By: \_\_\_\_\_\_\_\_\_

Introduced and read first time: \_\_\_\_\_\_\_\_\_\_

Assigned to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AN ACT concerning

Health Insurance – Parity reporting requirements for carriers – Implementation and reporting requirements for the Insurance Administration – Medication-assisted treatment requirements

FOR the purpose of carriers to report nonquantitative treatment limitation compliance activities; specifying implementation and reporting requirements for the MIA; specifying carrier coverage requirements for medication-assisted treatment for drug or alcohol misuse.

BY repealing and reenacting with amendments

 Article – Insurance

 Section – 15-802

 Annotated Code of Maryland

(2011 Replacement Volume and 2018 Supplement)

BY repealing and reenacting with amendments

 Article – Insurance

 Section – 15-851

 Annotated Code of Maryland

(2011 Replacement Volume and 2018 Supplement)

 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

That the laws of Maryland read as follows:

**Article — Insurance**

15-802

(a)    (1)   In this section the following words have the meanings indicated.

(2)   “Alcohol misuse” has the meaning stated in § 8–101 of the Health – General Article.

(3)   “Drug misuse” has the meaning stated in § 8–101 of the Health – General Article.

(4)   “Grandfathered health plan coverage” has the meaning stated in 45 C.F.R. § 147.140.

(5)   “Health benefit plan”:

(i)   for a group or blanket plan, has the meaning stated in § 15–1401 of this title; and

(ii)   for an individual plan, has the meaning stated in § 15–1301 of this title.

(6)   “Managed care system” means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.

(7)   “Partial hospitalization” means the provision of medically directed intensive or intermediate short–term treatment:

(i)   to an insured, subscriber, or member;

(ii)   in a licensed or certified facility or program;

(iii)   for mental illness, emotional disorders, drug misuse, or alcohol misuse; and

(iv)   for a period of less than 24 hours but more than 4 hours in a day.

(8)   “Small employer” has the meaning stated in § 31–101 of this article.

(b)   With the exception of small employer grandfathered health plan coverage, this section applies to each individual, group, and blanket health benefit plan that is delivered or issued for delivery in the State by an insurer, a nonprofit health service plan, or a health maintenance organization.

(c)   A health benefit plan subject to this section shall provide at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder:

(1)   inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits;

(2)   partial hospitalization benefits; and

(3)   outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes.

(d)    (1)   The benefits under this section are required only for expenses arising from the treatment of mental illnesses, emotional disorders, drug misuse, or alcohol misuse if, in the professional judgment of health care providers:

(i)   the mental illness, emotional disorder, drug misuse, or alcohol misuse is treatable; and

(ii)   the treatment is medically necessary.

(2)   The benefits required under this section:

(i)   shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug misuse, and alcohol misuse;

(ii)   shall comply with 45 C.F.R. § 146.136(a) through (d) and 29 C.F.R. § 2590.712(a) through (d);

(iii)   subject to paragraph (3) of this subsection, may be delivered under a managed care system; and

(iv)   for partial hospitalization under subsection (c)(2) of this section, may not be less than 60 days.

(3)   The benefits required under this section may be delivered under a managed care system only if the benefits for physical illnesses covered under the health benefit plan are delivered under a managed care system.

(4)   The processes, strategies, evidentiary standards, or other factors used to manage the benefits required under this section must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the health benefit plan.

(5)   An insurer, nonprofit health service plan, or health maintenance organization may not charge a copayment for methadone maintenance treatment that is greater than 50% of the daily cost for methadone maintenance treatment.

(e)   An entity that issues or delivers a health benefit plan subject to this section shall provide on its Web site and annually in print to its insureds or members:

(1)   notice about the benefits required under this section and the federal Mental Health Parity and Addiction Equity Act; and

(2)   notice that the insured or member may contact the Administration for further information about the benefits.

(f)   An entity that issues or delivers a health benefit plan subject to this section shall:

(1)   post a release of information authorization form on its Web site; and

(2)   provide a release of information authorization form by standard mail within 10 business days after a request for the form is received.

 **(G) AN ENTITY THAT ISSUES OR DELIVERS A HEALTH BENEFIT PLAN SUBJECT TO THIS SECTION SHALL SUMBIT AN ANNUAL REPORT TO THE INSURANCE ADMINISTRATION BY MARCH 1 THAT CONTAINS THE FOLLOWING INFORMATION:**

**(1) A DESCRIPTION OF THE PROCESS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MENTAL ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE BENEFITS AND THE PROCESS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MEDICAL SURGICAL BENEFITS;**

