SENATE BILL 430

J1 5lr1586
CF 5lr2686

By: **Senator Klausmeier**
Introduced and read first time: February 6, 2015
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Maryland Medical Assistance Program – Mental Health and Substance Use Disorder Benefits – Parity

FOR the purpose of providing that certain provisions of law apply to mental health and substance use disorder benefits provided by the Maryland Medical Assistance Program or administered by an administrative services organization; requiring the Department of Health and Mental Hygiene to use certain standards in determining compliance with a certain provision of law; requiring the Department to use certain criteria in determining medical necessity for substance use disorder services; and generally relating to the Maryland Medical Assistance Program and mental health and substance use disorder benefits.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 15–103(a)(1)
Annotated Code of Maryland
(2009 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–103(b)(21) and (22)
Annotated Code of Maryland
(2009 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–802
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

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

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

Article – Health – General

15–103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(b) (21) (i) The Department shall establish a delivery system for specialty mental health services for enrollees of managed care organizations.

(ii) The Behavioral Health Administration shall:

1. Design and monitor the delivery system;

2. Establish performance standards for providers in the delivery system; and

3. Establish procedures to ensure appropriate and timely referrals from managed care organizations to the delivery system that include:

A. Specification of the diagnoses and conditions eligible for referral to the delivery system;

B. Training and clinical guidance in appropriate use of the delivery system for managed care organization primary care providers;

C. Preauthorization by the utilization review agent of the delivery system; and

D. Penalties for a pattern of improper referrals.

(iii) The Department shall collaborate with managed care organizations to develop standards and guidelines for the provision of specialty mental health services.

(iv) The delivery system shall:

1. Provide all specialty mental health services needed by enrollees;

2. For enrollees who are dually diagnosed, coordinate the provision of substance abuse services provided by the managed care organizations of the enrollees;

3. Consist of a network of qualified mental health professionals from all core disciplines;

4. Include linkages with other public service systems; and

5. Comply with quality assurance, enrollee input, data collection, and other requirements specified by the Department in regulation.

(v) The Department may contract with a managed care organization for delivery of specialty mental health services if the managed care organization meets the performance standards adopted by the Department in regulations.

(vi) The provisions of § 15–1005 of the Insurance Article apply to the delivery system for specialty mental health services established under this paragraph and administered by an administrative services organization.

(VII) 1. THE PROVISIONS OF § 15–802 OF THE INSURANCE ARTICLE APPLY TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS PROVIDED BY THE PROGRAM OR ADMINISTERED BY AN ADMINISTRATIVE SERVICES ORGANIZATION.

2. THE DEPARTMENT SHALL USE THE STANDARDS USED TO DETERMINE COMPLIANCE WITH THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT IN DETERMINING COMPLIANCE WITH THIS SUBPARAGRAPH.

(22) **(I)** The Department shall include a definition of medical necessity in its quality and access standards.

(II) THE DEPARTMENT SHALL USE THE AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA IN DETERMINING MEDICAL NECESSITY FOR SUBSTANCE USE DISORDER SERVICES.

Article – Insurance

15–802.

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

(2) "Alcohol abuse" has the meaning stated in § 8–101 of the Health – General Article.

(3) "Drug abuse" has the meaning stated in § 8–101 of the Health – General Article.

(4) "Health benefit plan" has the meaning stated in § 15–1401 of this title.

(5) "Large employer" means an employer that has more than 50 employees and is not a small employer.

(6) "Managed care system" means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.

(7) "Partial hospitalization" means the provision of medically directed intensive or intermediate short–term treatment:

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

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

(iii) for mental illness, emotional disorders, drug abuse, or alcohol abuse; and

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

(8) "Small employer" means an employer that:

(i) employed an average of at least two, but not more than 50 employees on business days during the preceding calendar year; and

(ii) employs at least two employees on the first day of the plan year.

(b) This section applies to each health insurance policy or contract that is delivered or issued for delivery in the State to an employer or individual on a group or individual basis and that provides coverage on an expense–incurred basis.

(c) A policy or contract subject to this section may not discriminate against an individual with a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses.

