**MENTAL HEALTH PARITY AMENDMENTS**

2019 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: \_\_\_\_\_\_\_\_**

House Sponsor: \_\_\_\_\_\_

**LONG TITLE**

**General Description:**

 This bill amends the insurance code to provide parity reporting and implementation requirements and specify coverage for medications used to treat substance use disorders.

**Highlighted Provisions:**

 This bill:

 � defines terms

 � requires insurers to report compliance

 � requires the commissioner to implement

 � specifies coverage requirements for substance use disorder medications

**Money Appropriated in this Bill:**

None

**Other Special Clauses:**

 None

**Utah Codes Affected:**

ENACTS:

31A-22-650

31A-22-651

*Be it enacted by the Legislature of the state of Utah:*

 Section 1. Section 31A-22-650 is enacted to read:

 **31A-22-650. Mental health parity implementation requirements.**

 (1) As used in this section:

 (a) “Mental health and substance use disorder benefits” means benefits for the treatment of any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

 (b) “Nonquantitative treatment limitation” means limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment.

 (2) All insurers that offer health benefit plans in the individual or group markets that provide mental health and substance use disorder benefits submit an annual report to the commissioner on or before March 1 that contains the following information:

 (a) A description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

 (b) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits.

 (c) The results of an analysis that demonstrates that for the medical necessity criteria described in item (a) and for each NQTL identified in item (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

 (i) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

 (ii) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL;

 (iii) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL 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 NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

 (iv) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, 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 NQTL, in operation, for medical and surgical benefits; and

 (v) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the insurer is in compliance with this section and the 42 U.S.C. Sec. 300gg-26 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

 (3) The commissioner shall implement and enforce applicable provisions of 42 U.S.C. Sec. 300gg-26, and any amendments to, and any federal guidance or regulations relevant to, that section, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3), which includes:

 (a) Proactively ensuring compliance by insurers that offer health benefit plans in the individual or group markets that provide mental health and substance use disorder benefits.

 (b) Evaluating all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations.

 (c) Performing parity compliance market conduct examinations of insurers that offer health benefit plans in the individual or group markets that provide mental health and substance use disorder benefits, particularly market conduct examinations that focus on nonquantitative treatment limitations such as prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, and geographic restrictions, among other nonquantitative treatment limitations.

 (d) Requesting that insurers submit comparative analyses during the form review process demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental health and substance use disorder benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits.

 (e) The commissioner may adopt rules, in accordance with [Title 63G, Chapter 3, Utah Administrative Rulemaking Act](https://le.utah.gov/xcode/Title63G/Chapter3/63G-3.html?v=C63G-3_1800010118000101), as may be necessary to effectuate any provisions of the 42 U.S.C. Sec. 300gg-26 that relate to the business of insurance.

 (4) Not later than March 1, 2020, the commissioner shall issue a report and educational presentation to the Legislature, which shall:

 (a) Cover the methodology the commissioner is using to check for compliance with the 42 U.S.C. Sec. 300gg-26, and any federal regulations or guidance relating to the compliance and oversight of that section.

(b) Cover the methodology the commissioner is using to check for compliance with relevant 31A-22-625.

(c) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations.

(d) Detail any educational or corrective actions the commissioner has taken to ensure insurer compliance with 42 U.S.C. Sec. 300gg-26 and any federal regulations or guidance relating to the compliance and oversight of that section, and 31A-22-625.

(e) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the commissioner finds appropriate, posting the report on the Internet website of the Insurance Department.

Section 2. Section 31A-22-651 is enacted to read:

**31A-22-650. Medication-assisted treatment.**

(1) As used in this section:

 (a) “Prescription drug benefits for the treatment of substance use disorders” means prescription medication benefits for the treatment of any condition or disorder that involves a substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Disease or that is listed in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(2) All insurers that offer health benefit plans in the individual or group markets that provide prescription drug benefits for the treatment of substance use disorders shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance use disorders.

(3) All insurers that offer health benefit plans in the individual or group markets that provide prescription drug benefits for the treatment of substance use disorders shall not impose any step therapy requirements before the insurer will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(4) All insurers that offer health benefit plans in the individual or group markets that provide prescription drug benefits for the treatment of substance use disorders shall place all prescription medications approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the insurer.

(5) All insurers that offer health benefit plans in the individual or group markets that provide prescription drug benefits for the treatment of substance use disorders shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

**Legislative Review Note**

**As of x-xx-xx x:xx PM**

**Office of Legislative Research and General Counsel**