adopted all health insurance mandates.

[4] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

The bill is not anticipated to result in a cost to the Insurance Department to comply with the requirements of the bill as the agency has the expertise to do so.

The Out Years

The annualized ongoing fiscal impact identified above will continue into the future based on the: (1) utilization of services, (2) scope of services and prescription drugs required to be covered, and (3) for fully-insured municipalities, will be reflected in future premiums.

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)