HOUSE BILL 599

C3 9lr1885
CF SB 631

By: **Delegate Kelly**
Introduced and read first time: February 6, 2019
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Requirements and Reports

FOR the purpose of requiring certain carriers, on or before a certain date each year, to submit a report to the Maryland Insurance Commissioner to demonstrate the carrier's compliance with the federal Mental Health Parity and Addiction Equity Act; requiring certain carriers, on or before a certain date each year, to submit a report to the Commissioner on data for certain benefits by certain classification; requiring the reports to include certain information and be submitted in a certain manner; requiring the reports to be prepared in coordination with certain entities, contain a certain statement, and be made available to certain persons in a certain manner; requiring the reports to exclude certain identifiable information; requiring the Commissioner to review the reports, notify a carrier of noncompliance with certain federal law, and require the carrier to take certain actions under certain circumstances; requiring the Commissioner to impose a certain penalty for each day a carrier fails to submit a certain report; requiring that certain funds be used only for certain purposes; requiring the Commissioner, on or before a certain date, to develop certain forms and, in consultation with certain persons, adopt certain regulations; requiring an insurer, nonprofit health service plan, or health maintenance organization to use certain criteria for all medical necessity and utilization management determinations for substance use disorder benefits; repealing a certain limitation on the amount of copayment that an insurer, nonprofit health service plan, or health maintenance organization may charge under certain circumstances; requiring certain carriers to include certain information in a certain notice of an adverse decision or grievance by a carrier; requiring certain carriers to include certain information in certain notice of a coverage decision or appeal decision by a carrier; defining certain terms; making stylistic changes; providing for a delayed effective date for certain provisions of this Act; providing for the application of certain provisions of this Act; and generally relating to coverage for mental health benefits and substance use disorder benefits.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

BY adding to
Article – Insurance
Section 15–144
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–802, 15–10A–02, and 15–10D–02
Annotated Code of Maryland
(2017 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

15–144.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION.

(3) (I) "FINANCIAL REQUIREMENTS" INCLUDES:

1. DEDUCTIBLES;

2. COPAYMENTS;

3. COINSURANCE; AND

4. ANY OUT–OF–POCKET MAXIMUMS.

(II) "FINANCIAL REQUIREMENTS" DOES NOT INCLUDE AGGREGATED LIFETIME OR ANNUAL DOLLAR LIMITS.

(4) "MEDICAL/SURGICAL BENEFITS" HAS THE MEANING STATED IN 45 C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).

(5) "MENTAL HEALTH BENEFITS" HAS THE MEANING STATED IN 45 C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).

(6) "NONQUANTITATIVE TREATMENT LIMITATION" HAS THE MEANING STATED IN 45 C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).

(7) "PARITY ACT" MEANS THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 AND 45 C.F.R. 146.136 AND 45 C.F.R. 147.160.

(8) "PARITY ACT CLASSIFICATIONS" MEANS:

(I) IN–NETWORK BENEFITS;

(II) INPATIENT OUT–OF–NETWORK BENEFITS;

(III) OUTPATIENT IN–NETWORK BENEFITS;

(IV) OUTPATIENT OUT–OF–NETWORK BENEFITS;

(V) PRESCRIPTION DRUG BENEFITS; AND

(VI) EMERGENCY CARE BENEFITS.

(9) "QUANTITATIVE TREATMENT LIMITATIONS" MEANS NUMERICAL FACTORS THAT LIMIT THE TREATMENT OR BENEFIT OFFERED UNDER A PLAN OR COVERAGE.

(10) "SUBSTANCE USE DISORDER BENEFITS" HAS THE MEANING STATED IN 45 C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).

(11) "TREATMENT LIMITATIONS" INCLUDES LIMITS BASED ON:

(I) THE FREQUENCY OF TREATMENT;

(II) NUMBER OF VISITS;

(III) DAYS OF COVERAGE; AND

(IV) DAYS IN A WAITING PERIOD.

(B) THIS SECTION APPLIES TO A CARRIER THAT DELIVERS, OR ISSUES FOR DELIVERY, AN INDIVIDUAL, GROUP, OR BLANKET HEALTH BENEFIT PLAN IN THE STATE.