(d) It is not discriminatory under subsection (c) of this section if at least the following benefits are provided:

(1) with respect to inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient benefits, the total number of days for which benefits are payable and the terms and conditions that apply to those benefits are at least equal to those that apply to the benefits available under the policy or contract for physical illnesses;

(2) except as provided in item (3) of this subsection and subject to subsection (g) of this section, with respect to benefits for partial hospitalization, at least 60 days of partial hospitalization are covered under the same terms and conditions that apply to the benefits available under the policy or contract for physical illnesses;

(3) for group contracts covering employees of one or more large employers, with respect to benefits for partial hospitalization for the treatment of mental illness, emotional disorders, drug abuse, and alcohol abuse, the greater of:

(i) the same benefits payable under the contract for partial hospitalization for physical illness; or

(ii) at least 60 days of partial hospitalization covered under the same terms and conditions that apply to outpatient treatment of physical illnesses;

(4) except as provided in item (5) of this subsection, with respect to outpatient coverage, other than for inpatient or partial hospitalization services, benefits for covered expenses arising from services, including psychological and neuropsychological testing for diagnostic purposes, provided to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse are at a rate that, after the applicable deductible, is not less than:

(i) 80% for the first five visits in a calendar year or benefit period of not more than 12 months;

(ii) 65% for the 6th through 30th visit in a calendar year or benefit period of not more than 12 months; and

(iii) 50% for the 31st visit and any subsequent visit in a calendar year or benefit period of not more than 12 months; and

(5) for group contracts covering employees of one or more large employers, benefits for covered outpatient expenses arising from services, including all office visits and psychological and neuropsychological testing for diagnostic purposes, provided to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse are covered under the same terms and conditions that apply to similar benefits available under the contract for physical illnesses.

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

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

(ii) the treatment is medically necessary.

(2) The benefits required under this section:

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

(ii) shall have the same terms and conditions as the benefits for physical illnesses covered under the policy or contract subject to this section, except as specifically provided in this section; and

(iii) subject to paragraph (3) of this subsection, may be delivered under a managed care system.

(3) For group contracts covering employees of one or more large employers, the benefits required under this section may be delivered under a managed care system only if the benefits for physical illnesses covered under the contract are delivered under a managed care system.

(4) For group contracts covering employees of one or more large employers, the processes, strategies, evidentiary standards, or other factors used to manage the benefits required under this section must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the contract.

(5) Except for the coinsurance requirements under subsection (d)(4) of this section, a policy or contract subject to this section may not have:

(i) separate lifetime maximums for physical illnesses and illnesses covered under this section;

(ii) separate deductibles and coinsurance amounts for physical illnesses and illnesses covered under this section; or

(iii) separate out–of–pocket limits in a benefit period of not more than 12 months for physical illnesses and illnesses covered under this section.

(6) (i) Subject to subparagraph (ii) of this paragraph, any copayments required under a policy or contract subject to this section for benefits for illnesses covered under this section shall be:

1. actuarially equivalent to any coinsurance requirements under this section; or

2. if there are no coinsurance requirements, not greater than any copayment required under the policy or contract for a benefit for a physical illness.

(ii) An insurer or nonprofit health service plan may not charge a copayment that is greater than 50% of the daily cost for methadone maintenance treatment.

(f) An office visit to a physician or other health care provider for medication management:

(1) may not be counted against the number of visits required to be covered as a part of the benefits required under subsection (d)(4) of this section; and

(2) shall be reimbursed under the same terms and conditions as an office visit for a physical illness covered under the policy or contract subject to this section.

(g) This section does not prohibit exceeding the minimum benefits required under subsection (d)(2) or (3) of this section for any partial hospitalization day that is medically necessary and would serve to prevent inpatient hospitalization.

(h) An entity that issues or delivers a policy or contract subject to this section shall provide on its Web site and annually in print to its insureds:

(1) notice about the benefits required under this section and, if applicable to the policy or contract of the insured, the federal Mental Health Parity and Addiction Equity Act; and

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

(i) An entity that issues or delivers a policy or contract subject to this section shall:

(1) post a release of information authorization form on its Web site; and

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

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2015.