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**STATUS INFORMATION**

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Summary: Mental health and substance use disorder parity

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

**VERSIONS OF THIS BILL**

(AXX, RXX, SXX)

**AN ACT TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑885 SO AS TO REQUIRE HEALTH INSURANCE ISSUERS TO DEMONSTRATE COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) OF 2008; BY ADDING SECTION 38-890 TO ESTABLISH IMPLEMENTATION REQUIREMENTS FOR THE COMMISSIONER; BY ADDING SECTION 38-71-895 TO ESTABLISH INSURANCE REQUIREMENTS FOR MEDICATIONS USED TO TREAT SUBSTANCE USE DISORDERS.**

Be it enacted by the General Assembly of the State of South Carolina:

**Insurance, mental health and substance use disorder parity**

SECTION 1. Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑885. (A) All health insurance issuers 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 issuer that the results of the analyses above indicate that the issuer 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) For the purposes of this section:

(1) "Health insurance issuer" or "issuer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-840(16).

(2) “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.

**Department of Insurance, report to General Assembly**

SECTION 2. Chapter 71, Title 38 of the 1976 Code is further amended by adding:

“Section 38‑71‑890. (A) 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 health insurance issuers in the individual and group market.

(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 health insurance issuers in the individual and group market, 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 health insurance issuers 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 adopt rules, under 38-3-110, 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.

(B) Not later than March 1, 2020, the commissioner shall issue a report and educational presentation to the General Assembly, 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 38-71-290, 38-71-737, and 38-71-880.

(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 health insurance issuer compliance with MHPAEA and 38-71-290, 38-71-737, and 38-71-880.

(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 department of insurance.”

(C) For the purposes of this section:

(1) "Health insurance issuer" or "issuer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-840(16).

(2) “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.

**Insurance requirements for substance use disorder medications**

SECTION 3. Chapter 71, Title 38 of the 1976 Code is further amended by adding:

“Section 38 71 895. (A) Each health insurance issuer that provides prescription drug benefits for medications 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.

(B) Each health insurance issuer that provides prescription drug benefits for medications for the treatment of substance use disorders shall not impose any step therapy requirements before the issuer will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(C) Each health insurance issuer that provides prescription drug benefits for medications 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 issuer.

(D) Each health insurance issuer that provides prescription drug benefits for medications 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.”

(E) For the purposes of this section:

(1) "Health insurance issuer" or "issuer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-840(16).

**Time effective**

SECTION 4. This act takes effect June 30, 2019, and applies to health insurance issuers on or after the effective date of this act.