HOUSE BILL 455

C3 0lr1454
CF SB 334

By: **Delegate Kelly**
Introduced and read first time: January 24, 2020
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria

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 certain 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 certain penalties; requiring that certain funds be deposited by the Commissioner into a certain fund; requiring the Commissioner, on or before a certain date, to develop certain forms and, in consultation with certain persons, adopt certain regulations; establishing the Parity Enforcement and Education Fund as a special, nonlapsing fund; specifying the purposes of the Fund; requiring the Commissioner to administer the Fund; requiring the State Treasurer to hold the Fund and the Comptroller to account for the Fund; specifying the contents of the Fund; specifying the purpose for which the Fund may be used; providing for the investment of money in and expenditures from the Fund; requiring the interest earnings of the Fund to be credited to the Fund; exempting the Fund from a certain provision of law requiring interest earnings on State money to accrue to the General Fund of the State; requiring certain carriers to include a certain statement in a certain notice of an adverse decision or grievance by a carrier; requiring certain carriers to include a certain statement in a certain notice of a coverage decision or an appeal decision by a carrier; defining certain terms; providing for a delayed effective date for certain provisions of this Act; providing for the

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

application of certain provisions of this Act; and generally relating to coverage for mental health benefits and substance use disorder benefits.

BY adding to
Article – Insurance
Section 15–144 and 15–145
Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, without amendments,
Article – State Finance and Procurement
Section 6–226(a)(2)(i)
Annotated Code of Maryland
(2015 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, with amendments,
Article – State Finance and Procurement
Section 6–226(a)(2)(ii)121. and 122.
Annotated Code of Maryland
(2015 Replacement Volume and 2019 Supplement)

BY adding to
Article – State Finance and Procurement
Section 6–226(a)(2)(ii)123.
Annotated Code of Maryland
(2015 Replacement Volume and 2019 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–10A–02 and 15–10D–02
Annotated Code of Maryland
(2017 Replacement Volume and 2019 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 THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

(II) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO OPERATE IN THE STATE;

(III) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO OPERATE IN THE STATE; OR

(IV) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

(3) "HEALTH BENEFIT PLAN" MEANS:

(I) FOR A LARGE GROUP OR BLANKET PLAN, A HEALTH BENEFIT PLAN AS DEFINED IN § 15–1401 OF THIS TITLE;

(II) FOR A SMALL GROUP PLAN, A HEALTH BENEFIT PLAN AS DEFINED IN § 15–1201 OF THIS TITLE;

(III) FOR AN INDIVIDUAL PLAN:

1. A HEALTH BENEFIT PLAN AS DEFINED IN § 15–1301(L) OF THIS TITLE; OR

2. AN INDIVIDUAL HEALTH BENEFIT PLAN AS DEFINED IN § 15–1301(O) OF THIS TITLE;

(IV) SHORT–TERM LIMITED DURATION INSURANCE AS DEFINED IN § 15–1301(S) OF THIS TITLE; OR

(V) A STUDENT HEALTH PLAN AS DEFINED IN § 15–1318(A) OF THIS TITLE.

(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" MEANS TREATMENT LIMITATIONS AS DEFINED 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 29 C.F.R. § 2590.712.

(8) "PARITY ACT CLASSIFICATION" MEANS:

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

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

(C) (1) ON OR BEFORE MARCH 1 EACH YEAR, BEGINNING IN 2021, EACH CARRIER SUBJECT TO THIS SECTION 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 PLACEMENT OF EACH BENEFIT 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 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;

(IV) LIST THE FACTORS CONSIDERED IN THE DESIGN OF EACH NONQUANTITATIVE TREATMENT LIMITATION LISTED UNDER ITEM (III) 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 DISORDER 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;

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

1. AN IDENTIFICATION OF EACH PROCESS, STRATEGY, OR EVIDENTIARY STANDARD USED TO DESIGN THE NONQUANTITATIVE TREATMENT LIMITATION; AND

