



IN THE GENERAL ASSEMBLY STATE OF \_\_\_\_\_

**Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act**

1 Be it enacted by the People of the State of \_\_\_\_\_, represented in the General  
2 Assembly:

3 **Section 1. Title.** This Act shall be known and may be cited as the “Ensuring Access to **High**  
4 **Quality Care for the Treatment of Substance Use Disorders Act.**”

5 **Section 2. Purpose.** The Legislature hereby finds and declares that:

6 (a) The United States and [state] continue to struggle with a nationwide epidemic stemming  
7 from opioid-related misuse, overdose and death as well as accidental injury and death  
8 from other drugs.

9 (b) According to the U.S. Substance Abuse and Mental Health Services Administration  
10 (SAMHSA), more than two million people in the United States have a substance use  
11 disorder related to prescription opioid pain relievers and/or heroin.

12 (c) According to the U.S. Centers for Disease Control and Prevention (CDC), in 2016,  
13 20,145 Americans died from illicit fentanyl, 15,446 died from heroin, 14,427 died from  
14 natural and semi-synthetic opioids, and 3,314 died from methadone-related overdose  
15 (total = 53,332); a staggering increase from 2015 (fentanyl=9,945; heroin=13,219;  
16 prescription=12,726; methadone=3,276; total=39,166).

- 1 (d) Despite the millions with a substance use disorder, and the increasing death rate, nearly  
2 90 percent of Americans who need treatment for addiction are not receiving it, according  
3 to SAMHSA data. (Analysis available here:  
4 <http://opioid.amfar.org/indicator/pctunmetneed>)
- 5 (e) Part of this epidemic can be addressed through enhanced efforts to increase treatment and  
6 prevention in [state], including increased access to Medication Assisted Treatment  
7 (MAT), which has been proven to further recovery and help prevent relapse, overdose  
8 and death.
- 9 (f) MAT is the use of medications, commonly in combination with counseling and  
10 behavioral therapies, to provide a comprehensive approach to the treatment of substance  
11 use disorders. FDA-approved medications used to treat opioid addiction include  
12 methadone, buprenorphine (alone or in combination with naloxone) and extended-release  
13 injectable naltrexone. Types of behavioral therapies include individual therapy, group  
14 counseling, family behavior therapy, motivational incentives and other modalities.
- 15 (g) Research shows that when treating substance-use disorders, a combination of medication  
16 and behavioral therapies along with mental health services is most successful.
- 17 (h) According to the Centers for Medicaid and CHIP Services, “there is strong evidence that  
18 use of MAT in managing substance use disorders provides substantial cost savings” to  
19 states. MAT services also have been shown to help reduce recidivism for those drug  
20 courts that offer MAT services.
- 21 (i) Many medical societies, including the American Medical Association, the American  
22 Society of Addiction Medicine (ASAM), the American Academy of Addiction  
23 Psychiatry, and other medical associations have long supported the use of MAT services

1 due to their proven clinical benefits to patients and cost-effectiveness to society. A 2013  
2 ASAM report, however, found considerable restrictions on coverage “by governments,  
3 Medicaid, and insurance companies [on] the use of methadone, buprenorphine, and  
4 naltrexone.” The report is available at [http://www.asam.org/docs/default-](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final)  
5 [source/advocacy/aaam\\_implications-for-opioid-addiction-treatment\\_final](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final)

6 (j) Moreover, a Health Affairs analysis of SAMHSA data found that in 2016, only 41  
7 percent of treatment facilities in the United States offer one form of MAT; and only 319  
8 (2.7 percent) offer all three forms of MAT. The analysis noted that, “[e]ight states do not  
9 have any facilities that report offering all three forms of MAT, and 14 states do not have  
10 a facility offering all three forms of MAT that also accepts Medicaid.” The analysis is  
11 available at <https://www.healthaffairs.org/doi/10.1377/hblog20180104.835958/full/>

