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

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

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

PART I

SECTION 1-1.

The General Assembly finds that:

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

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

SECTION 1-2.

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

SECTION 1-3.

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

″ARTICLE 5

33-24-100.

As used in this article, the term:

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

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

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

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

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

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

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

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

(B) Formulary design for prescription drugs;

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

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

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Step therapy protocol;

(G) Exclusions based on failure to complete a course of treatment;

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan;

(I) In and out-of-network geographic limitations;

(J) Standards for providing access to out-of-network providers;

(K) Limitations on inpatient services for situations where the participant is a threat to self or others;

(L) Exclusions for court ordered and involuntary holds;

(M) Experimental treatment limitations;

(N) Service coding;

(O) Exclusions for services provided by clinical social workers;

(P) Network adequacy; and

(Q) Provider reimbursement rates, including rates of reimbursement for mental health and substance use services in primary care.

(7) 'Quantitative treatment limitation' or 'QTL' means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount. By way of example, the meaning may include an annual or lifetime limit on the days of coverage or number of visits, a deductible, a copayment, coinsurance, or another out-of-pocket expense, or another financial requirement.

(8) 'State healthcare plan' means:

(A) The state employees' health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45;

(B) The health insurance plan for public school teachers established pursuant to Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;

(C) The health insurance plan for public school employees established pursuant to Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and

(D) The Regents Health Plan established pursuant to authority granted to the board pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.

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

33-24-101.

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

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

33-24-102.

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

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

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

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

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

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

33-24-103.

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

disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical or surgical benefits in the same classification.

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

33-24-104.

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

33-24-105.

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

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

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

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

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

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

(A) Identify the factors used to determine that an NQTL will apply 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 evidentiary standards relied upon in designing each NQTL;

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

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

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

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

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

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

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

33-24-106.

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

(1) Ensuring compliance by individual and group policies;

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

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

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

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

33-24-107.

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

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

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

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

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

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

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

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

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

(4) Detail any educational or corrective actions that the department has taken to ensure plan compliance with the federal Mental Health Parity and Addiction Equity Act of 2008 and any amendments thereto as such provisions of federal law exist on the effective date of this article; and

(5) Detail the department's educational efforts to inform the public about mental disorder and substance use disorder parity protections under state and federal law.

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

PART II

SECTION 2-1.

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

"ARTICLE 10

49-4-200.

As used in this article, the term:

(1) 'Care management organization' means an entity that is organized for the purpose of providing or arranging healthcare, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of Title 33, and which has entered into a contract with the Department of Community Health to provide or arrange healthcare services on a prepaid, capitated basis to members.

(2) 'Department' means the Department of Community Health.

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

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

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

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

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

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

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

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

(B) Formulary design for prescription drugs;

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

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

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Step therapy protocol;

(G) Exclusions based on failure to complete a course of treatment;

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan;

(I) In and out-of-network geographic limitations;

(J) Standards for providing access to out-of-network providers;

(K) Limitations on inpatient services for situations where the participant is a threat to self or others;

(L) Exclusions for court ordered and involuntary holds;

(M) Experimental treatment limitations;

(N) Service coding;

(O) Exclusions for services provided by clinical social workers;

(P) Network adequacy; and

(Q) Provider reimbursement rates, including rates of reimbursement for mental health and substance use services in primary care.

(10) 'PeachCare for Kids' means the State of Georgia's State Children's Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 13 of Chapter 5 of this title.

(11) 'Quantitative treatment limitation' or 'QTL' means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount. By way of example, the meaning may include an annual or lifetime limit on the days of coverage or number of visits, a deductible, a copayment, coinsurance, or another out-of-pocket expense, or another financial requirement.

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

49-4-201.

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

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

49-4-202.

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

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

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

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

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

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

49-4-203.

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

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

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

49-4-204.

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

49-4-205.

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

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

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

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

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

(A) Identify the factors used to determine that an NQTL will apply 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 evidentiary standards relied upon in designing each NQTL;

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

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

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

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

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

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

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

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

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

49-4-206.

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

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

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

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

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

49-4-207.

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

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

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

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

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

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

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

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

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

(4) Detail any educational or corrective actions that the department has taken to ensure plan compliance with the federal Mental Health Parity and Addiction Equity Act of 2008 and any amendments thereto as such provisions of federal law exist on the effective date of this article; and

(5) Detail the department's educational efforts to inform members about mental disorder and substance use disorder parity protections under state and federal law.

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

PART III

SECTION 3-1.

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