2. AN EXPLANATION OF THE PROCESS AND FACTORS RELIED ON FOR ESTABLISHING ANY VARIATION IN THE APPLICATION OF A GUIDELINE OR STANDARD FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS;

(VI) INCLUDE A COMPARATIVE ANALYSIS THAT DEMONSTRATES THAT, AS WRITTEN, THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, AND ANY OTHER FACTORS USED TO DESIGN AND APPLY EACH NONQUANTITATIVE TREATMENT LIMITATION ARE COMPARABLE TO AND APPLIED NO MORE STRINGENTLY TO MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS THAN MEDICAL/SURGICAL BENEFITS, INCLUDING:

1. THE ANALYSIS, AUDIT, OR METHOD USED TO ASSESS COMPARABILITY AND NO–MORE–STRINGENT APPLICATION IN THE DESIGN AND APPLICATION OF EACH NONQUANTITIATIVE TREATMENT LIMITATION; AND

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

(VII) INCLUDE A COMPARATIVE ANALYSIS THAT DEMONSTRATES, FOR THE PLAN IN OPERATION, THAT THE PROCESSES, STRATEGIES, AND EVIDENTIARY STANDARDS USED TO IMPLEMENT EACH NONQUANTITATIVE TREATMENT LIMITATION ARE COMPARABLE TO THE PROCESSES, STRATEGIES, AND EVIDENTIARY STANDARDS USED TO IMPLEMENT EACH NONQUANTITATIVE TREATMENT LIMITATION TO MEDICAL/SURGICAL BENEFITS AND ARE 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 AND NO–MORE–STRINGENT APPLICATION IN THE IMPLEMENTATION OF EACH NONQUANTITATIVE TREATMENT LIMITATION;

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

3. THE NUMBER OF CLAIMS SUBMITTED IN THE IMMEDIATELY PRECEDING PLAN YEAR FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS BY CLASSIFICATION AND THE NUMBER AND RATE OF CLAIMS DENIED FOR EACH BENEFIT BY CLASSIFICATION; AND

(VIII) 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 A MEMBER'S REQUEST FOR GROUP PLAN INFORMATION AND FOR PURPOSES OF FILING AN INTERNAL COVERAGE OR GRIEVANCE MATTER 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 MARCH 1 EACH YEAR, BEGINNING IN 2021, EACH CARRIER SUBJECT TO THIS SECTION SHALL SUBMIT A REPORT TO THE COMMISSIONER ON THE CARRIER'S DATA FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR 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 §§ 15–802 AND 15–840 OF THIS TITLE, 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) RESIDENTIAL CRISIS 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 PERCENTAGE OF COVERED SERVICES AND PRESCRIPTION DRUGS SUBJECT TO EACH LEVEL OF REVIEW;

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

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

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

(V) THE NUMBER AND PERCENTAGE OF REQUESTED SERVICES DENIED BASED ON NONCOVERED SERVICE, MEDICAL NECESSITY CRITERIA, EXPERIMENTAL OR 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 REPORTED SEPARATELY FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS BY PARITY ACT CLASSIFICATION, INCLUDING:

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

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

(III) THE NUMBER AND PERCENTAGE OF DECISIONS THAT WERE APPEALED AND THE RESULT OF THE APPEALS; AND

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

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

(I) OUTPATIENT VISITS;

(II) OUTPATIENT FACILITY SERVICES;

(III) INPATIENT HOSPITALIZATION; AND

(IV) NONHOSPITAL RESIDENTIAL FACILITIES; AND

(6) DETAILS ON CLAIM REIMBURSEMENT, INCLUDING:

(I) ANNUAL CLAIM EXPENSES CALCULATED AS AN AVERAGE OF ALL MEMBER PAYMENTS FOR EACH MEMBER FOR EACH MONTH FOR MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS;

