HOUSE BILL 1085

J5, J1 EMERGENCY BILL 4lr1807
CF 4lr1810

By: **Delegate Cullison**
Introduced and read first time: February 7, 2024
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Maryland Insurance Administration – Mental Health Parity and Addiction Equity Reporting Requirements – Revisions and Sunset Repeal

FOR the purpose of altering certain reporting requirements on health insurance carriers relating to compliance with the federal Mental Health Parity and Addiction Equity Act; altering requirements for certain analyses of nonquantitative treatment limitations required of health insurance carriers; establishing certain remedies the Maryland Insurance Commissioner may use to enforce compliance with the reporting requirements; repealing the requirement that the Commissioner use a certain form for the reporting requirements; repealing the termination date for the reporting requirements; and generally relating to health insurance carriers and mental health parity and addiction equity reporting.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–144
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing
Chapter 211 of the Acts of the General Assembly of 2020
Section 2 and 3

BY repealing and reenacting, with amendments,
Chapter 211 of the Acts of the General Assembly of 2020
Section 4

BY repealing
Chapter 212 of the Acts of the General Assembly of 2020
Section 2 and 3

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

BY repealing and reenacting, with amendments,
Chapter 212 of the Acts of the General Assembly of 2020
Section 4

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**, AS AMENDED,** and **ITS IMPLEMENTING REGULATIONS, INCLUDING** 45 C.F.R. § 146.136 and 29 C.F.R. § 2590.712 **AND ANY OTHER RELATED REGULATIONS FOUND IN THE CODE OF FEDERAL REGULATIONS**.

(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) "PRODUCT" HAS THE MEANING STATED IN § 15–1309(A)(3) OF THIS TITLE.

[(9)**] (10)** "Substance use disorder benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(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, 2022, and March 1, 2024**] JULY 1, 2024, AND EVERY 2 YEARS THEREAFTER**, each carrier subject to this section shall**[**:

(i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and

(ii)**]** submit a report to the Commissioner **ON PRODUCTS IDENTIFIED BY THE COMMISSIONER** to demonstrate the carrier's compliance with the Parity Act.

(2) The report submitted under paragraph (1) of this subsection shall include **[**the following information for the health benefit plans identified under item (1)(i) of this subsection:

(i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(ii) for each Parity Act classification, identification of nonquantitative treatment limitations that are applied to mental health benefits and substance use disorder benefits and medical and surgical benefits;

(iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in documents and instruments under which the plan is established or operated; and

(iv)**]** the results of **[**the**]** **A** comparative analysis **[**as described under subsections (d) and (e) of this section**]** **CONDUCTED BY EACH CARRIER ON NOT LESS THAN FOUR NONQUANTITATIVE TREATMENT LIMITATIONS SELECTED BY THE COMMISSIONER IN ACCORDANCE WITH PARAGRAPH (3) OF THIS SUBSECTION**.

(3) IN SELECTING THE NONQUANTITATIVE TREATMENT LIMITATIONS REQUIRED TO BE INCLUDED IN EACH REPORTING PERIOD, THE COMMISSIONER:

(I) SHALL PRIORITIZE THE NONQUANTITATIVE TREATMENT LIMITATIONS IDENTIFIED BY THE COMMISSIONER AS HAVING THE GREATEST IMPACT ON PATIENT ACCESS TO CARE; AND

(II) MAY TAKE INTO CONSIDERATION OTHER FACTORS DETERMINED RELEVANT BY THE COMMISSIONER, INCLUDING COMPLAINT TRENDS AND WHETHER THE NONQUANTITATIVE TREATMENT LIMITATION WAS SELECTED FOR A PREVIOUS REPORTING YEAR.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations identified under subsection **[**(c)(2)(ii)**]** **(C)(2)** of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations identified under subsection **[**(c)(2)(ii)**]** **(C)(2)** of this section shall demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying **[**the medical necessity criteria and**]** each **SELECTED** nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying **[**the medical necessity criteria and**]** each **SELECTED** nonquantitative treatment limitation to medical and surgical benefits within the same Parity Act classification.