(C) (1) ON OR BEFORE JULY 1 EACH YEAR, EACH CARRIER SHALL SUBMIT A REPORT TO THE COMMISSIONER TO DEMONSTRATE THE CARRIER'S COMPLIANCE WITH THE PARITY ACT.

(2) THE REPORT SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) LIST ALL MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS OFFERED BY THE CARRIER AND THE PLACE THAT EACH BENEFIT IS OFFERED IN THE APPLICABLE PARITY ACT CLASSIFICATION OR SUBCLASSIFICATION;

(II) LIST ALL MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS THAT ARE EXCLUDED FROM COVERAGE BY THE CARRIER AND A DETAILED EXPLANATION FOR THE EXCLUSION;

(III) LIST ANY ANNUAL OR LIFETIME DOLLAR LIMITS ON MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS OFFERED BY THE CARRIER AND PROVIDE AN ACTUARIAL DEMONSTRATION THAT ANY ANNUAL OR LIFETIME DOLLAR LIMIT COMPLIES WITH THE PARITY ACT;

(IV) LIST ALL FINANCIAL REQUIREMENTS FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS OFFERED BY THE CARRIER BY CLASSIFICATION AND SUBCLASSIFICATION AND PROVIDE AN ACTUARIAL DEMONSTRATION THAT THE FINANCIAL REQUIREMENTS SATISFY THE SUBSTANTIALLY ALL AND PREDOMINANT STANDARDS OF THE PARITY ACT, INCLUDING:

1. A DESCRIPTION OF THE METHODOLOGY USED TO DETERMINE THE DOLLAR AMOUNT OF ALL PLAN PAYMENTS FOR THE SUBSTANTIALLY ALL AND PREDOMINANT ANALYSIS; AND

2. AN IDENTIFICATION OF ANY CUMULATIVE FINANCIAL REQUIREMENTS FOR MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS AND VERIFICATION OF COMPLIANCE WITH THE PARITY ACT;

(V) LIST ALL QUANTITATIVE TREATMENT LIMITATIONS FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND

MEDICAL/SURGICAL BENEFITS OFFERED BY THE CARRIER BY CLASSIFICATION AND SUBCLASSIFICATION AND PROVIDE AN ACTUARIAL DEMONSTRATION THAT THE QUANTITATIVE TREATMENT LIMITATIONS SATISFY THE SUBSTANTIALLY ALL AND PREDOMINANT STANDARDS OF THE PARITY ACT, INCLUDING:

1. A DESCRIPTION OF THE METHODOLOGY USED TO DETERMINE THE DOLLAR AMOUNT OF ALL PLAN PAYMENTS FOR SUBSTANTIALLY ALL AND PREDOMINANT ANALYSIS; AND

2. AN IDENTIFICATION OF ANY CUMULATIVE FINANCIAL REQUIREMENTS FOR MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS AND VERIFICATION OF COMPLIANCE WITH THE PARITY ACT;

(VI) LIST ALL NONQUANTITATIVE TREATMENT LIMITATIONS THAT APPLY TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS OFFERED BY THE CARRIER BY CLASSIFICATION AND IDENTIFY THE DESCRIPTION OF THE NONQUANTITATIVE TREATMENT LIMITATIONS IN THE CARRIER'S PLAN DOCUMENTS;

(VII) LIST THE FACTORS CONSIDERED IN THE DESIGN OF EACH NONQUANTITATIVE TREATMENT LIMITATION LISTED UNDER ITEM (VI) OF THIS PARAGRAPH;

(VIII) IDENTIFY THE SOURCES USED TO DEFINE OR ESTABLISH A THRESHOLD FOR APPLYING THE FACTORS LISTED UNDER ITEM (VII) OF THIS PARAGRAPH, INCLUDING:

1. THE TITLE AND QUALIFICATIONS OF THE EMPLOYEE WHO MAKES THE DECISIONS RELATED TO THE ADOPTION AND IMPLEMENTATION OF THE FACTORS;

2. A DESCRIPTION OF HOW THE FACTORS WERE USED TO APPLY EACH NONQUANTITATIVE TREATMENT LIMITATION TO MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, AND MEDICAL/SURGICAL BENEFITS;

