2019 SENATE BILL XXX

January XX, 2019 – Introduced by Senators \_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, cosponsored by Representatives \_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_, Referred to Committee on Insurance.

AN ACT to create 632.891 of the statutes; relating to mental health and substance use disorder parity.

*Analysis by the Legislative Reference Bureau*

 Under current law, health benefit plans and group health benefit plans must provide mental health and substance use disorder benefits (called “nervous and mental disorders and alcoholism and other drug abuse problems” in section 632.89). Under federal statutes and regulations, mental health and substance use disorder benefits in the individual and group markets must be at parity with medical and surgical benefits (42 U.S.C. 300gg-26; 45 CFR 146.136; 45 CFR 147.160; 45 CFR 156.115(a)(3)). Federal statute (42 U.S.C. 300gg-22) allows the commissioner of insurance to enforce the provisions of Part A of Subchapter 25 of Chapter 6A of Title 42 of the United States Code as they relate to health insurance issuers (called “insurers” in 632.745). Part A includes 42 U.S.C. 300gg-26 and its implementing and related regulations.

 This bill would require insurers to report their compliance with 42 U.S.C. 300gg-26 and its implementing and related regulations. This bill also establishes implementation requirements for the commissioner.

The bill establishes coverage requirements for medications for the treatment of substance use disorders.

*The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:*

 Section 1. 632.891 of the statutes is created to read:

 632.891: PARITY. (a) All insurers that issue health benefit plans or group health benefit plans that provide mental health and substance use disorder benefits shall submit an annual report to the commissioner on or before March 1 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 use 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 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.

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 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:

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 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

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 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

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).

(b) 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 all insurers that issue health benefit plans or group health benefit plans that provide mental health and substance use disorder benefits.

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

3. Performing parity compliance market conduct examinations of All insurers that issue health benefit plans or group health benefit plans 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.

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

5. The commissioner may promulgate rules as may be necessary to effectuate any provisions of this section.

(c) Not later than February 1, 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 632.89.

3. 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.

4. Detail any educational or corrective actions the commissioner has taken to ensure insurer compliance with MHPAEA and 632.89.

5. 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 Office of the Commissioner of Insurance.

 (d) All insurers that issue health benefit plans or group health benefit plans that provide prescription medication benefits for the treatment of substance use disorders shall:

1. 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.

2. 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.

3. 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.

4. 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.

(e) DEFINITIONS. In this section:

1. “Group health benefit plan" means a health benefit plan that is issued by an insurer to or through an employer on behalf of a group consisting of at least 2 employees or a group including at least 2 eligible employees. The term includes individual health benefit plans covering eligible employees when 3 or more are sold to or through an employer.

2. “Health benefit plan" means any hospital or medical policy or certificate.

3. “Insurer" means an insurer that is authorized to do business in this state, in one or more lines of insurance that includes health insurance, and that offers health benefit plans covering individuals in this state or eligible employees of one or more employers in this state. The term includes a health maintenance organization, a preferred provider plan, as defined in s. 609.01 (4), an insurer operating as a cooperative association organized under ss. 185.981 to 185.985 and a limited service health organization, as defined in s. 609.01 (3).

4. “Substance use disorder” means 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.

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