(3) REGARDLESS OF WHETHER IT WAS USED BEFORE THE PARITY ACT WAS ENACTED, A CARRIER SHALL PERFORM AND PROVIDE A COMPARATIVE ANALYSIS FOR EACH PROCESS, STRATEGY, EVIDENTIARY STANDARD OR OTHER FACTOR USED IN APPLYING A SELECTED NONQUANTITATIVE TREATMENT LIMITATION USED DURING A REPORTING PERIOD AND REQUESTED BY THE COMMISSIONER.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors;

(ii) the factors that were considered but rejected; and

(iii) if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(3) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection **[**(c)(2)(ii)**]** **(C)(2) AND (3)** of this section to conduct the analysis required under subsection (d)(2) of this section for the **[**plans**]** **PRODUCTS** as written;

(4) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection **[**(c)(2)(ii)**]** **(C)(2) AND (3)** of this section to conduct the analysis required under subsection (d)(2) of this section for the **[**plans**]** **PRODUCTS** as in operation;

(5) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

(6) disclose the specific findings and conclusions reached by the carrier that indicate that the **[**health benefit plan**]** **PRODUCT** is in compliance with this section and the Parity Act **[**and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations**]**; and

(7) 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:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

(iii) 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.

[(f) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall submit a report for the health benefit plans identified under subsection (c)(1)(i) of this section to the Commissioner on the following data for the immediately preceding calendar year for mental health benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification:

(1) the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year; and

(2) the number of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year and the number and rates of, and reasons for, denial of claims.**]**

(F) THE COMMISSIONER MAY DEVELOP AND REQUIRE ADDITIONAL STANDARDIZED DATA SUBMISSIONS TO EVALUATE A COMPARATIVE ANALYSIS OF NONQUANTITATIVE TREATMENT LIMITATIONS.

(g) The reports required under **[**subsections (c) and (f) of**]** this section shall:

(1) be submitted on a standard form **THAT IS** developed by the Commissioner **IN ACCORDANCE WITH CURRENT BEST PRACTICES**;

(2) be submitted by the carrier that issues or delivers the **[**health benefit plan**]** **PRODUCT**;

(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 a corporate officer, attesting to the accuracy of the information contained in the report;

(5) be available to plan members and the public on the carrier's website in a summary form that removes confidential or proprietary information and is developed by the Commissioner **[**in accordance with subsection (m)(2) of this section**]**; and

(6) exclude any identifying information of any plan member.

(h) (1) A carrier submitting a report under **[**subsections (c) and (f) of**]** this section may submit a written request to the Commissioner that disclosure of specific information included in the report be denied under the Public Information Act and, if submitting a request, shall:

(i) identify the particular information the disclosure of which the carrier requests be denied; and

(ii) cite the statutory authority under the Public Information Act that authorizes denial of access to the information.

(2) The Commissioner may review a request submitted under paragraph (1) of this subsection on receipt of a request for access to the information under the Public Information Act.

(3) The Commissioner may notify the carrier that submitted the request under paragraph (1) of this subsection before granting access to information that was the subject of the request.

(4) A carrier shall disclose to a member on request any plan information contained in a report that is required to be disclosed to that member under federal or State law.

(i) The Commissioner shall:

(1) review each report submitted in accordance with **[**subsections (c) and (f) of**]** this section to assess each carrier's compliance with the Parity Act;

(2) notify a carrier in writing of any noncompliance with the Parity Act before issuing an administrative order; and

(3) within 90 days after the notice of noncompliance is issued, allow the carrier to:

(i) submit a compliance plan to the Administration to comply with the Parity Act; and

(ii) reprocess any claims that were improperly denied, in whole or in part, because of the noncompliance.

(j) **(1)** If the Commissioner finds that the carrier failed to submit a complete report required under **[**subsection (c) or (f) of**]** this section, the Commissioner may**:**

(I) TAKE ACTION AUTHORIZED UNDER PARAGRAPH (2) OF THIS SUBSECTION;

(II) CHARGE THE CARRIER, IN ACCORDANCE WITH § 2–208 OF THIS ARTICLE, FOR ANY ADDITIONAL EXPENSES INCURRED BY THE COMMISSIONER AFTER THE COMMISSIONER DETERMINES THE INITIALLY SUBMITTED REPORT WAS INCOMPLETE; OR

(III) impose any penalty or take any action as authorized:

[(1)**]** **1.** for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

[(2)**]** **2.** for a health maintenance organization, under this article or the Health – General Article.