12 (k) Despite the proven safety and efficacy of MAT services, more widespread use often is  
13 limited by a lack of understanding about its benefits, the stigma associated with having a  
14 substance use disorder as well as financial and administrative barriers. [One study](#) of six  
15 large cities found that prior authorization for buprenorphine occurred 42 percent of the  
16 time: [https://www.urban.org/sites/default/files/publication/81856/2000838-Coverage-of-](https://www.urban.org/sites/default/files/publication/81856/2000838-Coverage-of-Substance-Use-Disorder-Treatments-in-Marketplace-Plans-in-Six-Cities.pdf)  
17 [Substance-Use-Disorder-Treatments-in-Marketplace-Plans-in-Six-Cities.pdf](https://www.urban.org/sites/default/files/publication/81856/2000838-Coverage-of-Substance-Use-Disorder-Treatments-in-Marketplace-Plans-in-Six-Cities.pdf)

### 18 **Section 3. Definitions.**

19 (a) “ASAM criteria” means the American Society of Addiction Medicine (ASAM) national  
20 set of criteria for providing outcome-oriented and results-based care in the treatment of  
21 addiction; a comprehensive set of guidelines for placement, continued stay and  
22 transfer/discharge of patients with addiction and co-occurring conditions.

- 1 (b) “Behavioral therapy” means an individual, family or group therapy designed to help  
2 patients engage in the treatment process, modify their attitudes and behaviors related to  
3 substance use, and increase healthy life skills.
- 4 (c) “Department of Health” means the state agency or department that has jurisdiction over  
5 the provision of medical care, including substance use disorders.
- 6 (d) “Department of Insurance” means the state agency or department that has jurisdiction  
7 regulating a health insurer.
- 8 (e) “Financial requirements” means deductibles, copayments, coinsurance, or out-of-pocket  
9 maximums.
- 10 (f) “Health care professional” means the person licensed under the professional licensing  
11 statutes of this state to provide care to individuals.
- 12 (g) “Health insurer” means any person or entity that issues, offers, delivers, or administers a  
13 health insurance plan.
- 14 (h) “Health insurance plan” means an individual or group plan that provides, or pays the cost  
15 of, health care items or services.
- 16 (i) “Mental Health Parity and Addiction Equity Act of 2008” (MEPAEA) means The Paul  
17 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008  
18 found at 42 U.S.C. 300gg-26 and its implementing and related regulations found at 45  
19 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115.
- 20 (j) “Nonquantitative treatment limitation”, means any limitation on the scope or duration of  
21 treatment that is not expressed numerically.
- 22 (k) “Pharmacy benefit management company” means a company that administers the  
23 prescription drug plan(s) for commercial health plans, self-insured employer plans, union

1 plans, Medicare Part D plans, the Federal Employees Health Benefits Program, state  
2 government employee plans, managed Medicaid plans, and others.

3 (l) “Pharmacologic therapy” means a prescribed course of treatment that may include  
4 methadone, buprenorphine, naltrexone or other FDA-approved or evidence-based  
5 medications for the treatment of substance use disorder.

6 (m) “Prior Authorization” means the process by which the health insurer or the pharmacy  
7 benefit management company determines the medical necessity of otherwise covered  
8 health care services prior to the rendering of such health care services. “Prior  
9 authorization” also includes any health insurer’s or utilization review entity’s requirement  
10 that a subscriber or health care provider notify the health insurer or utilization review  
11 entity prior to providing a health care service.

12 (n) “Quantitative treatment limitation” means numerical limits on the scope or duration of  
13 treatment, which include annual, episode, and lifetime day and visit limits.

14 (o) “Step Therapy” or fail first means a protocol or program that establishes the specific  
15 sequence in which prescription drugs for a medical condition that are medically  
16 appropriate for a particular patient are authorized by a health insurers or prescription drug  
17 management company.

