

House Bill 49

By: Representatives Hutchinson of the 107th, Smyre of the 135th, Wilson of the 80th, Clark of the 108th, Schofield of the 60th, and others

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to
2 insurance generally, so as to require that insurer treatment of claims concerning mental and
3 substance use disorders are treated in parity with other health insurance claims; to amend
4 Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to public assistance,
5 so as to require that care management organization treatment of claims concerning mental
6 and substance use disorders are treated in parity with other Medicaid claims; to ensure that
7 insurers and care management organizations comply with certain federal law; to provide for
8 reporting; to provide for enforcement; to provide for definitions; to prohibit certain actions;
9 to provide for applicability; to provide for legislative findings; to provide for a short title; to
10 provide for related matters; to repeal conflicting laws; and for other purposes.

11 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

PART I

SECTION 1-1.

14 The General Assembly finds that:

15 (1) A growing number of Georgians suffer from mental health related disorders and
16 substance use disorders; and

17 (2) There is a significant need for greater parity of treatment of such disorders with other
18 health insurance needs.

SECTION 1-2.

20 This Act shall be known and may be cited as the "Mental Health Parity Act."

SECTION 1-3.

22 Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance
23 generally, is amended by adding a new article to read as follows:

"ARTICLE 5

25 33-24-100.

26 As used in this article, the term:

27 (1) 'FDA' means the United States Food and Drug Administration.

28 (2) 'Healthcare plan' or 'plan' means any hospital or medical insurance policy or
29 certificate, healthcare plan contract or certificate, qualified higher deductible health plan,
30 health maintenance organization or other managed care subscriber contract, or state
31 healthcare plan. This term shall not include limited benefit insurance policies or plans
32 listed under paragraph (3) of Code Section 33-1-2, air ambulance insurance, or policies
33 issued in accordance with Chapter 21A or 31 of this title or Chapter 9 of Title 34, relating

34 to workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act
35 (Medicare), or any plan or program not described in this paragraph over which the
36 Commissioner does not have regulatory authority. Notwithstanding paragraph (3) of
37 Code Section 33-1-2 and any other provision of this title, for purposes of this chapter this
38 term shall include standalone dental insurance and standalone vision insurance.

39 (3) 'Healthcare services' means any services included in the furnishing to any individual
40 of medical or dental care or hospitalization or incident to the furnishing of such care or
41 hospitalization, as well as the furnishing to any person of any and all other services for
42 the purpose of preventing, alleviating, curing, or healing human illness or injury.

43 (4) 'Insurer' means an entity subject to the insurance laws and regulations of this state,
44 or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or
45 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the
46 costs of healthcare services, including those of an accident and sickness insurance
47 company, a health maintenance organization, a healthcare plan, a managed care plan, or
48 any other entity providing a health insurance plan, a health benefit plan, or healthcare
49 services.

50 (5) 'Mental disorder' shall have the same meaning as defined by *The Diagnostic and*
51 *Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The*
52 *International Classification of Diseases* (World Health Organization) as of
53 January 1, 1981, or as the Commissioner may further define such term by rule and
54 regulation.

55 (6) 'Nonquantitative treatment limitation' or 'NQTL' means limitations that are not
56 expressed numerically, but otherwise limit the scope or duration of benefits for treatment.
57 NQTLs include, but are not limited to, the following:

58 (A) Medical management standards limiting or excluding benefits based on medical
59 necessity or medical appropriateness, or based on whether the treatment is experimental
60 or investigative;

- 61 (B) Formulary design for prescription drugs;
62 (C) For plans with multiple network tiers, network tier design;
63 (D) Standards for provider admission to participate in a network, including
64 reimbursement rates;
65 (E) Plan methods for determining usual, customary, and reasonable charges;
66 (F) Step therapy protocol;
67 (G) Exclusions based on failure to complete a course of treatment;
68 (H) Restrictions based on geographic location, facility type, provider specialty, and
69 other criteria that limit the scope or duration of benefits for services provided under the
70 plan;
71 (I) In and out-of-network geographic limitations;
72 (J) Standards for providing access to out-of-network providers;
73 (K) Limitations on inpatient services for situations where the participant is a threat to
74 self or others;
75 (L) Exclusions for court ordered and involuntary holds;
76 (M) Experimental treatment limitations;
77 (N) Service coding;
78 (O) Exclusions for services provided by clinical social workers;
79 (P) Network adequacy; and
80 (Q) Provider reimbursement rates, including rates of reimbursement for mental health
81 and substance use services in primary care.
82 (7) 'Quantitative treatment limitation' or 'QTL' means a treatment limitation that
83 determines whether, or to what extent, benefits are provided based on an accumulated
84 amount. By way of example, the meaning may include an annual or lifetime limit on the
85 days of coverage or number of visits, a deductible, a copayment, coinsurance, or another
86 out-of-pocket expense, or another financial requirement.
87 (8) 'State healthcare plan' means:

88 (A) The state employees' health insurance plan established pursuant to Article 1 of
89 Chapter 18 of Title 45;
90 (B) The health insurance plan for public school teachers established pursuant to
91 Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;
92 (C) The health insurance plan for public school employees established pursuant to
93 Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and
94 (D) The Regents Health Plan established pursuant to authority granted to the board
95 pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.
96 (9) 'Substance use disorder' shall have the same meaning as defined by *The Diagnostic*
97 *and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The*
98 *International Classification of Diseases* (World Health Organization) as of
99 January 1, 1981, or as the Commissioner may further define such term by rule and
100 regulation.

101 33-24-101.

102 (a) Nothing in this article shall be applicable to healthcare plans which are subject to the
103 exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.
104 Section 1001, et seq.

105 (b) This article shall be applicable only to healthcare plans and state healthcare plans as
106 defined in this article.

107 33-24-102.

108 (a) A healthcare plan that provides coverage for prescription drugs shall not exclude
109 coverage for any FDA approved forms of medication assisted treatment prescribed for the
110 treatment of any category of mental disorder or substance use disorder, including but not
111 limited to alcohol or opioid dependence, if such treatment is considered medically
112 necessary upon the effective date of this article according to the most updated published

113 representations of the American Society of Addiction Medicine of the treatment criteria for
114 addictive, substance related, and co-occurring conditions.

115 (b) A healthcare plan shall use policies and procedures for the election and placement of
116 mental disorder and substance use disorder treatment drugs on their formulary that are no
117 less favorable to the insured as those policies and procedures the plan uses for the selection
118 and placement of other drugs.

119 (c) A healthcare plan providing both medical and surgical prescription drug benefits and
120 mental disorder or substance use disorder prescription drug benefits shall place all
121 prescription medications approved by the FDA for the treatment of mental disorders or
122 substance use disorders on the lowest cost tier of the drug formulary developed and
123 maintained by the plan.

124 (d) A healthcare plan providing both medical and surgical prescription drug benefits and
125 mental disorder or substance use disorder prescription drug benefits shall not impose any
126 step therapy requirements before the plan will authorize coverage for a prescription
127 medication approved by the FDA for the treatment of mental disorders or substance use
128 disorders.

129 (e) A healthcare plan providing both medical and surgical prescription drug benefits and
130 mental disorder or substance use disorder prescription drug benefits shall not impose any
131 prior authorization requirements due to safety risks associated with any prescription
132 medication approved by the FDA for the treatment of mental disorders or substance use
133 disorders.

134 33-24-103.

135 (a) A healthcare plan shall not impose a nonquantitative treatment limitation with respect
136 to a mental disorder or substance use disorder in any classification of benefits unless, under
137 the terms of the plan as written and in operation, any processes, strategies, evidentiary
138 standards, or other factors used in applying the NQTL to mental disorder or substance use

139 disorder benefits in the classification are comparable to, and are applied no more
140 stringently than, the processes, strategies, evidentiary standards, or other factors used in
141 applying the NQTL with respect to medical or surgical benefits in the same classification.
142 (b) For any utilization review or benefit determination for the treatment of a mental
143 disorder or substance use disorder, including but not limited to prior authorization and
144 medical necessity determinations, the clinical review criteria shall be the most updated
145 published representations of the American Society of Addiction Medicine of the treatment
146 criteria for addictive, substance related, and co-occurring conditions. No additional criteria
147 may be used during utilization review or benefit determination for treatment of substance
148 use disorders.

149 33-24-104.

150 All healthcare plans governed by the laws of this state shall also meet the requirements of
151 the federal Mental Health Parity and Addiction Equity Act of 2008, any amendments
152 thereto, and 45 C.F.R. 147.136 and 45 C.F.R. 147.160 as any such requirements exist in
153 statute or regulation on the effective date of this article.

154 33-24-105.