(2) IF THE COMMISSIONER CANNOT MAKE A DETERMINATION THAT A SPECIFIC CONDUCT OR PRACTICE IS COMPLIANT WITH THE PARITY ACT BECAUSE THE CARRIER FAILED TO PROVIDE A SUFFICIENT COMPARATIVE ANALYSIS FOR A NONQUANTITATIVE TREATMENT LIMITATION, THE COMMISSIONER MAY:

(I) ISSUE AN ADMINISTRATIVE ORDER REQUIRING THE CARRIER OR AN ENTITY DELEGATED BY THE CARRIER TO TAKE THE FOLLOWING ACTION UNTIL THE COMMISSIONER CAN MAKE A DETERMINATION OF COMPLIANCE WITH THE PARITY ACT:

1. MODIFY THE CONDUCT OR PRACTICE AS SPECIFIED BY THE COMMISSIONER;

2. CEASE THE CONDUCT OR PRACTICE; OR

3. SUBMIT PERIODIC DATA RELATED TO THE CONDUCT OR PRACTICE; OR

(II) SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, REQUIRE THE CARRIER TO PERFORM A NEW COMPARATIVE ANALYSIS.

(3) THE COMMISSIONER MAY REQUIRE THE CARRIER TO ESTABLISH SPECIFIC QUANTITATIVE THRESHOLDS FOR EVIDENTIARY STANDARDS AND CONDUCT A NEW COMPARATIVE ANALYSIS FOR A NONQUANTITATIVE TREATMENT LIMITATION IF THE COMMISSIONER DETERMINES A CARRIER FAILED TO PROVIDE A SUFFICIENT COMPARATIVE ANALYSIS BECAUSE THE CARRIER DID NOT:

(I) USE APPLICABLE QUANTITATIVE THRESHOLDS FOR THE EVIDENTIARY STANDARD; OR

(II) PROVIDE A SPECIFIC, DETAILED, AND REASONED EXPLANATION OF HOW THE CARRIER ENSURES THE FACTORS FOR THE NONQUANTITATIVE TREATMENT LIMITATION ARE BEING APPLIED COMPARABLY AND NO MORE STRINGENTLY TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

(k) If, as a result of the review required under subsection (i)(1) of this section, the Commissioner finds that the carrier failed to comply with the provisions of the Parity Act, and did not submit a compliance plan to adequately correct the noncompliance, the Commissioner may:

(1) issue an administrative order that requires:

(i) the carrier or an entity delegated by the carrier to cease the noncompliant conduct or practice; or

(ii) the carrier to provide a payment that has been denied improperly because of the noncompliance; or

(2) impose any penalty or take any action as authorized:

(i) for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

(ii) for a health maintenance organization, under this article or the Health – General Article.

(l) In determining an appropriate penalty under subsection (j) or (k) of this section, the Commissioner shall consider the late filing of a report required under

[subsection (c) or (f) of**]** this section and any parity violation to be a serious violation with a significantly deleterious effect on the public.

[(m) On or before December 31, 2021, the Commissioner shall create:

(1) a standard form for entities to submit the reports in accordance with subsection (g)(1) of this section; and

(2) a summary form for entities to post to their websites in accordance with subsection (g)(5) of this section.**]**

(M) ON OR BEFORE JANUARY 1, 2026, AND EVERY 2 YEARS THEREAFTER, THE COMMISSIONER SHALL SUBMIT A REPORT TO THE GENERAL ASSEMBLY, IN ACCORDANCE WITH § 2–1257 OF THE STATE GOVERNMENT ARTICLE, THAT:

(1) SUMMARIZES THE FINDINGS OF THE COMMISSIONER AFTER REVIEWING THE REPORTS REQUIRED UNDER THIS SECTION; AND

(2) MAKES SPECIFIC RECOMMENDATIONS REGARDING:

