129th MAINE LEGISLATURE

FIRST REGULAR SESSION-2019

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S.P. 559	In Senate, May 7, 2019

An Act To Amend the Mental Health Insurance Coverage Laws

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator GRATWICK of Penobscot.
Cosponsored by Representative SCHNECK of Bangor and
Senators: CARPENTER of Aroostook, CLAXTON of Androscoggin, DILL of Penobscot, MILLETT of Cumberland, ROSEN of Hancock.

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

Sec. 1. 24 MRSA §2325-A, sub-§8, as amended by PL 1995, c. 407, §3, is repealed and the following enacted in its place:

8. Reports to the superintendent. A nonprofit hospital and medical service organization shall submit annual reports in accordance with this subsection.

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

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

(1) A description of the process used to develop or select the medically necessary health care criteria for mental illness and substance use disorder benefits and the process used to develop or select the medically necessary health care criteria for medical and surgical benefits;

(2) Identification of all nonquantitative treatment limitations that are applied to mental illness and substance use disorder benefits and medical and surgical benefits within each classification of benefits. The report must include information demonstrating that each nonquantitative treatment limitation that applies to mental illness and substance use disorder benefits also applies to medical and surgical benefits within any classification of benefits; and

(3) The results of an analysis that demonstrate that for the medically necessary health care criteria described in subparagraph (1) and for each nonquantitative treatment limitation identified in subparagraph (2), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to mental illness and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits. At a minimum, the results of the analysis must:

(a) Identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(b) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(c) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental illness and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(d) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental illness and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(e) Disclose the specific findings and conclusions reached by the nonprofit hospital or medical service organization that the results of the analyses in this subparagraph indicate that the nonprofit hospital or medical service organization is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which include 45 Code of Federal Regulations, Sections 146.136, 147.160 and 156.115(a)(3).

For the purposes of this paragraph, "nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment.

Sec. 2. 24 MRSA §2325-D is enacted to read:

§2325-D. Prescription drug benefits for substance use disorder treatment

A nonprofit hospital or medical service organization that issues group health care contracts that provide prescription drug benefits for the treatment of substance use disorder:

1. Prior authorization requirements. May not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder;

2. Step therapy requirements. May not impose any step therapy requirements before the nonprofit hospital or medical service organization authorizes coverage for a prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder;

3. Drug formulary. Shall place all prescription medications approved by the federal Food and Drug Administration for the treatment of substance use disorder on the lowest

tier of the drug formulary developed and maintained by the nonprofit hospital or medical service organization; and

4. Court-ordered medication. May not exclude coverage for any prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder or any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Sec. 3. 24-A MRSA §238 is enacted to read:

§238. Implementation of federal mental health parity laws

1. Implementation of federal mental health parity laws. The superintendent shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any amendments to and federal guidance or regulations relevant to that Act, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3), by:

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

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

C. Performing parity compliance market conduct examinations of insurers, health maintenance organizations and nonprofit hospital or medical service organizations that execute, deliver, issue for delivery, continue or renew individual policies or individual and group health care contracts, particularly market conduct examinations that focus on nonquantitative treatment limitations, including, but not limited to, prior authorization, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates and geographic restrictions; and

D. Requesting that insurers, health maintenance organizations and nonprofit hospital or medical service organizations submit comparative analyses during the form review process demonstrating how they design and apply nonquantitative treatment limitation, both as written and in operation, for mental illness and substance use disorder benefits as compared to how they design and apply nonquantitative treatment limitation, as written and in operation, for medical and surgical benefits.

The superintendent may adopt rules, as authorized under section 212, as may be necessary to effectuate any provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

2. Report. No later than March 1, 2020 and periodically thereafter, the superintendent shall provide a report and educational presentation to the Legislature. The report must:

A. Cover the methodology the superintendent is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any federal regulations or guidance relating to the compliance and oversight of that Act;

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

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

D. Detail any educational or corrective actions the superintendent has taken to ensure insurer compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and sections 2749-C, 2842, 2843 and 4234-A and Title 24, sections 2325-A and 2329; and

E. Be written in nontechnical, understandable language and made available to the public by posting the report on the bureau's publicly accessible website and other means the superintendent finds appropriate.

Sec. 4. 24-A MRSA §2749-C, sub-§4, as enacted by PL 1995, c. 407, §5, is repealed and the following enacted in its place:

4. Reports to the superintendent. An insurer shall submit annual reports in accordance with this subsection.

A. An insurer subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services, as those terms are defined in section 2843. The superintendent shall compile this data for all insurers in an annual report.

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

(1) A description of the process used to develop or select the medically necessary health care criteria for mental illness and substance use disorder benefits and the process used to develop or select the medically necessary health care criteria for medical and surgical benefits;

(2) Identification of all nonquantitative treatment limitations that are applied to mental illness and substance use disorder benefits and medical and surgical benefits within each classification of benefits. The report must include information demonstrating that each nonquantitative treatment limitation that applies to mental illness and substance use disorder benefits also applies to medical and surgical benefits within any classification of benefits; and

(3) The results of an analysis that demonstrate that for the medically necessary health care criteria described in subparagraph (1) and for each nonquantitative treatment limitation identified in subparagraph (2), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to mental illness and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits. At a minimum, the results of the analysis must:

(a) Identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(b) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(c) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental illness and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(d) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental illness and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(e) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses in this subparagraph indicate that the insurer is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which include 45 Code of Federal Regulations, Sections 146.136, 147.160 and 156.115(a)(3).