18 (p) “Urgent health care service” means a health care service with respect to which the  
19 application of the time periods for making a non-expedited prior authorization, which, in  
20 the opinion of a physician with knowledge of the subscriber’s medical condition:

- 21 a. could seriously jeopardize the life or health of the subscriber or the ability of the  
22 subscriber to regain maximum function; or

1           b. could subject the subscriber to severe pain that cannot be adequately managed  
2           without the care or treatment that is the subject of the utilization review.

3           For the purpose of this Act, urgent health care service shall include services provided for  
4           the treatment of substance use disorders.

5  
6           *Drafting note. You may want to include additional information about*  
7           *the following:*

8           Buprenorphine is an opioid medication that acts as a partial agonist at  
9           opioid receptors—it does not produce the euphoria and sedation caused by  
10          heroin or other opioids but reduces or eliminates withdrawal symptoms  
11          associated with opioid dependence and has a low risk of overdose.

12          Methadone is a long-acting opioid agonist medication that can prevent  
13          withdrawal symptoms and reduce craving in opioid-addicted individuals.

14          Naloxone is an opioid antagonist that binds to opioid receptors and blocks  
15          or inhibits the effects of opioids acting on those receptors. Naloxone has  
16          no potential for abuse, and it is not addictive.

17          Naltrexone is an opioid antagonist—it blocks opioids from binding to their  
18          receptors and thereby prevents their euphoric and other effects. Naltrexone  
19          itself has no subjective effects following detoxification (that is, a person  
20          does not perceive any particular drug effect), and it has no potential for  
21          abuse.

22          Suboxone is the brand name of the combination of buprenorphine and  
23          naloxone.

1 **Section 4. Requirements for provision and coverage of MAT services.**

2 (a) MAT services shall include, but not be limited to pharmacologic and behavioral  
3 therapies. At a minimum, a formulary used by a health insurer or managed by a  
4 pharmacy benefit management company, or medical benefit coverage in the case of  
5 medications dispensed through an opioid treatment program, shall include all current  
6 and new formulations and medications approved by the U.S. Food and Drug  
7 Administration for the treatment of substance use disorder.

- 8 1. Buprenorphine
- 9 2. Methadone
- 10 3. Naloxone
- 11 4. Extended-release injectable naltrexone
- 12 5. Buprenorphine/naloxone combination

13 (b) All MAT medications required for compliance under this Act shall be placed on the  
14 lowest cost-sharing tier of the formulary managed by the health insurer or the  
15 pharmacy benefit management company.

16 (c) MAT services provided for under this Act shall not be subject to any of the following:

- 17 1. Any annual or lifetime dollar limitations;
- 18 2. Limitations to a pre-designated facility, specific number of visits, days of  
19 coverage, days in a waiting period, scope or duration of treatment, or other  
20 similar limits;
- 21 3. Financial requirements and quantitative treatment limitations that do not  
22 comply with the Mental Health Parity and Addiction Equity Act of 2008  
23 (MEPAEA), specifically 45 CFR 146.136(c)(3);

- 1           4. Step therapy or other similar drug utilization strategies or policies, when they  
2           conflict or interfere with a prescribed or recommended course of treatment  
3           from a licensed health care professional; and
- 4           5. Prior authorization for MAT services as specified in this Act, as well as any  
5           behavioral, cognitive or mental health services prescribed in conjunction with  
6           or supplementary to the MAT services for the purpose of treating a substance  
7           use disorder.

8           (d) The health care benefits and MAT services outlined in this Act shall apply to all  
9           health insurance plans offered to consumers in [state].

10          (e) Any entity that holds itself out as a treatment program or that applies for licensure by  
11          the state to provide clinical treatment services for substance use disorders shall be  
12          required to:

- 13           1. Use the ASAM Criteria or other such nationally recognized, research-  
14           validated criteria, for patient placement and review of ongoing need for  
15           treatment and meet or exceed the standards set forth in the ASAM or other  
16           criteria for the level(s) of care being provided by such program; and
- 17           2. Disclose the MAT services it provides, as well as which of its level(s) of care  
18           have been certified by an independent, national or other organization that has  
19           competencies in the use of the applicable placement guidelines and level of  
20           care standards.

