

SENATE BILL 631

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9lr2617
CF HB 599

By: **Senator Augustine**

Introduced and read first time: February 4, 2019

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

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

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

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 BY adding to
2 Article – Insurance
3 Section 15–144
4 Annotated Code of Maryland
5 (2017 Replacement Volume and 2018 Supplement)

6 BY repealing and reenacting, with amendments,
7 Article – Insurance
8 Section 15–802, 15–10A–02, and 15–10D–02
9 Annotated Code of Maryland
10 (2017 Replacement Volume and 2018 Supplement)

11 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
12 That the Laws of Maryland read as follows:

13 **Article – Insurance**

14 **15–144.**

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

17 **(2) “CARRIER” MEANS:**

18 **(I) AN INSURER;**

19 **(II) A NONPROFIT HEALTH SERVICE PLAN; OR**

20 **(III) A HEALTH MAINTENANCE ORGANIZATION.**

21 **(3) (I) “FINANCIAL REQUIREMENTS” INCLUDES:**

22 **1. DEDUCTIBLES;**

23 **2. COPAYMENTS;**

24 **3. COINSURANCE; AND**

25 **4. ANY OUT–OF–POCKET MAXIMUMS.**

26 **(II) “FINANCIAL REQUIREMENTS” DOES NOT INCLUDE**
27 **AGGREGATED LIFETIME OR ANNUAL DOLLAR LIMITS.**

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

1 **(5) “MENTAL HEALTH BENEFITS” HAS THE MEANING STATED IN 45**
2 **C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).**

3 **(6) “NONQUANTITATIVE TREATMENT LIMITATION” HAS THE**
4 **MEANING STATED IN 45 C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).**

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

8 **(8) “PARITY ACT CLASSIFICATIONS” MEANS:**

9 **(I) IN-NETWORK BENEFITS;**

10 **(II) INPATIENT OUT-OF-NETWORK BENEFITS;**

11 **(III) OUTPATIENT IN-NETWORK BENEFITS;**

12 **(IV) OUTPATIENT OUT-OF-NETWORK BENEFITS;**

13 **(V) PRESCRIPTION DRUG BENEFITS; AND**

14 **(VI) EMERGENCY CARE BENEFITS.**

15 **(9) “QUANTITATIVE TREATMENT LIMITATIONS” MEANS NUMERICAL**
16 **FACTORS THAT LIMIT THE TREATMENT OR BENEFIT OFFERED UNDER A PLAN OR**
17 **COVERAGE.**

18 **(10) “SUBSTANCE USE DISORDER BENEFITS” HAS THE MEANING**
19 **STATED IN 45 C.F.R. § 146.136(A) AND 29 C.F.R. 2590.712(A).**

20 **(11) “TREATMENT LIMITATIONS” INCLUDES LIMITS BASED ON:**

21 **(I) THE FREQUENCY OF TREATMENT;**

22 **(II) NUMBER OF VISITS;**

23 **(III) DAYS OF COVERAGE; AND**

24 **(IV) DAYS IN A WAITING PERIOD.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 1. THE CRITERIA FOR A MEDICAL NECESSITY
25 DETERMINATION;

26 2. REASONS FOR A DENIAL OF BENEFITS; AND

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

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

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

8 **(I) OUTPATIENT;**

9 **(II) INTENSIVE OUTPATIENT;**

10 **(III) OPIOID TREATMENT SERVICES;**

11 **(IV) PARTIAL HOSPITALIZATION;**

12 **(V) RESIDENTIAL TREATMENT;**

13 **(VI) INPATIENT TREATMENT; AND**

14 **(VII) CRISIS RESIDENTIAL SERVICES;**

15 **(2) THE TOTAL NUMBER OF MEMBERS RECEIVING SERVICES FOR**
16 **WHICH DATA IS PROVIDED UNDER ITEM (1) OF THIS SUBSECTION CALCULATED PER**
17 **1,000 MEMBERS;**

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (I) OUTPATIENT VISITS;

23 (II) INPATIENT HOSPITALIZATION; AND

24 (III) NONHOSPITAL RESIDENTIAL FACILITIES; AND

25 (6) DETAILS ON CLAIM REIMBURSEMENT, INCLUDING:

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

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

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

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

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

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

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

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

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

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

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

28 **(7) EXCLUDE ANY IDENTIFYING INFORMATION OF ANY PLAN**
29 **MEMBERS.**

30 **(F) THE COMMISSIONER SHALL:**

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

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

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

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

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

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

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

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

21 **(H) THE COMMISSIONER SHALL:**

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

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

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

1 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read
2 as follows:

3 **Article – Insurance**

4 15–802.

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

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

8 **(3) “ASAM CRITERIA” MEANS THE MOST RECENT EDITION OF THE**
9 **AMERICAN SOCIETY OF ADDICTION MEDICINE TREATMENT CRITERIA FOR**
10 **ADDICTIVE, SUBSTANCE–RELATED, AND CO–OCCURRING CONDITIONS THAT**
11 **ESTABLISHES GUIDELINES FOR PLACEMENT, CONTINUED STAY AND TRANSFER OR**
12 **DISCHARGE OF PATIENTS WITH ADDICTION AND CO–OCCURRING CONDITIONS.**

13 **[(3)] (4)** “Drug misuse” has the meaning stated in § 8–101 of the Health
14 – General Article.

15 **[(4)] (5)** “Grandfathered health plan coverage” has the meaning stated in
16 45 C.F.R. § 147.140.

17 **[(5)] (6)** “Health benefit plan”:

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

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

22 **[(6)] (7)** “Managed care system” means a system of cost containment
23 methods that a carrier uses to review and preauthorize a treatment plan developed by a
24 health care provider for a covered individual in order to control utilization, quality, and
25 claims.

26 **[(7)] (8)** “Partial hospitalization” means the provision of medically
27 directed intensive or intermediate short–term treatment:

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

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

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

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

2 **[(8)] (9)** “Small employer” has the meaning stated in § 31–101 of this
3 article.

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

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

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

13 (2) partial hospitalization benefits; and

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

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

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

22 (ii) the treatment is medically necessary.

23 (2) The benefits required under this section:

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

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

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

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

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

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

9 (5) An insurer, nonprofit health service plan, or health maintenance
10 organization [may not charge a copayment for methadone maintenance treatment that is
11 greater than 50% of the daily cost for methadone maintenance treatment] **SHALL USE THE**
12 **ASAM CRITERIA FOR ALL MEDICAL NECESSITY AND UTILIZATION MANAGEMENT**
13 **DETERMINATIONS FOR SUBSTANCE USE DISORDER BENEFITS.**

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

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

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

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

22 (1) post a release of information authorization form on its [Web site]
23 **WEBSITE**; and

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

26 15-10A-02.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (e) Each carrier shall:

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

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

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

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

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

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

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

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

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

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

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

10 (v) includes the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 4. includes the following information:

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

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

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

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

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

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

17 (j) (1) For an emergency case under subsection (b)(2)(i) of this section, within
18 1 day after a decision has been orally communicated to the member, the member's
19 representative, or the health care provider, the carrier shall send notice in writing of any
20 adverse decision or grievance decision to:

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

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

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

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

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

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

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

6 (1) (1) Nothing in this subtitle prohibits a carrier from delegating its internal
7 grievance process to a private review agent that has a certificate issued under Subtitle 10B
8 of this title and is acting on behalf of the carrier.

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

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

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

15 15-10D-02.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 (i) The Commissioner shall:

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

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

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

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

6 SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in Section
7 3 of this Act, this Act shall take effect October 1, 2019.