For the purposes of this paragraph, "nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment.

Sec. 5. 24-A MRSA §2749-D is enacted to read:

§2749-D. Prescription drug benefits for substance use disorder treatment

An insurer that executes, delivers, issues for delivery, continues or renews individual health care policies that provide prescription drug benefits for the treatment of substance use disorder:

1. Prior authorization requirements. May not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder;

2. Step therapy requirements. May not impose any step therapy requirements before the insurer authorizes coverage for a prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder;

3. Drug formulary. Shall place all prescription medications approved by the federal Food and Drug Administration for the treatment of substance use disorder on the lowest tier of the drug formulary developed and maintained by the insurer; and

4. Court-ordered medication. May not exclude coverage for any prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder or any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Sec. 6. 24-A MRSA §2843, sub-§7, as amended by PL 1995, c. 407, §8, is repealed and the following enacted in its place:

7. Reports to the superintendent. An insurer shall submit annual reports in accordance with this subsection.

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

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

(1) A description of the process used to develop or select the medically necessary health care criteria for mental illness and substance use disorder benefits and the process used to develop or select the medically necessary health care criteria for medical and surgical benefits;

(2) Identification of all nonquantitative treatment limitations that are applied to mental illness and substance use disorder benefits and medical and surgical benefits within each classification of benefits. The report must include information demonstrating that each nonquantitative treatment limitation that applies to mental illness and substance use disorder benefits also applies to medical and surgical benefits within any classification of benefits; and

(3) The results of an analysis that demonstrate that for the medically necessary health care criteria described in subparagraph (1) and for each nonquantitative treatment limitation identified in subparagraph (2), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to mental illness and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits. At a minimum, the results of the analysis must:

(a) Identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(b) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(c) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental illness and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(d) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental illness and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(e) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses in this subparagraph indicate that the insurer is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which include 45 Code of Federal Regulations, Sections 146.136, 147.160 and 156.115(a)(3).

For the purposes of this paragraph, "nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment.

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

1 **§2847-V. Prescription drug benefits for substance use disorder treatment**

2 An insurer that issues group health care contracts that provide prescription drug
3 benefits for the treatment of substance use disorder:

4 **1. Prior authorization requirements.** May not impose any prior authorization
5 requirements on any prescription medication approved by the federal Food and Drug
6 Administration for the treatment of substance use disorder;

7 **2. Step therapy requirements.** May not impose any step therapy requirements
8 before the insurer authorizes coverage for a prescription medication approved by the
9 federal Food and Drug Administration for the treatment of substance use disorder;

10 **3. Drug formulary.** Shall place all prescription medications approved by the federal
11 Food and Drug Administration for the treatment of substance use disorder on the lowest
12 tier of the drug formulary developed and maintained by the insurer; and

13 **4. Court-ordered medication.** May not exclude coverage for any prescription
14 medication approved by the federal Food and Drug Administration for the treatment of
15 substance use disorder or any associated counseling or wraparound services on the
16 grounds that such medications and services were court ordered.

17 **Sec. 8. 24-A MRSA §4234-A, sub-§10,** as enacted by PL 1995, c. 407, §10, is
18 repealed and the following enacted in its place:

19 **10. Reports to the superintendent.** A health maintenance organization shall submit
20 annual reports in accordance with this subsection.

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

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

32 (1) A description of the process used to develop or select the medically
33 necessary health care criteria for mental illness and substance use disorder
34 benefits and the process used to develop or select the medically necessary health
35 care criteria for medical and surgical benefits;

36 (2) Identification of all nonquantitative treatment limitations that are applied to
37 mental illness and substance use disorder benefits and medical and surgical
38 benefits within each classification of benefits. The report must include
39 information demonstrating that each nonquantitative treatment limitation that

applies to mental illness and substance use disorder benefits also applies to medical and surgical benefits within any classification of benefits; and

(3) The results of an analysis that demonstrate that for the medically necessary health care criteria described in subparagraph (1) and for each nonquantitative treatment limitation identified in subparagraph (2), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to mental illness and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits. At a minimum, the results of the analysis must:

(a) Identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(b) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(c) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental illness and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(d) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental illness and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(e) Disclose the specific findings and conclusions reached by the health maintenance organization that the results of the analyses in this subparagraph indicate that the health maintenance organization is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which include 45 Code of Federal Regulations, Sections 146.136, 147.160 and 156.115(a)(3).

For the purposes of this paragraph, "nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment.

Sec. 9. 24-A MRSA §4234-F is enacted to read:

§4234-F. Prescription drug benefits for substance use disorder treatment

A health maintenance organization that executes, delivers, issues for delivery, continues or renews individual and group health care contracts that provide prescription drug benefits for the treatment of substance use disorder:

1. Prior authorization requirements. May not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder;

2. Step therapy requirements. May not impose any step therapy requirements before the health maintenance organization authorizes coverage for a prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder;

3. Drug formulary. Shall place all prescription medications approved by the federal Food and Drug Administration for the treatment of substance use disorder on the lowest tier of the drug formulary developed and maintained by the health maintenance organization; and

4. Court-ordered medication. May not exclude coverage for any prescription medication approved by the federal Food and Drug Administration for the treatment of substance use disorder or any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

Sec. 10. Application. The requirements of this Act apply to all insurers, health maintenance organizations and nonprofit hospital or medical service organizations that execute, deliver, issue for delivery, continue or renew individual and group health care policies, contracts and certificates in this State on or after January 1, 2020.

SUMMARY

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