21          (f) The [state] Medicaid program shall cover the MAT medications and services  
22          provided for under this Act, and include those MAT medications in its preferred drug  
23          lists for the treatment of substance use disorder and prevention of overdose and death.



1 At a minimum, the preferred drug list shall include all current and new formulations  
2 and medications that are approved by the U.S. Food and Drug Administration for the  
3 treatment of substance use disorder.

4 (g) The Department of Corrections and all other state entities responsible for the care of  
5 persons detained or incarcerated in jails or prisons shall be required to ensure all  
6 persons under their care be assessed for substance use disorders using standard  
7 diagnostic criteria by a licensed physician who actively treats patients with substance  
8 use disorders. The entity shall make available the MAT services covered under this  
9 Act consistent with a treatment plan developed by the physician and shall not impose  
10 any limitations on the type of medication or other treatment prescribed or the dose or  
11 duration of MAT recommended by the physician.

12 (h) Drug courts or other diversion programs that provide for alternatives to jail or prison  
13 for persons with a substance use disorder shall be required to ensure all persons under  
14 their care be assessed for substance use disorders using standard diagnostic criteria by  
15 a licensed physician who actively treats patients with substance use disorders. The  
16 entity shall make available the MAT services covered under this Act consistent with a  
17 treatment plan developed by the physician and shall not impose any limitations on the  
18 type of medication or other treatment prescribed or the dose or duration of MAT  
19 recommended by the physician.

20 (i) Requirements under this section shall not be subject to a covered person's prior  
21 success(es) or failure(s) of the service(s) provided.

1 **Section 5. Requirements for payer compliance**

2 (a) All health insurers and other payers providing health coverage in [state] shall be required  
3 to disclose which providers in its network provide MAT services, and what level of care is  
4 provided pursuant to ASAM criteria or other nationally recognized, research-validated  
5 substance use disorder-specific program standards recognized by the state’s applicable  
6 licensure body. Such disclosure shall be made in a prominent location in the online and  
7 print provider directories.

8 (b) The Insurance Commissioner shall require that provider networks meet maximum  
9 time/distance standards and minimum wait time standards for providers of MAT services.

10 1. Such standards shall be established by the Commissioner and reviewed biennially  
11 to ensure patient access to MAT services.

12 2. Health insurers must include a description of how their provider network(s) meet  
13 the requirements under this Section as part of their access plan and/or other required  
14 network adequacy documentation provided to the department of insurance.

15 (c) A health insurance plan shall have a process to assure that an enrollee obtains a covered  
16 benefit for MAT and related treatment services at an in-network level of coverage or shall  
17 make other arrangements acceptable to the commissioner when:

18 1. The health insurance plan has an otherwise sufficient network, but does not have  
19 an appropriate type of in-network provider available to provide the covered MAT  
20 services to the enrollee or it does not have an in-network provider available to  
21 provide the covered MAT services to the enrollee without unreasonable travel or  
22 delay; or

1           2. The health insurance plan has an insufficient number or type of appropriate in-  
2           network providers available to provide the covered MAT services to the enrollee  
3           without unreasonable travel or delay.

4           (d) For purposes of an enrollee's financial responsibilities when the health insurance plan is  
5           deemed inadequate under the requirements of this Section, the health insurance plan shall  
6           treat the health care services the enrollee receives from an out-of-network provider  
7           pursuant to this section as if the services were provided by an in-network provider,  
8           including counting the enrollee's cost-sharing for such services toward the enrollee's  
9           deductible and maximum out-of-pocket limit applicable to services obtained from in-  
10          network providers under the health insurance plan.