**(2) IDENTIFICATION OF ALL NONQUANTITATIVE TREATMENT LIMITATIONS (NQTLS) THAT ARE APPLIED TO BOTH MENTAL ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE BENEFITS AND MEDICAL AND SURGICAL BENEFITS; THERE MAY BE NO SEPARATE NQTLS THAT APPLY TO MENTAL ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE 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 IDENTIFIED IN ITEM (1) AND EACH NQTL IDENTIFIED IN ITEM (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 ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE 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:**

 **(I) IDENTIFY THE FACTORS USED TO DETERMINE THAT AN NQTL WILL APPLY TO A BENEFIT, INCLUDING FACTORS THAT WERE CONSIDERED BUT REJECTED;**

 **(II) IDENTIFY AND DEFINE THE SPECIFIC EVIDENTIARY STANDARDS USED TO DEFINE THE FACTORS AND ANY OTHER EVIDENCE RELIED UPON IN DESIGNING EACH NQTL;**

 **(III) 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 ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE 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;**

 **(IV) 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 ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE BENEFITS ARE COMPARABLE TO, AND ARE APPLIED NO MORE STRINGENTLY THAN, THE PROCESSES AND STRATEGIES USED TO APPLY EACH NQTL, IN OPERATION, TO MEDICAL AND SURGICAL BENEFITS; AND**

 **(V) DISCLOSE THE SPECIFIC FINDINGS AND CONCLUSIONS REACHED BY THE ENTITY THAT THE RESULTS OF THE ANALYSES ABOVE INDICATE THAT THE ENTITY 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).**

 **(H) NOT LATER THAN MARCH 31ST, 2020, THE INSURANCE ADMINISTRATION SHALL ISSUE A REPORT AND EDUCATIONAL PRESENTATION TO THE GENERAL ASSEMBLY, WHICH SHALL:**

 **(1) COVER THE METHODOLODY THE INSURANCE ADMINISTRATION 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) IDENTIFY MARKET CONDUCT EXAMINATIONS CONDUCTED OR COMPLETED DURING THE PRECEDING 12-MONTH PERIOD REGARDING COMPLIANCE WITH PARITY IN MENTAL ILLNESS, EMOTIONAL DISORDERS, ALCOHOL MISUSE, OR DRUG MISUSE BENEFITS UNDER STATE AND FEDERAL LAWS AND SUMMARIZE THE RESULTS OF SUCH MARKET CONDUCT EXAMINATIONS.**

 **(3) DETAIL ANY EDUCATIONAL OR CORRECTIVE ACTIONS THE INSURANCE ADMINISTRATION HAS TAKEN TO ENSURE ENTITY COMPLIANCE WITH MHPAEA AND THIS SECTION.**

 **(4) 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 INSURANCE ADMINISTRATION FINDS APPROPRIATE, POSTING THE REPORT ON THE WEBSITE OF THE INSURANCE ADMINISTRATION.**

**Article — Insurance**

15-851

(a) (1)    This section applies to:

              (i)    insurers and nonprofit health service plans that provide coverage for substance use disorder benefits or prescription drugs under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

             (ii)    health maintenance organizations that provide coverage for substance use disorder benefits or prescription drugs under individual or group contracts that are issued or delivered in the State.

          (2)    An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for substance use disorder benefits under the medical benefit or for prescription drugs through a pharmacy benefits manager is subject to the requirements of this section.

(b)    An entity subject to this section may not apply a prior authorization requirement for a prescription drug:

         (1)    when used for treatment of an opioid use disorder; and

         (2)    that contains methadone, buprenorphine, or naltrexone.

**(C) AN ENTITY SUBJECT TO THIS SECTION MAY NOT APPLY STEP THERAPY REQUIREMENTS FOR A PRESCRIPTION DRUG:**

 **(1) WHEN USED FOR TREATMENT OF AN OPIOID USE DISORDER; AND**

 **(2) THAT CONTAINS METHADONE, BUPRENORPHINE, OR NALTREXONE.**

**(D) AN ENTITY SUBJECT TO THIS SECTION MUST PLACE PRESCRIPTION DRUGS ON THE LOWEST TIER OF THE FORMULARY DEVELOPED AND MAINTAINED BY THE ENTITY:**

 **(1) WHEN USED FOR THE TREATMENT OF AN OPIOID USE DISORDER; AND**

 **(2) THAT CONTAINS METHADONE, BUPRENORPHINE, OR NALTREXONE .**

**(E) AN ENTITY SUBJECT TO THIS SECTION MAY NOT DENY COVERAGE OF ANY PRESCRIPTION DRUGS OR ASSOCIATED COUNSELING OR WRAPAROUND SERVICES ON THE GROUNDS THAT THE DRUGS OR SERVICES ARE COURT ORDERED:**

 **(1) WHEN USED FOR THE TREATMENT OF AN OPIOID USE DISORDER; AND**

**(2) THAT CONTAIN METHADONE, BUPRENORPHINE, OR NALTREXONE.**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 21 1, 2019.