155 With regard to each of its healthcare plans, every insurer shall submit an annual report to
156 the department no later than March 1, 2022, and by every March 1 thereafter concerning
157 the prior calendar year that contains the following information:

158 (1) The frequency with which the plan required prior authorization for all prescribed
159 procedures, services, or medications for mental disorder and substance use disorder
160 benefits during the previous calendar year and the frequency with which such plan
161 required prior authorization for all prescribed procedures, services, or medications for
162 medical and surgical benefits during the previous calendar year; plans shall submit this
163 information separately for inpatient in-network benefits, inpatient out-of-network

164 benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency
165 care benefits, and prescription drug benefits; frequency shall be expressed as a
166 percentage, with total prescribed procedures, services, or medications within each
167 classification of benefits as the denominator and the overall number of times prior
168 authorization was required for any prescribed procedures, services, or medications within
169 each corresponding classification of benefits as the numerator;

170 (2) A description of the process used to develop or select the medical necessity criteria
171 for mental disorder or substance use disorder benefits and the process used to develop or
172 select the medical necessity criteria for medical and surgical benefits;

173 (3) Identification of all NQTLs that are applied to both mental disorder and substance
174 use disorder benefits and medical and surgical benefits; there shall be no separate NQTLs
175 that apply to mental disorder and substance use disorder benefits but do not apply to
176 medical and surgical benefits within any classification of benefits;

177 (4) The results of an analysis that demonstrates that for the medical necessity criteria
178 described in paragraph (2) of this Code section and for each NQTL identified in
179 paragraph (3) of this Code section, as written and in operation, the processes, strategies,
180 evidentiary standards, or other factors used to apply the medical necessity criteria and
181 each NQTL to mental disorder and substance use disorder benefits are comparable to, and
182 are applied no more stringently than, the processes, strategies, evidentiary standards, or
183 other factors used to apply the medical necessity criteria and each NQTL, as written and
184 in operation, to medical and surgical benefits; at a minimum, the results of the analysis
185 shall:

186 (A) Identify the factors used to determine that an NQTL will apply to a benefit,
187 including factors that were considered but rejected;

188 (B) Identify and define the specific evidentiary standards used to define the factors and
189 any other evidentiary standards relied upon in designing each NQTL;

190 (C) Identify and describe the methods and analyses used, including the results of the
191 analyses, to determine that the processes and strategies used to design each NQTL as
192 written for mental disorder and substance use disorder benefits are comparable to and
193 no more stringent than the processes and strategies used to design each NQTL as
194 written for medical and surgical benefits;

195 (D) Identify and describe the methods and analyses used, including the results of the
196 analyses, to determine that processes and strategies used to apply each NQTL in
197 operation for mental disorder and substance use disorder benefits are comparable to and
198 no more stringent than the processes or strategies used to apply each NQTL in
199 operation for medical and surgical benefits; and

200 (E) Disclose the specific findings and conclusions reached by the plan that the results
201 of the type of analyses described in this paragraph indicate that the plan is in
202 compliance with this article and the federal Mental Health Parity and Addiction Equity
203 Act of 2008 and 45 C.F.R. 146.136, as such provisions exist on the effective date of this
204 article;

205 (5) The rates of and reasons for denial of claims for inpatient in-network, inpatient
206 out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and
207 emergency care mental disorder or substance use disorder services during the previous
208 calendar year compared to the rates of and reasons for denial of claims in those same
209 classifications of benefits for medical and surgical services during the previous calendar
210 year;

211 (6) The rates of and reasons for denial of claims for inpatient in-network, inpatient
212 out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and
213 emergency care substance use disorder services during the previous calendar year
214 compared to the rates of and reasons for denial of claims in those same classifications of
215 benefits for medical and surgical services during the previous calendar year;

216 (7) A certification signed by the plan's chief executive officer and chief medical officer
217 that states that the plan has completed a comprehensive review of the administrative
218 practices of the plan's for the prior calendar year for compliance with the necessary
219 provisions of relevant sections of state law and the federal Mental Health Parity and
220 Addiction Equity Act of 2008, any amendments thereto, and 45 C.F.R. 147.136 and 45
221 C.F.R. 147.160 as any such requirements exist in statute or regulation on the effective
222 date of this article; and

223 (8) Any other information necessary to clarify data provided in accordance with this
224 Code section requested by the Commissioner, including information that may be
225 proprietary or have commercial value. The Commissioner shall not approve a plan if the
226 relevant submission of data to the department does not include all data as required by this
227 Code section.

