

**129th MAINE LEGISLATURE**

**First REGULAR SESSION-2019**

# Legislative Document No. XXXX

S.P. XXX In Senate, January \_\_, 2019

# An Act To Amend the Mental Health Insurance Coverage Laws

(AFTER DEADLINE)

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 205.

Reference to the Committee on Labor, Commerce, Research and Economic Development suggested and ordered printed.



HEATHER J.R. PRIEST

Secretary of the Senate

Presented by Senator \_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Be it enacted by the People of the State of Maine as follows:**

 **Sec. 1. 24-A MRSA §2749-C, sub-§4,** as enacted by PL 1995, c. 407, §5, is amended to read:

 4. Insurers shall submit the following annual reports:

A. Every insurer subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

B. Every insurer subject to this section shall submit an annual report to the superintendent no later than April 30th that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental illness and substance abuse-related 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 illness and substance abuse-related disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental illness and substance abuse-related 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 item (1) and for 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 and substance abuse-related 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 illness and substance abuse-related 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 illness and substance abuse-related disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

(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).

**Sec. 2. 24-A MRSA §2843, sub-§7,** as enacted by PL 1995, c. 407, §8, is amended to read:

7. Insurers shall submit the following annual reports:

A. Every insurer subject to this section shall report its experience for each calendar year to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

B. Every insurer subject to this section shall submit an annual report to the superintendent no later than April 30th that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental illness and substance abuse-related 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 illness and substance abuse-related disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental illness and substance abuse-related 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 item (1) and for 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 and substance abuse-related 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 illness and substance abuse-related 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 illness and substance abuse-related disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

(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).

**Sec. 3. 24-A MRSA §4234, sub-§10,** as enacted by PL 1995, c. 407, §10, is amended to read:

 10. Health maintenance organizations shall submit the following annual reports:

A. Every health maintenance organization subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual and group health care contracts, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

B. Every health maintenance organization subject to this section shall submit an annual report to the superintendent no later than April 30th that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental illness and substance abuse-related 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 illness and substance abuse-related disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental illness and substance abuse-related 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 item (1) and for 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 and substance abuse-related 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 illness and substance abuse-related 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 illness and substance abuse-related disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

(e) Disclose the specific findings and conclusions reached by the health maintenance organization that the results of the analyses above indicate that the health maintenance organization 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).

**Sec. 4. 24 MRSA §2325-A, sub-§8,** as enacted by PL 1995, c. 407, §3, is amended to read:

8. Nonprofit hospital or medical service organizations shall submit the following annual reports:

A. Every nonprofit hospital or medical service organization subject to this section shall report its experience for each calendar year to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all nonprofit hospital or medical service organizations in an annual report.

B. Every nonprofit hospital or medical service organization subject to this section shall submit an annual report to the superintendent no later than April 30th that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental illness and substance abuse-related 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 illness and substance abuse-related disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental illness and substance abuse-related 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 item (1) and for 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 and substance abuse-related 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 illness and substance abuse-related 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 illness and substance abuse-related disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

(e) Disclose the specific findings and conclusions reached by the nonprofit hospital or medical service organization that the results of the analyses above indicate that the nonprofit hospital or medical service organization 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).

 Sec. 5. **24**-**A MRSA §238** is enacted to read:

 1. The superintendent 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:

A. Proactively ensuring compliance by insurers, health maintenance organizations, and nonprofit hospital or medical service organizations that execute, deliver, issue for delivery, continue or renew individual and group policies or individual and group health care contracts;

B. Evaluating all consumer or provider complaints regarding mental illness and substance abuse-related disorder coverage for possible parity violations;

C. Performing parity compliance market conduct examinations of insurers, health maintenance organizations, and nonprofit hospital or medical service organizations that execute, deliver, issue for delivery, continue or renew individual and group policies or individual and group health care contracts, 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;

D. Requesting that insurers, health maintenance organizations, and nonprofit hospital or medical service organizations 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 illness and substance abuse-related disorder benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits; and

E. The superintendent may adopt rules, as authorized under section 212 or this Title, 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.