11          (e) A health insurer shall render a determination to a request by an enrollee concerning a  
12          covered benefit for MAT services from an out-of-network provider and notify the enrollee  
13          and the enrollee's health care provider of that determination within 24 hours from the date  
14          and time on which the health insurer receives that request.

15          (f) A health insurer shall render a determination concerning urgent care services for MAT and  
16          related services, and notify the enrollee and the enrollee's health care provider of that  
17          determination within 24 hours from the date and time on which the health insurer receives  
18          that request.

19          (g) The health insurance plan shall report bi-annually to the commissioner the frequency with  
20          which the process outlined in (d), (e) and (f) in this Section is used. All payers providing  
21          health coverage in [state] shall submit an annual report to the regulatory agency on or  
22          before insert date that contains the following information:

- 1           1. A description of the process used to develop or select the medical necessity criteria  
2           for mental health and substance use disorder and the process used to develop or  
3           select the medical necessity criteria for medical and surgical benefits.
- 4           2. Identification of all non-quantitative treatment limitations (NQTLs) that are applied  
5           to mental health and substance use disorder benefits
- 6           3. An analysis that demonstrates that for the medical necessity criteria and each  
7           NQTL, as written and in operation, the processes, strategies, evidentiary standards,  
8           or other factors used in applying the medical necessity criteria and each NQTL to  
9           mental health and substance use disorder benefits within each classification of  
10          benefits are comparable to, and applied no more stringently than the processes,  
11          strategies, evidentiary standards, or other factors used in applying the medical  
12          necessity criteria and each NQTL to medical and surgical benefits within the  
13          corresponding classification of benefits; at a minimum, the results of the analysis  
14          shall:
  - 15                i. Identify how the factors used to determine that NQTL will apply  
16                to a benefit, including factors that were considered but rejected;
  - 17                ii. Identify and define the specific evidentiary standards used to  
18                define the factors and any other evidence relied upon in  
19                designing each NQTL;
  - 20                iii. Provide the comparative analyses, including the results of the  
21                analyses, performed to determine that the processes and  
22                strategies used to design each NQTL, as written, for mental  
23                health and substance use disorder benefits are comparable to,

1 and are applied no more stringently than, the processes and  
2 strategies used to design each QTL and NQTL, as written, for  
3 medical and surgical benefits; and

4 iv. Provide the comparative analyses, including the results of the  
5 analyses, performed to determine that the processes and  
6 strategies used to apply each NQTL, in operation, for mental  
7 health and substance use disorder benefits are comparable to,  
8 and applied no more stringently than, the processes or strategies  
9 used to apply each NQTL, in operation, for medical and surgical  
10 benefits.

11 (h) The department of insurance shall publicly disclose the specific findings and conclusions  
12 reached by the payer.

13 (i) The department of insurance shall be required to periodically perform parity compliance  
14 market conduct examinations of all health insurers that provide coverage for mental  
15 health and substance use disorder care in this state with a focus on determining  
16 compliance the requirements of this Act.

17 (j) The regulatory agency shall promote and make prominent on its website a mechanism to  
18 explain the requirements of this Act and a feedback/complaint process for consumers and  
19 providers who have a bona fide complaint that a payer is not meeting the requirements of  
20 this Act.

21 (k) The regulatory agency (or agencies) shall promulgate guidelines or regulations as-needed  
22 to implement and enforce the requirements of this Act. Consultation with representatives

1 of the mental health, medical , social work and other relevant organizations is strongly  
2 encouraged.

3 **Section 6. Nullification and voidance.** Any contract provision, written policy, or written  
4 procedure in violation of this Section shall be deemed to be unenforceable and null and void.

5 **Section 7. Severability.** If any provision of this Act or the application thereof to any person or  
6 circumstance is held invalid, such invalidity shall not affect other provisions of applications of  
7 the Act which can be given effect without the invalid provision or application, and to this end the  
8 provisions of this Act are declared to be severable.