(II) THE AVERAGE PAYMENT RATE FOR PSYCHIATRISTS AND NONPSYCHIATRIST PHYSICIANS FOR EACH EVALUATION AND MANAGEMENT COMMON PROCEDURAL TECHNOLOGY CODE AND THE PERCENTAGE REDUCTIONS OR INCREASES IN RELATION TO THE MEDICARE FEE SCHEDULE FOR PSYCHIATRISTS AND NONPSYCHIATRIST PHYSICIANS FOR EACH CODE;

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

(IV) THE METHODOLOGY FOR DETERMINING THE ALLOWABLE AMOUNT FOR OUT–OF–NETWORK MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER 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 USE 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 MEMBER.

(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:

(I) AT LEAST $100 FOR EACH DAY FOR EACH MEMBER AND BENEFICIARY TO WHICH THE FAILURE TO COMPLY APPLIES AND FOR THE DURATION OF THE NONCOMPLIANCE PERIOD BEGINNING ON THE DATE THE PLAN IS ISSUED; AND

(II) $5,000 FOR EACH DAY FOR WHICH A CARRIER FAILS TO SUBMIT A COMPLETE REPORT REQUIRED UNDER SUBSECTION (C) OR (D) OF THIS SECTION.

(2) THE PENALTIES COLLECTED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE DEPOSITED BY THE COMMISSIONER INTO THE PARITY ENFORCEMENT AND EDUCATION FUND ESTABLISHED UNDER § 15–145 OF THIS SUBTITLE.

(H) ON OR BEFORE DECEMBER 31, 2020, THE COMMISSIONER SHALL CREATE:

(1) A STANDARD FORM FOR ENTITIES TO SUBMIT THE REPORTS IN ACCORDANCE WITH SUBSECTION (E)(1) OF THIS SECTION; AND

(2) 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, 2020, THE COMMISSIONER SHALL, IN CONSULTATION WITH INTERESTED STAKEHOLDERS, ADOPT REGULATIONS TO IMPLEMENT THIS SECTION TO ENSURE UNIFORM DEFINITIONS AND METHODOLOGY FOR DATA CALCULATIONS REQUIRED IN SUBSECTION (D) OF THIS SECTION AND OTHER REPORTING.

15–145.

(A) IN THIS SECTION, "FUND" MEANS THE PARITY ENFORCEMENT AND EDUCATION FUND.

(B) THERE IS A PARITY ENFORCEMENT AND EDUCATION FUND.

(C) THE PURPOSES OF THE FUND ARE TO PROVIDE FUNDING FOR THE ADMINISTRATION TO:

(1) SUPPORT ADMINISTRATIVE ACTIVITIES TO ENFORCE THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND STATE PARITY LAWS; AND

(2) CONDUCT OUTREACH AND EDUCATION ACTIVITIES TO INFORM CONSUMERS OF THEIR RIGHTS UNDER THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND STATE PARITY LAWS.

(D) THE COMMISSIONER SHALL ADMINISTER THE FUND.

(E) (1) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(2) THE STATE TREASURER SHALL HOLD THE FUND SEPARATELY, AND THE COMPTROLLER SHALL ACCOUNT FOR THE FUND.

(F) THE FUND CONSISTS OF:

(1) MONEY DEPOSITED INTO THE FUND UNDER § 15–144 OF THIS SUBTITLE;

(2) MONEY APPROPRIATED IN THE STATE BUDGET TO THE FUND;

(3) INTEREST EARNINGS; AND

(4) ANY OTHER MONEY FROM ANY OTHER SOURCE ACCEPTED FOR THE BENEFIT OF THE FUND.

(G) THE FUND MAY BE USED ONLY FOR:

(1) ADMINISTRATIVE ACTIVITIES TO ENFORCE THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND STATE PARITY LAWS; AND

(2) CONDUCTING OUTREACH AND EDUCATION ACTIVITIES RELATED TO THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND STATE PARITY LAWS.