2. Not later than March 1st, 2020, the superintendent shall issue a report and educational presentation to the Legislature, which shall contain the following:

A. Cover the methodology the superintendent 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;

B. Cover the methodology the superintendent is using to check for compliance with sections 2749-C, 2843, 4234, and 2842 of this Title and sections 2325-A and 2329 of Title 24;

C. Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental illness and substance abuse-related disorder benefits under state and federal laws and summarize the results of such market conduct examinations;

D. Detail any educational or corrective actions the superintendent has taken to ensure insurer compliance with MHPAEA and sections 2749-C, 2843, 4234, and 2842 of this Title and sections 2325-A and 2329 of Title 24; and

E. 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 superintendent finds appropriate, posting the report on the Internet website of the Bureau of Insurance.

Sec. 6. **24**-**A MRSA §2749-D** is enacted to read:

 1. All insurers that execute, deliver, issue for delivery, continue or renew individual policies and contracts that provide prescription drug benefits for the treatment of substance abuse-related disorders shall comply with the following:

A. Each insurer 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 abuse-related disorders;

B. Each insurer shall 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 abuse-related disorders;

C. Each insurer shall place all prescription medications approved by the FDA for the treatment of substance abuse-related disorders on the lowest tier of the drug formulary developed and maintained by the insurer; and

D. Each insurer shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse-related disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Sec. 7. **24**-**A MRSA §2847-V** is enacted to read:

 1. Every insurer that issues group health care contracts that provide prescription drug benefits for the treatment of substance abuse-related disorders shall comply with the following:

A. Each insurer 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 abuse-related disorders;

B. Each insurer shall 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 abuse-related disorders;

C. Each insurer shall place all prescription medications approved by the FDA for the treatment of substance abuse-related disorders on the lowest tier of the drug formulary developed and maintained by the insurer; and

D. Each insurer shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse-related disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Sec. 8. **24**-**A MRSA §4234-F** is enacted to read:

 1. Every health maintenance organization that issues individual or group health care contracts that provide prescription drug benefits for the treatment of substance abuse-related disorders shall comply with the following:

A. Each health maintenance organization 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 abuse-related disorders;

B. Each health maintenance organization shall not impose any step therapy requirements before the health maintenance organization will authorize coverage for a prescription medication approved by the FDA for the treatment of substance abuse-related disorders;

C. Each health maintenance organization shall place all prescription medications approved by the FDA for the treatment of substance abuse-related disorders on the lowest tier of the drug formulary developed and maintained by the health maintenance organization; and

D. Each health maintenance organization shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse-related disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Sec. 9. **24 MRSA §2325-D** is enacted to read:

1. Every nonprofit hospital or medical service organization that issues group health care contracts that provide prescription drug benefits for the treatment of substance abuse-related disorders shall comply with the following:

A. Each nonprofit hospital or medical service organization 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 abuse-related disorders;

B. Each nonprofit hospital or medical service organization shall not impose any step therapy requirements before the nonprofit hospital or medical service organization will authorize coverage for a prescription medication approved by the FDA for the treatment of substance abuse-related disorders;

C. Each nonprofit hospital or medical service organization shall place all prescription medications approved by the FDA for the treatment of substance abuse-related disorders on the lowest tier of the drug formulary developed and maintained by the nonprofit hospital or medical service organization; and

D. Each nonprofit hospital or medical service organization shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance abuse-related disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

 **Sec. 10. Application.** The requirements of this Act apply to all insurers, health maintenance organizations, and nonprofit hospital or medical service organizations that execute, deliver, issue for delivery, continue or renew individual and group policies, contracts and certificates in this State on or after January, 2019.

**Summary**

This bill requires insurers, health maintenance organizations, and nonprofit hospital or medical service organizations to submit mental health and substance abuse-related disorder parity compliance reports. It specifies how the Superintendent of Insurance may enforce parity requirements and stipulates parity reporting requirements for the Superintendent. This bill also prohibits certain types of medical management protocols from being used in conjunction with prescription medications used to treat substance abuse-related disorders.