Date: March 7, 2019
To: Insurance & Real Estate Committee
From: Ben Shaiken, Manager of Advocacy & Public Policy, The Alliance
Re: H.B. 7125 AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.

Good afternoon Senator Lesser, Representative Scanlon, Senator Kelly, Representative Pavalock-D'Amato, and distinguished members of the Insurance and Real Estate Committee:

My name is Ben Shaiken, Manager of Advocacy & Public Policy at the CT Community Nonprofit Alliance (The Alliance). The Alliance is the statewide advocacy organization representing nonprofits, with a membership of more than 300 community organizations and associations. Nonprofits deliver essential services to more than half a million people each year and employ almost 14% of Connecticut's workforce. The Alliance is part of the CT Parity Coalition, a group of organizations and people committed to ensuring Connecticut residents can access and receive equitable health insurance coverage.

The Alliance supports H.B. 7125 An Act Concerning Parity for Mental Health and Substance Use Disorder Benefits, Nonquantitative Treatment Limitations, Drugs Prescribed for the Treatment of Substance Use Disorders, and Substance Abuse Services and **ask the Committee to pass it with the substitute language** the CT Parity Coalition is suggesting, which is attached to this testimony.

This bill would help ensure private insurance's adherence to federal parity laws. Currently, Connecticut statute requires that insurers follow regulations set forth in the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which was passed in 2008. MHPAEA requires health insurers that offer mental health and addiction benefits to do so on par with medical and surgical benefits. Health insurers and managed care organizations can no longer apply financial requirements and treatment limitations that are more restrictive for mental health and addiction benefits than those applied to medical and surgical services. The federal parity law applies to most commercial and to all Medicaid plans in America, and state insurance commissioners and Medicaid Directors have the authority to enforce it.

But it is not always clear if these regulations are being followed by private health insurance plans. Anecdotally, community nonprofits tell us that commercial insurance does not cover all the services they believe are medically necessary to treat their clients. We simply do not know whether insurers are actually complying with the complicated parts of the law. The December 2017 Milliman report, "Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates," identified **CT as the state with the highest disparity between physical and behavioral healthcare** in terms of the proportion of office visits that are out-of-network. Significant disparities were also identified in inpatient care and payments to behavioral health providers compared with primary care providers.

Community nonprofits provide behavioral health services—mental health and substance abuse treatment—to people across Connecticut. By their missions and their contracts with the State, they serve all clients and provide them the care they need, regardless of their ability to pay. This means that when a commercial insurer denies a claim, the nonprofit delivers the services anyway without being paid for them by an individual's insurance. After years of state budget cuts, community nonprofit providers are already under pressure and underfunded. They cannot afford to continue subsidizing private insurance plans that will not pay for care, and the State should enforce penalties for wrongful claim denials.

The Departments of Mental Health and Addiction Services and Children and Families both provide limited grant funding, which has been cut significantly in recent years, to cover the cost of care to people who are uninsured or under-insured. If more commercial insurance plans paid for the behavioral health services their customers need, the more this grant funding could be used to pay for people experiencing real gaps in coverage. In some cases, the State is footing the bill to pay through grants for treatment that should be covered by insurance.

What H.B. 7125 Will Do to Ensure Parity

Nationally, 20-30 states are considering or adopting new legislation to standardize compliance with the federal MHPAEA law. The CT Parity Coalition is advocating that Connecticut follow suit. We urge the Committee to:

1. Establish reporting requirements for insurers to demonstrate how they design and apply their managed care tactics, so regulators can determine if there is compliance with the law

2. Specify how state insurance departments can implement parity and then report on their activities

We also recommend eliminating some managed care barriers to medication-assisted treatment (MAT) for substance use disorders. While not purely parity requirements, these provisions can be a vital tool in combating the opioid epidemic.

Regarding the bill language necessary that will result in compliance with the federal law, please ensure that the reporting requirements mirror the components of the final MHPAEA rules. Numerous state and federal investigations have revealed that insurers are in fact applying Non-Quantitative Treatment Limitations (NQTLs) to mental health and substance use disorder benefits in a way that is noncomparable and more stringent than how they apply them to medical and surgical benefits. That is why we request the comparative analyses.

The analysis recommendation stems from a national model created by leading parity experts from the Kennedy Forum, the American Psychiatric Association, and the Parity Implementation Coalition. This approach was also adopted by United States Department of Labor in its Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act, released April 23, 2018. Again, these reporting requirements are essential to have in the bill so that this next iteration of parity compliance can be achieved.

Passing this legislation is an important step towards gaining clarity on parity compliance and, ultimately, ensuring that Connecticut's consumer rights are protected.

Thank you for your consideration of this important issue.

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Incl.

DRAFT SUBSTITUTE LANGUAGE

AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.

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 World Health Organization's "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, Attorney General, Healthcare Advocate and executive director of the Office of Health Strategy, in a form and manner prescribed by the Insurance 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, or (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. 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 the evidentiary standards that such health carrier applied in considering the factors

described in subparagraph (A) of this subdivision; [and]

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

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

[(C)](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, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance each report that the commissioner received pursuant to subsection (b) of this section for the calendar year immediately preceding.

(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, Attorney General, Healthcare Advocate and executive director of the Office of Health Strategy, or their designees, shall attend the public hearing and inform the committee whether, in their 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 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), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state 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. 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 that provides coverage for prescription drugs shall provide coverage for each prescription drug that is prescribed to a person 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 that provides coverage for prescription drugs shall provide coverage for each prescription drug that is prescribed to a person 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 shall refuse to provide 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 shall refuse to provide 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 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 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.