(H) (1) THE STATE TREASURER SHALL INVEST THE MONEY OF THE FUND IN THE SAME MANNER AS OTHER STATE MONEY MAY BE INVESTED.

(2) ANY INTEREST EARNINGS OF THE FUND SHALL BE CREDITED TO THE FUND.

(I) EXPENDITURES FROM THE FUND MAY BE MADE ONLY IN ACCORDANCE WITH THE STATE BUDGET.

(J) THE FUND IS SUBJECT TO AUDIT BY THE OFFICE OF LEGISLATIVE AUDITS AS PROVIDED IN § 2–1220 OF THE STATE GOVERNMENT ARTICLE.

(K) THE MONEY IN THE FUND SHALL BE USED TO SUPPLEMENT, AND MAY NOT SUPPLANT, MONEY APPROPRIATED FOR THE PURPOSES DESCRIBED IN SUBSECTION (C) OF THIS SECTION.

Article – State Finance and Procurement

6–226.

(a) (2) (i) Notwithstanding any other provision of law, and unless inconsistent with a federal law, grant agreement, or other federal requirement or with the terms of a gift or settlement agreement, net interest on all State money allocated by the State Treasurer under this section to special funds or accounts, and otherwise entitled to receive interest earnings, as accounted for by the Comptroller, shall accrue to the General Fund of the State.

(ii) The provisions of subparagraph (i) of this paragraph do not apply to the following funds:

121. the Markell Hendricks Youth Crime Prevention and Diversion Parole Fund; **[**and**]**

122. the Federal Government Shutdown Employee Assistance Loan Fund**; AND**

123. THE PARITY ENFORCEMENT AND EDUCATION FUND.

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

Article – Insurance

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, THE FOLLOWING STATEMENT: "FEDERAL AND STATE PARITY LAWS GIVE YOU THE RIGHT TO RECEIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL AS PHYSICAL HEALTH BENEFITS. IF YOU THINK YOUR PLAN IS NOT COVERING MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL, YOU MAY FILE A COMPLAINT WITH THE MARYLAND INSURANCE ADMINISTRATION AND THE HEALTH ADVOCACY UNIT.".

(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 GRIEVANCE DECISION FOR MENTAL HEALTH BENEFITS OR SUBSTANCE USE DISORDER BENEFITS, THE FOLLOWING STATEMENT: "FEDERAL AND STATE PARITY LAWS GIVE YOU THE RIGHT TO RECEIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL AS PHYSICAL HEALTH BENEFITS. IF YOU THINK YOUR PLAN IS NOT COVERING MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL, YOU MAY FILE A COMPLAINT WITH THE MARYLAND INSURANCE ADMINISTRATION AND THE HEALTH ADVOCACY UNIT.".

(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, THE FOLLOWING STATEMENT: "FEDERAL AND STATE PARITY LAWS GIVE YOU THE RIGHT TO RECEIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL AS PHYSICAL HEALTH BENEFITS. IF YOU THINK YOUR PLAN IS NOT COVERING MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL, YOU MAY FILE A COMPLAINT WITH THE MARYLAND INSURANCE ADMINISTRATION AND THE HEALTH ADVOCACY UNIT.".

(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 AN APPEAL DECISION FOR MENTAL HEALTH BENEFITS OR SUBSTANCE USE DISORDER BENEFITS, THE FOLLOWING STATEMENT: "FEDERAL AND STATE PARITY LAWS GIVE YOU THE RIGHT TO RECEIVE MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL AS PHYSICAL HEALTH BENEFITS. IF YOU THINK YOUR PLAN IS NOT COVERING MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AT THE SAME LEVEL, YOU MAY FILE A COMPLAINT WITH THE MARYLAND INSURANCE ADMINISTRATION AND THE HEALTH ADVOCACY UNIT.".

(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, 2021, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2021.

SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in Section 3 of this Act, this Act shall take effect October 1, 2020.