STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

HOUSE BILL XXXX By: \_\_\_\_\_\_\_\_

As Introduced

An Act relating to insurance; creating Tim’s Law; requiring insurer transparency and accountability; specifying Commissioner implementation requirements; prohibiting certain utilization review protocols for medications for the treatment of substance abuse.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

Section 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.12b of Title 36, unless there is created a duplication in numbering, reads as follows:

A. This section shall be known and may be cited as “Tim’s Law”.

B. Each insurer that offers, issues, or renews any individual or group health benefit plan that provides mental health or substance abuse disorder benefits shall submit an annual report to the Commissioner on or before April 1st that contains the following information:

1. A description of the process used to develop or select the medical necessity criteria for mental health and substance abuse disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

2. Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and substance abuse 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 abuse disorder benefits but do not apply to medical and surgical benefits within any classification of benefits;

3. The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph 1 and for each NQTL identified in paragraph 2, 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 abuse 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:

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

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

c. 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 abuse 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;

d. 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 abuse 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

e. 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 Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

C. The Commissioner shall implement and enforce applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any amendments to, and any federal guidance or regulations relevant to, that act, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3), which includes:

1. Proactively ensuring compliance by each insurer that offers, issues, or renews any individual or group health benefit plan that provides mental health or substance abuse disorder benefits;

2. Evaluating all consumer or provider complaints regarding mental health and substance abuse disorder coverage for possible parity violations;

3. Performing parity compliance market conduct examinations of insurers that offer, issue, or renew individual or group health benefit plans that provide mental health or substance abuse 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;

4. 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 abuse disorder benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits; and

5. The Commissioner may adopt rules, under 36-307.1, as may be necessary to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

D. Not later than March 1st, 2020, the Commissioner shall issue a report and educational presentation to the Legislature, which shall:

1. Cover the methodology the Commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and any federal regulations or guidance relating to the compliance and oversight of MHPAEA;

2. Cover the methodology the Commissioner is using to check for compliance with 36-6060.10, 36-6060.11, and 36-6060.12;

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

4. Detail any educational or corrective actions the Commissioner has taken to ensure insurer compliance with MHPAEA and 36-6060.10, 36-6060.11, and 36-6060.12; and

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.

E. For the purposes of this section:

1. “Health benefit plan” means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;

2. “Insurer” means any entity that provides an accident and health insurance policy in this state, including but not limited to a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner; and

3. “Mental health and substance abuse disorder benefits” means benefits for the treatment of any condition or disorder that involves a mental health condition or substance abuse 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.

Section 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.23 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Each insurer that offers, issues, or renews any individual or group health benefit plan that provides prescription drug benefits for the treatment of substance abuse 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 abuse disorders.

B. Each insurer that offers, issues, or renews any individual or group health benefit plan that provides prescription drug benefits for the treatment of substance abuse 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 abuse disorders.

C. Each insurer that offers, issues, or renews any individual or group health benefit plan that provides prescription drug benefits for the treatment of substance abuse disorders shall place all prescription medications approved by the FDA for the treatment of substance abuse disorders on the lowest tier of the drug formulary developed and maintained by the insurer.

D. Each insurer that offers, issues, or renews any individual or group health benefit plan that provides prescription drug benefits for the treatment of substance abuse disorders shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

E. For the purposes of this section:

1. “Health benefit plan” means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes; and

2. “Insurer” means any entity that provides an accident and health insurance policy in this state, including but not limited to a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.

Section 3. This Act shall become effective November 1, 2019.

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