PEHP Health & Benefits

# HB 130, MENTAL HEALTH COVERAGE AMENDMENTS, (Watkins, C)

# Anticipated Fiscal Impact: $916,305 Ongoing

## I. Summary

HB 130 would impact the State Employee Health Insurance Plan as follows:

(1) The bill would eliminate the Plan's 60-day limit on residential treatment and the requirement of in-network only providers at an approximate cost of $676,371.

(2) The bill would impose a compliance reporting requirement at an approximate cost of $25,000. Because this requirement would not result in the addition of an FTE, PEHP would absorb this cost within the existing budget.

(3) The bill would eliminate pharmacy cost management tools for substance use disorder drugs at an approximate cost of $239,934.

## II. Eliminating 60-day Limit and In-network Requirement

"Mental Health Parity" refers to a federal law that requires health plans to cover mental health conditions under the same terms as physical health conditions. Mental Health Parity does not apply to the State Employee Health Insurance Plan because of an exemption afforded to governmental entities. Even so, the State Health Plan complies with Mental Health Parity except for residential treatment.

Historically, residential treatment was not covered. This is because day treatment and intensive outpatient treatment follow the same programmatic features as residential treatment, but are less expensive treatment options. Hence as between options, residential treatment involves overnight stays whereas the other two do not.

A few years ago, PEHP and its nurse case managers began to identify circumstances in which residential treatment--and the opportunity to live and receive treatment in a different setting--was not only the best choice for a member but also cost-effective for the state. Key to this was the use of an annual 60-day limit to avoid long-term states

that can average more 90+ days and a tightly managed controlled list of in-network providers.

HB 130 would prohibit both measures as a matter of state law. It would eliminate the cap on days and would allow for an out-of-network benefit.

We estimate the following costs under the bill:

- Adding residential treatment as a general benefit and making it available on an out-of-network basis would increase utilization by 77% over the current program at a cost of $238,756. This is based on PEHP data showing how often day treatment patients receive residential treatment when it is a general benefit.
- Removing the day limit would allow for long-term residential treatment stays, which on average is about 90 days. It would also allow for multiple residential treatment admissions in a single year. Using 2015 federal days published in 2018 from the Substance Abuse and Mental Health Services Administration to determine the frequency in Utah of long-term residential treatment as compared to short-term residential treatment, we would expect days to rise by 52% over the current program for a total of 58.4 days at a cost of $292,033. Further, we would expect a 17% increase in readmissions to residential treatment for a cost of $145,582 using national statistics in a JAMA 2019 article.

After adjusting the costs above to reflect member cost sharing, we estimate that the total cost to the state would be approximately $676,371.

## III. Compliance Reporting

This bill would require an insurance company to report compliance with mental health parity to the Department of Insurance. Because the State Health Plan is a self-funded, government plan that is overseen by the Utah Retirement Systems Board, PEHP would comply with this provision by reporting to the URS Board.

We estimate that compliance with this requirement would cost approximately $25,000 a year. Because this requirement would not result in the addition of an FTE, PEHP would absorb this cost within the existing budget.

## IV. Eliminating Pharmacy Cost Management Tools for SUD Drugs

HB 130 would eliminate the use of pharmacy cost management tools for substance use disorder (SUD) drugs as follows.

(1) Placement of all available SUD drugs on PEHP's formulary. Currently, PEHP excludes certain drugs from its formulary that have not shown to be effective as compared to available alternatives. HB 130 would prohibit this and require all SUD drugs to be included.

(2) Placement of all substance abuse disorder drugs on the lowest payment tier. Currently, $10 is the State Health Plan's lowest cost tier. This tier is largely reserved for low-cost generic drugs. Brand drugs, which are typically more expensive, are placed on tiers with higher out-of-pocket costs. HB 130 would prohibit this and require all SUD drugs be placed at the lowest payment tier.

(3) Prohibition of Pre-authorization and Step-Therapy. Currently, PEHP requires pre-authorization for certain drugs to ensure that they are clinically appropriate for a member. In addition, PEHP can require that a member take an effective, lower-cost drug before escalating to a higher-cost, brand name drug. HB 130 would prohibit Pre-authorization and Step therapy.

Currently, 73% of SUD drugs paid for the State Health Plan are generics and 27% are brand name. With the elimination of the pharmacy cost management tools described above, we would expect brand names to increase by at least 23%--so that half of SUD drugs would be generic and half brand name—for a cost of $239,934. This reflects the current per day cost difference of $7.95 for generic SUD drugs and $27.15 for brand name SUD drugs.