3. AN EXPLANATION ABOUT WHETHER ANY FACTOR WAS GIVEN MORE WEIGHT THAN ANOTHER FACTOR; AND

4. IF A FACTOR WAS GIVEN MORE WEIGHT THAN ANOTHER FACTOR, THE REASON FOR THE DIFFERENCE IN WEIGHTING;

(IX) AN ANALYSIS THAT DEMONSTRATES, FOR THE PLAN AS WRITTEN AND IN OPERATION, THE PROCESSES, STRATEGIES, AND EVIDENTIARY

STANDARDS USED IN DEVELOPING AND APPLYING EACH NONQUANTITATIVE TREATMENT LIMITATION IS COMPARABLE TO AND APPLIED NO MORE STRINGENTLY TO MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS THAN TO MEDICAL/SURGICAL BENEFITS, INCLUDING:

1. THE ANALYSIS, AUDIT, OR METHOD USED TO ASSESS COMPARABILITY UNDER THIS ITEM;

2. ANY FACTORS USED, EVIDENTIARY STANDARDS RELIED ON, AND THE PROCESS EMPLOYED IN DEVELOPING AND APPLYING A NONQUANTITATIVE TREATMENT LIMITATION FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, AND MEDICAL/SURGICAL BENEFITS; AND

3. ANY IDENTIFICATION MEASURES THAT WERE USED TO ENSURE COMPARABLE APPLICATION OF NONQUANTITATIVE TREATMENT LIMITATIONS THAT ARE IMPLEMENTED BY THE CARRIER AND ANY ENTITY DELEGATED TO MANAGE MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, OR MEDICAL/SURGICAL BENEFITS ON BEHALF OF THE CARRIER;

(X) INCLUDE A RECORD OF ALL CLAIMS SUBMITTED FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, AND MEDICAL/SURGICAL BENEFITS AND THE NUMBER OF CLAIMS DENIED FOR EACH BENEFIT BY CLASSIFICATION; AND

(XI) IDENTIFY THE PROCESS USED TO COMPLY WITH THE PARITY ACT DISCLOSURE REQUIREMENTS FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS, INCLUDING:

1. THE CRITERIA FOR A MEDICAL NECESSITY DETERMINATION;

2. REASONS FOR A DENIAL OF BENEFITS; AND

3. IN CONNECTION WITH INTERNAL CLAIMS AND APPEALS, PLAN DOCUMENTS THAT CONTAIN INFORMATION ABOUT PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, AND ANY OTHER FACTORS USED TO APPLY A NONQUANTITATIVE TREATMENT LIMITATION.

(D) ON OR BEFORE JULY 1 EACH YEAR, EACH CARRIER SHALL SUBMIT A REPORT TO THE COMMISSIONER ON THE CARRIER'S DATA FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS BY PARITY ACT CLASSIFICATION, INCLUDING:

(1) THE DELIVERY OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING THE TOTAL NUMBER OF MEMBERS WHO RECEIVED SERVICES FOR A COVERED BENEFIT UNDER § 18–840 OF THIS ARTICLE IN THE IMMEDIATELY PRECEDING CALENDAR YEAR, REPORTED SEPARATELY FOR A PRIMARY DIAGNOSIS OF MENTAL ILLNESS OR MENTAL DISORDER AND A PRIMARY DIAGNOSIS OF ALCOHOL OR DRUG MISUSE BASED ON THE FOLLOWING LEVELS OF CARE:

(I) OUTPATIENT;

(II) INTENSIVE OUTPATIENT;

(III) OPIOID TREATMENT SERVICES;

(IV) PARTIAL HOSPITALIZATION;

(V) RESIDENTIAL TREATMENT;

(VI) INPATIENT TREATMENT; AND

(VII) CRISIS RESIDENTIAL SERVICES;

(2) THE TOTAL NUMBER OF MEMBERS RECEIVING SERVICES FOR WHICH DATA IS PROVIDED UNDER ITEM (1) OF THIS SUBSECTION CALCULATED PER 1,000 MEMBERS;

(3) UTILIZATION MANAGEMENT REQUIREMENTS AND PLAN DECISIONS RELATED TO PRIOR AUTHORIZATION AND CONCURRENT OR CONTINUING REVIEW BY PARITY ACT CLASSIFICATION, INCLUDING:

(I) THE NUMBER AND PERCENT OF COVERED SERVICES AND PRESCRIPTION DRUGS SUBJECT TO EACH LEVEL OF REVIEW;

(II) THE NUMBER AND PERCENT OF REQUESTED SERVICES AND PRESCRIPTION DRUGS APPROVED AT EACH LEVEL OF REVIEW;