228 33-24-106.

229 The department shall enforce all applicable provisions of the federal Mental Health Parity
230 and the federal Mental Health Parity and Addiction Equity Act of 2008, any amendments
231 thereto, and 45 C.F.R. 147.136 and 45 C.F.R. 147.160 as any such requirements exist in
232 statute or regulation on the effective date of this article, and which enforcement shall
233 include:

234 (1) Ensuring compliance by individual and group policies;

235 (2) Detecting violations of the law by individual and group policies;

236 (3) Accepting, evaluating, and responding to complaints regarding such violations;

237 (4) Maintaining and regularly reviewing for possible parity violations a publicly
238 available consumer complaint log regarding mental disorder and substance use disorder
239 coverage; and

240 (5) Performing parity compliance market conduct examinations of individual and group
241 plan, including but not limited to reviews of medical management practices, network
242 adequacy, reimbursement rates, denials, prior authorizations, and geographic restrictions.

243 33-24-107.

244 (a) No later than June 1, 2022, and June 1 of every year thereafter, the department shall
245 deliver a report to the House Insurance Committee and Senate Insurance and Labor
246 Committee. Such report shall include:

247 (1) The methodology that the department is using to check for compliance with the
248 federal Mental Health Parity and Addiction Equity Act of 2008, any amendments thereto,
249 and 45 C.F.R. 147.136 and 45 C.F.R. 147.160 as any such requirements exist in statute
250 or regulation on the effective date of this article;

251 (2) The methodology that the department used to check plan compliance with relevant
252 state law;

253 (3) Identification of market conduct examinations conducted or completed during the
254 preceding 12 month period regarding compliance with parity in mental disorder and
255 substance use disorder benefits under relevant state and federal law and summarization
256 of the results of such market conduct examinations. Such summary shall include the
257 following:

258 (A) The number of market conduct examinations initiated and completed;

259 (B) The benefit classifications examined by each market conduct examination;

260 (C) The subject matters of each market conduct examination, including quantitative
261 and nonquantitative treatment limitations;

262 (D) A summary of the basis for the final decision rendered in each market conduct
263 examination; and

264 (E) Individually identifiable information shall be excluded from the reports consistent
265 with federal privacy protections;

266 (4) Detail any educational or corrective actions that the department has taken to ensure
267 plan compliance with the federal Mental Health Parity and Addiction Equity Act of 2008
268 and any amendments thereto as such provisions of federal law exist on the effective date
269 of this article; and
270 (5) Detail the department's educational efforts to inform the public about mental disorder
271 and substance use disorder parity protections under state and federal law.
272 (b) The report must be written in nontechnical, readily understandable language and shall
273 be made available to the public by such means as the department finds appropriate,
274 including the posting of the report to the department's website homepage."

275 PART II

276 SECTION 2-1.

277 Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to public assistance,
278 is amended by adding a new article to read as follows:

279 "ARTICLE 10

280 49-4-200.

281 As used in this article, the term:

- 282 (1) 'Care management organization' means an entity that is organized for the purpose of
283 providing or arranging healthcare, which has been granted a certificate of authority by the
284 Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21
285 of Title 33, and which has entered into a contract with the Department of Community
286 Health to provide or arrange healthcare services on a prepaid, capitated basis to members.
287 (2) 'Department' means the Department of Community Health.
288 (3) 'FDA' means the United States Food and Drug Administration.

289 (4) 'Healthcare plan' or 'plan' means any care management organization plan which
290 allows for the provision of healthcare services to Medicaid or PeachCare for Kids
291 recipients.

292 (5) 'Healthcare services' means any services included in the furnishing to any individual
293 of medical or dental care or hospitalization or incident to the furnishing of such care or
294 hospitalization, as well as the furnishing to any person of any and all other services for
295 the purpose of preventing, alleviating, curing, or healing human illness or injury.

296 (6) 'Medicaid' means the joint federal and state program of medical assistance established
297 by Title XIX of the federal Social Security Act, which is administered in this state by the
298 Department of Community Health pursuant to Article 7 of this chapter.

299 (7) 'Member' means a Medicaid or PeachCare for Kids recipient who is currently
300 enrolled in a care management organization plan.

