AN ACT CONCERNING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

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

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

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

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

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

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

(1) A description of the processes that such health carrier used 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 3. (NEW) (Effective January 1, 2020) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2),
Sec. 4. (NEW) (Effective January 1, 2020) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, that provides coverage for prescription drugs shall provide coverage for each prescription drug that is prescribed to an individual covered under such policy for the treatment of a substance use disorder, provided use of such drug for such treatment is in compliance with approved federal Food and Drug Administration indications.

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

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

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

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

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

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

Sec. 7. (NEW) (Effective January 1, 2020) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2020, shall deny coverage for covered substance abuse services solely because such substance abuse services were provided pursuant to an order issued by a court of competent jurisdiction.
Sec. 8. Subsection (a) of section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (Effective January 1, 2020):

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

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

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

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested
an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

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

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

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

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

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize
dispensation of and coverage for the drug prescribed by the insured's
treating health care provider, provided such drug is a covered drug
under such policy or contract. If such provider does not deem such
step therapy drug regimen clinically ineffective or has not requested
an override pursuant to subdivision (1) of subsection (b) of this section,
such drug regimen may be continued. For purposes of this section,
"step therapy" means a protocol or program that establishes the
specific sequence in which prescription drugs for a specified medical
condition are to be prescribed.

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

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

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

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

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

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

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

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

This act shall take effect as follows and shall amend the following sections:

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**INS** Joint Favorable Subst.

**APP** Joint Favorable