(III) THE NUMBER AND PERCENT OF REQUESTED SERVICES AND PRESCRIPTION DRUGS DENIED AT EACH LEVEL OF REVIEW;

(IV) THE NUMBER AND PERCENT OF REQUESTED SERVICES DENIED WITH AN APPROVAL FOR A LOWER LEVEL OF CARE OF A DIFFERENT PRESCRIPTION DRUG;

(V) THE NUMBER AND PERCENT OF REQUESTED SERVICES DENIED BASED ON NONCOVERED SERVICE, MEDICAL NECESSITY CRITERIA, EXPERIMENTAL, INVESTIGATIVE SERVICE, INCOMPLETE SUBMISSION, DUPLICATE SUBMISSION, OR ANY ADDITIONAL REASON; AND

(VI) FOR CONCURRENT OR CONTINUING REVIEW, THE AVERAGE NUMBER OF DAYS AUTHORIZED FOR EACH REVIEW PERIOD AND AVERAGE INTERVAL FOR REQUIRING REVIEW, EXPRESSED IN THE NUMBER OF DAYS;

(4) DENIALS AND APPEALS OF ADVERSE AND COVERAGE DECISIONS BY PARITY ACT CLASSIFICATION, INCLUDING:

(I) THE NUMBER AND PERCENT OF DENIALS OF A REQUESTED SERVICE;

(II) THE NUMBER AND PERCENT OF DECISIONS FOR WHICH A PEER–TO–PEER REVIEW WAS REQUESTED;

(III) THE NUMBER AND PERCENT OF DECISIONS THAT WERE APPEALED AND THE RESULT OF THE APPEAL; AND

(IV) THE NUMBER AND PERCENT OF DECISIONS THAT WENT TO EXTERNAL REVIEW AT THE ADMINISTRATION AND THE RESULT OF THE APPEAL;

(5) NETWORK UTILIZATION REPORTED SEPARATELY FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, AND MEDICAL/SURGICAL BENEFITS, INCLUDING THE NUMBER AND PERCENT OF CLAIMS PAID FOR OUT–OF–NETWORK USE OF:

(I) OUTPATIENT VISITS;

(II) INPATIENT HOSPITALIZATION; AND

(III) NONHOSPITAL RESIDENTIAL FACILITIES; AND

(6) DETAILS ON CLAIM REIMBURSEMENT, INCLUDING:

(I) CLAIM EXPENSES FOR EACH MEMBER FOR EACH MONTH FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, AND MEDICAL/SURGICAL BENEFITS;

(II) THE AVERAGE REIMBURSEMENT RATE FOR PSYCHIATRISTS AND NONPSYCHIATRIST PHYSICIANS FOR EACH EVALUATION AND MANAGEMENT COMMON PROCEDURAL TECHNOLOGY CODE;

(III) THE NETWORK PROVIDER REIMBURSEMENT RATE METHODOLOGY BY PARITY ACT CLASSIFICATION AND THE AUDITS CONDUCTED TO ASSESS COMPLIANCE WITH THE RATE METHODOLOGY; AND

(IV) THE METHODOLOGY FOR DETERMINING THE ALLOWABLE AMOUNT FOR OUT–OF–NETWORK MENTAL HEALTH BENEFITS, SUBSTANCE USE BENEFITS, AND MEDICAL/SURGICAL BENEFITS, INCLUDING ANY REDUCTIONS MADE IN ALLOWABLE AMOUNTS FOR SPECIFIED PROVIDERS OR SERVICES AND THE AUDITS CONDUCTED TO ASSESS COMPLIANCE WITH METHODOLOGIES.