301 (8) 'Mental disorder' shall have the same meaning as defined by *The Diagnostic and*
302 *Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The*
303 *International Classification of Diseases* (World Health Organization) as of
304 January 1, 1981, or as the Commissioner may further define such term by rule and
305 regulation.

306 (9) 'Nonquantitative treatment limitation' or 'NQTL' means limitations that are not
307 expressed numerically, but otherwise limit the scope or duration of benefits for treatment.
308 NQTLs include, but are not limited to, the following:

309 (A) Medical management standards limiting or excluding benefits based on medical
310 necessity or medical appropriateness, or based on whether the treatment is experimental
311 or investigative;

312 (B) Formulary design for prescription drugs;

313 (C) For plans with multiple network tiers, network tier design;

314 (D) Standards for provider admission to participate in a network, including
315 reimbursement rates;

- 316 (E) Plan methods for determining usual, customary, and reasonable charges;
317 (F) Step therapy protocol;
318 (G) Exclusions based on failure to complete a course of treatment;
319 (H) Restrictions based on geographic location, facility type, provider specialty, and
320 other criteria that limit the scope or duration of benefits for services provided under the
321 plan;
322 (I) In and out-of-network geographic limitations;
323 (J) Standards for providing access to out-of-network providers;
324 (K) Limitations on inpatient services for situations where the participant is a threat to
325 self or others;
326 (L) Exclusions for court ordered and involuntary holds;
327 (M) Experimental treatment limitations;
328 (N) Service coding;
329 (O) Exclusions for services provided by clinical social workers;
330 (P) Network adequacy; and
331 (Q) Provider reimbursement rates, including rates of reimbursement for mental health
332 and substance use services in primary care.
- 333 (10) 'PeachCare for Kids' means the State of Georgia's State Children's Health Insurance
334 Program established pursuant to Title XXI of the federal Social Security Act, which is
335 administered in this state by the Department of Community Health pursuant to Article 13
336 of Chapter 5 of this title.
- 337 (11) 'Quantitative treatment limitation' or 'QTL' means a treatment limitation that
338 determines whether, or to what extent, benefits are provided based on an accumulated
339 amount. By way of example, the meaning may include an annual or lifetime limit on the
340 days of coverage or number of visits, a deductible, a copayment, coinsurance, or another
341 out-of-pocket expense, or another financial requirement.

342 (12) 'Substance use disorder' shall have the same meaning as defined by *The Diagnostic*
343 *and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The*
344 *International Classification of Diseases* (World Health Organization) as of
345 January 1, 1981, or as the Commissioner may further define such term by rule and
346 regulation.

347 49-4-201.

348 (a) Nothing in this chapter shall be applicable to healthcare plans which are subject to the
349 exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C.
350 Section 1001, et seq.

351 (b) This article shall be applicable only to healthcare plans as defined in this article.

352 49-4-202.

353 (a) A healthcare plan that provides coverage for prescription drugs shall not exclude
354 coverage for any FDA approved forms of medication assisted treatment prescribed for the
355 treatment of any category of mental disorder or substance use disorder, including but not
356 limited to alcohol or opioid dependence, if such treatment is considered medically
357 necessary upon the effective date of this article according to the most updated published
358 representations of the American Society of Addiction Medicine of the treatment criteria for
359 addictive, substance related, and co-occurring conditions.

360 (b) A healthcare plan shall use policies and procedures for the election and placement of
361 mental disorder and substance use disorder treatment drugs on their formulary that are no
362 less favorable to the insured as those policies and procedures the plan uses for the selection
363 and placement of other drugs.

364 (c) A healthcare plan providing both medical and surgical prescription drug benefits and
365 mental disorder or substance use disorder prescription drug benefits shall place all
366 prescription medications approved by the FDA for the treatment of mental disorders or

367 substance use disorders on the lowest cost tier of the drug formulary developed and
368 maintained by the plan.

369 (d) A healthcare plan providing both medical and surgical prescription drug benefits and
370 mental disorder or substance use disorder prescription drug benefits shall not impose any
371 step therapy requirements before the plan will authorize coverage for a prescription
372 medication approved by the FDA for the treatment of mental disorders or substance use
373 disorders.

374 (e) A healthcare plan providing both medical and surgical prescription drug benefits and
375 mental disorder or substance use disorder prescription drug benefits shall not impose any
376 prior authorization requirements due to safety risks associated with any prescription
377 medication approved by the FDA for the treatment of mental disorders or substance use
378 disorders.