(I) THE INFORMATION GAINED FROM THE REPORTS;

(II) THE VALUE OF AND NEED FOR ONGOING COMPLIANCE AND DATA REPORTING;

(III) THE FREQUENCY OF REPORTING IN SUBSEQUENT YEARS AND WHETHER TO REPORT ON AN ANNUAL OR BIENNIAL BASIS; AND

(IV) BASED ON THE CARRIER REPORTS AND OTHER GUIDANCE FROM FEDERAL REGULATORS AND OTHER STATES, ANY CHANGES IN THE REPORTING AND DATA REQUIREMENTS THAT SHOULD BE IMPLEMENTED IN SUBSEQUENT YEARS, INCLUDING FREQUENCY AND CONTENT AND WHETHER ADDITIONAL NONQUANTITATIVE TREATMENT LIMITATIONS SHOULD BE INCLUDED IN THE REPORTING AND DATA REQUIREMENTS.

(n) **[**On or before December 31, 2021, the**]** **THE** Commissioner shall, in consultation with interested stakeholders, adopt regulations to implement this section, including to ensure uniform definitions and methodology for the reporting requirements established under this section.

Chapter 211 of the Acts of 2020

[SECTION 2. AND BE IT FURTHER ENACTED, That the standard form the Maryland Insurance Commissioner is required to develop under § 15–144(m)(1) of the Insurance Article, as enacted by Section 1 of this Act, for the report required under §

15–144(c) of the Insurance Article, as enacted by Section 1 of this Act, shall be the National Association of Insurance Commissioners' Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations and any amendments by the Commissioner to the tool necessary to incorporate the requirements of § 15–144(c), (d), and (e) of the Insurance Article, as enacted by Section 1 of this Act.**]**

[SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Insurance Commissioner shall submit to the General Assembly an interim report on or before December 1, 2023, and a final report on or before December 1, 2025, in accordance with § 2–1257 of the State Government Article, that:

(1) summarize the findings of the Commissioner after reviewing the reports required under Section 1 of this Act; and

(2) make specific recommendations regarding:

(i) the information gained from the reports;

(ii) the value of and need for ongoing compliance and data reporting;

(iii) the frequency of reporting in subsequent years and whether to report on an annual or biennial basis; and

(iv) based on the carrier reports and other guidance from federal regulators and other states, any changes in the reporting and data requirements that should be implemented in subsequent years, including frequency and content and whether additional nonquantitative treatment limitations should be included in the reporting and data requirements.**]**

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020. **[**It shall remain in effect for a period of 6 years and, at the end of September 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.**]**

Chapter 212 of the Acts of 2020

[SECTION 2. AND BE IT FURTHER ENACTED, That the standard form the Maryland Insurance Commissioner is required to develop under § 15–144(m)(1) of the Insurance Article, as enacted by Section 1 of this Act, for the report required under § 15–144(c) of the Insurance Article, as enacted by Section 1 of this Act, shall be the National Association of Insurance Commissioners' Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations and any amendments by the Commissioner to the tool necessary to incorporate the requirements of § 15–144(c), (d), and (e) of the Insurance Article, as enacted by Section 1 of this Act.**]**

[SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Insurance Commissioner shall submit to the General Assembly an interim report on or before December 1, 2023, and a final report on or before December 1, 2025, in accordance with § 2–1257 of the State Government Article, that:

(1) summarize the findings of the Commissioner after reviewing the reports required under Section 1 of this Act; and

(2) make specific recommendations regarding:

(i) the information gained from the reports;

(ii) the value of and need for ongoing compliance and data reporting;

(iii) the frequency of reporting in subsequent years and whether to report on an annual or biennial basis; and

(iv) based on the carrier reports and other guidance from federal regulators and other states, any changes in the reporting and data requirements that should be implemented in subsequent years, including frequency and content and whether additional nonquantitative treatment limitations should be included in the reporting and data requirements.**]**

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020. **[**It shall remain in effect for a period of 6 years and, at the end of September 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.