(E) THE REPORTS REQUIRED UNDER SUBSECTIONS (C) AND (D) OF THIS SECTION SHALL:

(1) BE SUBMITTED ON A STANDARD FORM DEVELOPED BY THE COMMISSIONER;

(2) BE SUBMITTED BY THE CARRIER THAT ISSUES OR DELIVERS THE HEALTH BENEFIT PLAN;

(3) BE PREPARED IN COORDINATION WITH ANY ENTITY THE CARRIER CONTRACTS WITH TO PROVIDE MENTAL HEALTH BENEFITS AND SUBSTANCE DISORDER BENEFITS;

(4) CONTAIN A STATEMENT, SIGNED BY THE CARRIER'S CHIEF EXECUTIVE OFFICER, ATTESTING TO THE ACCURACY OF THE INFORMATION CONTAINED IN THE REPORT;

(5) BE MADE AVAILABLE TO ALL PLAN MEMBERS AND BENEFICIARIES ON THE CARRIER'S WEBSITE AND ON REQUEST;

(6) BE AVAILABLE TO PLAN MEMBERS AND THE PUBLIC ON THE CARRIER'S WEBSITE IN A SUMMARY FORM DEVELOPED BY THE COMMISSIONER; AND

(7) EXCLUDE ANY IDENTIFYING INFORMATION OF ANY PLAN MEMBERS.

(F) THE COMMISSIONER SHALL:

(1) REVIEW EACH REPORT SUBMITTED IN ACCORDANCE WITH SUBSECTIONS (C) AND (D) OF THIS SECTION TO ASSESS EACH CARRIER'S COMPLIANCE WITH THE PARITY ACT;

(2) NOTIFY A CARRIER OF ANY NONCOMPLIANCE WITH THE PARITY ACT;

(3) REQUIRE THE CARRIER TO ADDRESS ANY NONCOMPLIANCE WITH THE PARITY ACT WITHIN 90 DAYS AFTER THE CARRIER IS NOTIFIED UNDER ITEM (2) OF THIS SUBSECTION;

(4) REQUIRE THE CARRIER TO SEND NOTIFICATION TO MEMBERS AND BENEFICIARIES OF THE CARRIER'S NONCOMPLIANCE;

(5) REQUIRE REIMBURSEMENT TO MEMBERS AND BENEFICIARIES FOR COSTS INCURRED AS A RESULT OF ANY NONCOMPLIANCE WITH THE PARITY ACT; AND

(6) AS APPROPRIATE, IMPOSE A PENALTY FOR EACH VIOLATION.

(G) (1) THE COMMISSIONER SHALL IMPOSE A PENALTY OF $5,000 FOR EACH DAY FOR WHICH A CARRIER FAILS TO SUBMIT A REPORT REQUIRED UNDER SUBSECTION (C) OR (D) OF THIS SECTION.

(2) THE PENALTIES COLLECTED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE USED BY THE COMMISSIONER ONLY FOR ENFORCEMENT OF A CARRIER'S COMPLIANCE WITH THE PARITY ACT.

(H) THE COMMISSIONER SHALL:

(1) ON OR BEFORE DECEMBER 31, 2019, CREATE A STANDARD FORM FOR ENTITIES TO SUBMIT THE REPORTS IN ACCORDANCE WITH SUBSECTION (E)(1) OF THIS SECTION; AND

(2) ON OR BEFORE DECEMBER 31, 2019, CREATE A SUMMARY FORM FOR ENTITIES TO POST WITH THEIR REPORTS IN ACCORDANCE WITH SUBSECTION (E)(6) OF THIS SECTION.

(I) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSIONER SHALL, IN CONSULTATION WITH INTERESTED STAKEHOLDERS, ADOPT REGULATIONS TO IMPLEMENT THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, 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) "ASAM CRITERIA" MEANS THE MOST RECENT EDITION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE–RELATED, AND CO–OCCURRING CONDITIONS THAT ESTABLISHES GUIDELINES FOR PLACEMENT, CONTINUED STAY AND TRANSFER OR DISCHARGE OF PATIENTS WITH ADDICTION AND CO–OCCURRING CONDITIONS.

[(3)**] (4)** "Drug misuse" has the meaning stated in § 8–101 of the Health – General Article.

[(4)**] (5)** "Grandfathered health plan coverage" has the meaning stated in 45 C.F.R. § 147.140.

[(5)**] (6)** "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)**] (7)** "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)**] (8)** "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)**] (9)** "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**]** **SHALL USE THE ASAM CRITERIA FOR ALL MEDICAL NECESSITY AND UTILIZATION MANAGEMENT DETERMINATIONS FOR SUBSTANCE USE DISORDER BENEFITS**.

(e) An entity that issues or delivers a health benefit plan subject to this section shall provide on its **[**Web site**]** **WEBSITE** 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**]** **WEBSITE**; and

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

15–10A–02.

(a) Each carrier shall establish an internal grievance process for its members.