379 49-4-203.

380 (a) A healthcare plan shall not impose a nonquantitative treatment limitation with respect
381 to a mental disorder or substance use disorder in any classification of benefits unless, under
382 the terms of the plan as written and in operation, any processes, strategies, evidentiary
383 standards, or other factors used in applying the NQTL to mental disorder or substance use
384 disorder benefits in the classification are comparable to, and are applied no more
385 stringently than, the processes, strategies, evidentiary standards, or other factors used in
386 applying the NQTL with respect to medical or surgical benefits in the same classification.

387 (b) For any utilization review or benefit determination for the treatment of a mental
388 disorder or substance use disorder, including but not limited to prior authorization and
389 medical necessity determinations, the clinical review criteria shall be the most updated
390 published representations of the American Society of Addiction Medicine of the treatment
391 criteria for addictive, substance related, and co-occurring conditions. No additional criteria

392 may be used during utilization review or benefit determination for treatment of substance
393 use disorders.

394 49-4-204.

395 All healthcare plans governed by the laws of this state shall also meet the requirements of
396 the federal Mental Health Parity and Addiction Equity Act of 2008, any amendments
397 thereto, and 45 C.F.R. 147.136 and 45 C.F.R. 147.160 as any such requirements exist in
398 statute or regulation on the effective date of this article.

399 49-4-205.

400 With regard to each of its healthcare plans, every care management organization shall
401 submit an annual report to the department no later than March 1, 2022, and by every
402 March 1 thereafter concerning the prior calendar year that contains the following
403 information:

404 (1) The frequency with which the plan required prior authorization for all prescribed
405 procedures, services, or medications for mental disorder and substance use disorder
406 benefits during the previous calendar year and the frequency with which such plan
407 required prior authorization for all prescribed procedures, services, or medications for
408 medical and surgical benefits during the previous calendar year; plans shall submit this
409 information separately for inpatient in-network benefits, inpatient out-of-network
410 benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency
411 care benefits, and prescription drug benefits; frequency shall be expressed as a
412 percentage, with total prescribed procedures, services, or medications within each
413 classification of benefits as the denominator and the overall number of times prior
414 authorization was required for any prescribed procedures, services, or medications within
415 each corresponding classification of benefits as the numerator;

416 (2) A description of the process used to develop or select the medical necessity criteria
417 for mental disorder or substance use disorder benefits and the process used to develop or
418 select the medical necessity criteria for medical and surgical benefits;

419 (3) Identification of all NQTLs that are applied to both mental disorder and substance
420 use disorder benefits and medical and surgical benefits; there shall be no separate NQTLs
421 that apply to mental disorder and substance use disorder benefits but do not apply to
422 medical and surgical benefits within any classification of benefits;

423 (4) The results of an analysis that demonstrates that for the medical necessity criteria
424 described in paragraph (2) of this Code section and for each NQTL identified in
425 paragraph (3) of this Code section, as written and in operation, the processes, strategies,
426 evidentiary standards, or other factors used to apply the medical necessity criteria and
427 each NQTL to mental disorder and substance use disorder benefits are comparable to, and
428 are applied no more stringently than, the processes, strategies, evidentiary standards, or
429 other factors used to apply the medical necessity criteria and each NQTL, as written and
430 in operation, to medical and surgical benefits; at a minimum, the results of the analysis
431 shall:

432 (A) Identify the factors used to determine that an NQTL will apply to a benefit,
433 including factors that were considered but rejected;

434 (B) Identify and define the specific evidentiary standards used to define the factors and
435 any other evidentiary standards relied upon in designing each NQTL;

436 (C) Identify and describe the methods and analyses used, including the results of the
437 analyses, to determine that the processes and strategies used to design each NQTL as
438 written for mental disorder and substance use disorder benefits are comparable to and
439 no more stringent than the processes and strategies used to design each NQTL as
440 written for medical and surgical benefits;

441 (D) Identify and describe the methods and analyses used, including the results of the
442 analyses, to determine that processes and strategies used to apply each NQTL in

443 operation for mental disorder and substance use disorder benefits are comparable to and
444 no more stringent than the processes or strategies used to apply each NQTL in
445 operation for medical and surgical benefits; and

446 (E) Disclose the specific findings and conclusions reached by the plan that the results
447 of the type of analyses described in this paragraph indicate that the plan is in
448 compliance with this article and the Mental Health Parity and Addiction Equity Act
449 of 2008 and its implementing regulations, and 45 C.F.R.146.136, as such provision
450 exists on the effective date of this article;

451 (5) The rates of and reasons for denial of claims for inpatient in-network, inpatient
452 out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and
453 emergency care mental disorder or substance use disorder services during the previous
454 calendar year compared to the rates of and reasons for denial of claims in those same
455 classifications of benefits for medical and surgical services during the previous calendar
456 year;

457 (6) The rates of and reasons for denial of claims for inpatient in-network, inpatient
458 out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and
459 emergency care substance use disorder services during the previous calendar year
460 compared to the rates of and reasons for denial of claims in those same classifications of
461 benefits for medical and surgical services during the previous calendar year;

462 (7) A certification signed by the plan's chief executive officer and chief medical officer
463 that states that the plan has completed a comprehensive review of the administrative
464 practices of the plan for the prior calendar year for compliance with the necessary
465 provisions of relevant sections of state law and the federal Mental Health Parity and
466 Addiction Equity Act of 2008, any amendments thereto, and 45 C.F.R. 147.136 and 45
467 C.F.R. 147.160 as any such requirements exist in statute or regulation on the effective
468 date of this article;

469 (8) Any other information necessary to clarify data provided in accordance with this
470 Code section requested by the department, including information that may be proprietary
471 or have commercial value; and

472 (9) The department shall annually review all care management organization plans
473 affecting members and shall not approve of any plan if the department determines that
474 the care management organization failed to timely submit all data as required by this
475 Code section.

476 49-4-206.

477 The department shall enforce all applicable provisions of the federal Mental Health Parity
478 and Addiction Equity Act of 2008, any amendments thereto, and 45 C.F.R. 147.136 and 45
479 C.F.R. 147.160 as any such requirements exist in statute or regulation on the effective date
480 of this article, and which enforcement shall include:

481 (1) Detecting relevant violations of law by care management organizations;

482 (2) Accepting, evaluating, and responding to complaints regarding such violations;

483 (3) Maintaining and regularly reviewing for possible parity violations a publicly
484 available consumer complaint log regarding mental disorder and substance use disorder
485 coverage; and

486 (4) Performing parity compliance market conduct examinations of individual and group
487 plans, including but not limited to reviews of medical management practices, network
488 adequacy, reimbursement rates, denials, prior authorizations, and geographic restrictions.

489 49-4-207.

490 (a) No later than June 1, 2022, and June 1 of every year thereafter, the department shall
491 deliver a report to the House Insurance Committee and Senate Insurance and Labor
492 Committee. Such report shall include:

- 493 (1) The methodology that the department is using to check for compliance with the
494 federal Mental Health Parity and Addiction Equity Act of 2008, any amendments thereto,
495 and 45 C.F.R. 147.136 and 45 C.F.R. 147.160 as any such requirements exist in statute
496 or regulation on the effective date of this article;
- 497 (2) The methodology that the department used to check plan compliance with relevant
498 state law;
- 499 (3) Identification of market conduct examinations conducted or completed during the
500 preceding 12 month period regarding compliance with parity in mental disorder and
501 substance use disorder benefits under relevant state and federal law and summarization
502 of the results of such market conduct examinations. Such summary shall include the
503 following:
- 504 (A) The number of market conduct examinations initiated and completed;
505 (B) The benefit classifications examined by each market conduct examination;
506 (C) The subject matters of each market conduct examination, including quantitative
507 and nonquantitative treatment limitations;
508 (D) A summary of the basis for the final decision rendered in each market conduct
509 examination; and
- 510 (E) Individually identifiable information shall be excluded from the reports consistent
511 with federal privacy protections;
- 512 (4) Detail any educational or corrective actions that the department has taken to ensure
513 plan compliance with the federal Mental Health Parity and Addiction Equity Act of 2008
514 and any amendments thereto as such provisions of federal law exist on the effective date
515 of this article; and
- 516 (5) Detail the department's educational efforts to inform members about mental disorder
517 and substance use disorder parity protections under state and federal law.

518 (b) The report must be written in nontechnical, readily understandable language and shall
519 be made available to the public by such means as the department finds appropriate,
520 including the posting of the report to the department's website homepage."

521

PART III

522

SECTION 3-1.

523 All laws and parts of laws in conflict with this Act are repealed.