(b) (1) An internal grievance process shall meet the same requirements established under Subtitle 10B of this title.

(2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;

2. the member, the member's representative, or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider or the member's representative;

(iv) provide that a carrier render a final decision in writing on a grievance within 45 working days after the date on which the grievance is filed when the grievance involves a retrospective denial; and

(v) for a retrospective denial, allow a member, the member's representative, or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision.

(3) For purposes of using the expedited procedure for an emergency case that a carrier is required to include under paragraph (2)(i) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(c) Except as provided in subsection (d) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) (1) (i) A member, the member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if:

1. the carrier waives the requirement that the carrier's internal grievance process be exhausted before filing a complaint with the Commissioner;

2. the carrier has failed to comply with any of the requirements of the internal grievance process as described in this section; or

3. the member, the member's representative, or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member, a member's representative, or a health care provider may file a complaint with the Commissioner if the member, the member's representative, or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(e) Each carrier shall:

(1) file for review with the Commissioner and submit to the Health Advocacy Unit a copy of its internal grievance process established under this subtitle; and

(2) file any revision to the internal grievance process with the Commissioner and the Health Advocacy Unit at least 30 days before its intended use.

(f) For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(1) document the adverse decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(2) send, within 5 working days after the adverse decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

(i) states in detail in clear, understandable language the specific factual bases for the carrier's decision;

(ii) references the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

(iii) states the name, business address, and business telephone number of:

1. the medical director or associate medical director, as appropriate, who made the decision if the carrier is a health maintenance organization; or

2. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization;

(iv) gives written details of the carrier's internal grievance process and procedures under this subtitle; and

(v) includes the following information:

1. that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

2. that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

3. the Commissioner's address, telephone number, and facsimile number;

4. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing a grievance under the carrier's internal grievance process; **[**and**]**

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit**; AND**

6. FOR A COVERAGE DECISION FOR MENTAL HEALTH BENEFITS OR SUBSTANCE USE DISORDER BENEFITS, NOTICE REGARDING THE BENEFITS REQUIRED UNDER § 15–802 OF THIS ARTICLE AND THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND NOTICE THAT THE MEMBER MAY CONTACT THE COMMISSIONER FOR FURTHER INFORMATION ABOUT BENEFITS.

(g) If within 5 working days after a member, the member's representative, or a health care provider, who has filed a grievance on behalf of a member, files a grievance with the carrier, and if the carrier does not have sufficient information to complete its internal grievance process, the carrier shall:

(1) notify the member, the member's representative, or the health care provider that it cannot proceed with reviewing the grievance unless additional information is provided; and

(2) assist the member, the member's representative, or the health care provider in gathering the necessary information without further delay.

(h) A carrier may extend the 30–day or 45–day period required for making a final grievance decision under subsection (b)(2)(ii) of this section with the written consent of the member, the member's representative, or the health care provider who filed the grievance on behalf of the member.

(i) (1) For nonemergency cases, when a carrier renders a grievance decision, the carrier shall:

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(ii) send, within 5 working days after the grievance decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision;

2. references the specific criteria and standards, including interpretive guidelines, on which the grievance decision was based;

3. states the name, business address, and business telephone number of:

A. the medical director or associate medical director, as appropriate, who made the grievance decision if the carrier is a health maintenance organization; or

B. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization; and

4. includes the following information:

A. that the member or the member's representative has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

B. the Commissioner's address, telephone number, and facsimile number;

C. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner; **[**and**]**

D. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit**; AND**

E. FOR A COVERAGE DECISION FOR MENTAL HEALTH BENEFITS OR SUBSTANCE USE DISORDER BENEFITS, NOTICE REGARDING THE BENEFITS REQUIRED UNDER § 15–802 OF THIS ARTICLE AND THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND NOTICE THAT THE MEMBER MAY CONTACT THE COMMISSIONER FOR FURTHER INFORMATION ABOUT BENEFITS.

(2) A carrier may not use solely in a notice sent under paragraph (1) of this subsection generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" to satisfy the requirements of this subsection.

(j) (1) For an emergency case under subsection (b)(2)(i) of this section, within 1 day after a decision has been orally communicated to the member, the member's representative, or the health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member and the member's representative, if any; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) A notice required to be sent under paragraph (1) of this subsection shall include the following:

(i) for an adverse decision, the information required under subsection (f) of this section; and

(ii) for a grievance decision, the information required under subsection (i) of this section.

(k) (1) Each carrier shall include the information required by subsection (f)(2)(iii), (iv), and (v) of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

(2) Each carrier shall include as part of the information required by paragraph (1) of this subsection a statement indicating that, when filing a complaint with the Commissioner, the member or the member's representative will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint.

(l) (1) Nothing in this subtitle prohibits a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

(2) If a carrier delegates its internal grievance process to a private review agent, the carrier shall be:

(i) bound by the grievance decision made by the private review agent acting on behalf of the carrier; and

(ii) responsible for a violation of any provision of this subtitle regardless of the delegation made by the carrier under paragraph (1) of this subsection.

15–10D–02.

(a) (1) Each carrier shall establish an internal appeal process for use by its members, its members' representatives, and health care providers to dispute coverage decisions made by the carrier.

(2) The carrier may use the internal grievance process established under Subtitle 10A of this title to comply with the requirement of paragraph (1) of this subsection.

(b) A carrier under this section shall render a final decision in writing to a member, a member's representative, and a health care provider acting on behalf of the member within 60 working days after the date on which the appeal is filed.

(c) Except as provided in subsection (d) of this section, the carrier's internal appeal process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) A member, a member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing an appeal with a carrier only if the coverage decision involves an urgent medical condition, as defined by regulation adopted by the Commissioner, for which care has not been rendered.

(e) (1) Within 30 calendar days after a coverage decision has been made, a carrier shall send a written notice of the coverage decision to the member and the member's representative, if any, and, in the case of a health maintenance organization, the treating health care provider.

(2) Notice of the coverage decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language, the specific factual bases for the carrier's decision; and

(ii) include the following information:

1. that the member, the member's representative, or a health care provider acting on behalf of the member has a right to file an appeal with the carrier;

2. that the member, the member's representative, or a health care provider acting on behalf of the member may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an urgent medical condition for which care has not been rendered;

3. the Commissioner's address, telephone number, and facsimile number;

4. that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing an appeal under the carrier's internal appeal process; **[**and**]**

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit**; AND**

6. FOR A COVERAGE DECISION FOR MENTAL HEALTH BENEFITS OR SUBSTANCE USE DISORDER BENEFITS, NOTICE REGARDING THE BENEFITS REQUIRED UNDER § 15–802 OF THIS ARTICLE AND THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND NOTICE THAT THE MEMBER MAY CONTACT THE COMMISSIONER FOR FURTHER INFORMATION ABOUT BENEFITS.

(f) (1) Within 30 calendar days after the appeal decision has been made, each carrier shall send to the member, the member's representative, and the health care provider acting on behalf of the member a written notice of the appeal decision.

(2) Notice of the appeal decision required to be sent under paragraph (1) of this subsection shall:

(i) state in detail in clear, understandable language the specific factual bases for the carrier's decision; and

(ii) include the following information:

1. that the member, the member's representative, or a health care provider acting on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's appeal decision;

2. the Commissioner's address, telephone number, and facsimile number;

3. a statement that the Health Advocacy Unit is available to assist the member in filing a complaint with the Commissioner; **[**and**]**

4. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit**; AND**

5. FOR A COVERAGE DECISION FOR MENTAL HEALTH BENEFITS, NOTICE REGARDING THE BENEFITS REQUIRED UNDER § 15–802 OF THIS ARTICLE AND THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND NOTICE THAT THE MEMBER MAY CONTACT THE COMMISSIONER FOR FURTHER INFORMATION ABOUT BENEFITS.

(g) The Commissioner may request the member that filed the complaint or a legally authorized designee of the member to sign a consent form authorizing the release of the member's medical records to the Commissioner or the Commissioner's designee that are needed in order for the Commissioner to make a final decision on the complaint.

(h) (1) A carrier shall have the burden of persuasion that its coverage decision or appeal decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with Title 10, Subtitle 2 of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

(i) The Commissioner shall:

(1) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(2) provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with Title 10, Subtitle 2

of the State Government Article to contest a final decision of the Commissioner made and issued under this subtitle.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect January 1, 2020, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2020.

SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in Section 3 of this Act, this Act shall take effect October 1, 2019.