APPROVED
APRIL 20, 2022
BY GOVERNOR

CHAPTER
638
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

H.P. 1355 - L.D. 1822

An Act To Improve Access to Behavioral Health Services by Limiting Cost Sharing by Insurers

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

Sec. 1. 24-A MRSA §4320-A, sub-§3, as enacted by PL 2019, c. 653, Pt. C, §1, is amended to read:

3. Primary health services. An individual or small group health plan with an effective date ~~on or after~~ from January 1, 2021 to December 31, 2022 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any ~~copays~~ copayments for the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year count toward the deductible. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent shall conduct a study analyzing the effects of this subsection on premiums based on experience in plan years 2020 and 2021. The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 24-A MRSA §4320-A, sub-§3-A is enacted to read:

3-A. Parity in cost sharing for primary care and behavioral health office visits; individual or small group health plan. An individual or small group health plan with an effective date on or after January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copayments for primary care office visits and behavioral health office visits in a plan year count toward the deductible. After the first behavioral health office visit, a health plan may not apply a copayment amount to

a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 3. 24-A MRSA §4320-A, sub-§3-B is enacted to read:

3-B. Parity in cost sharing for primary care and behavioral health office visits; group health plan. A group health plan, other than a small group health plan subject to subsection 3-A, with an effective date on or after January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year. After the first behavioral health office visit, a health plan may not apply a copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 4. 24-A MRSA §4320-R is enacted to read:

§4320-R. Implementation of federal mental health parity laws

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

2. Compliance with federal mental health parity laws. A carrier offering a health plan in this State providing health coverage for mental health and substance use disorder services pursuant to sections 2749-C, 2842, 2843, 4234-A and 4320-D and Title 24, sections 2325-A and 2329 must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any amendments to, and any federal guidance or regulations relevant to, that Act, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3).

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

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

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

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

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

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

4. Reports to superintendent. As part of the report submitted to the superintendent, and subsequently reported by the superintendent to the Legislature, pursuant to section 2749-C, subsection 4, section 2843, subsection 7, section 4234-A, subsection 10 and Title 24, section 2325-A, subsection 8, a carrier shall submit the following information to the superintendent:

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

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

C. The results of an analysis that demonstrate that for the medically necessary health care criteria described in paragraph A and for each nonquantitative treatment limitation identified in paragraph B, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary

standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits. At a minimum, the results of the analysis must:

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

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

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

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

(5) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses in this paragraph indicate that the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3).

Information submitted by a carrier to the superintendent pursuant to this subsection is public information in accordance with section 216, except for information that a carrier requests be designated as confidential and the superintendent has determined is proprietary information. For the purposes of this subsection, "proprietary information" means information that is a trade secret or business or financial information the disclosure of which would impair the competitive position of a carrier or that would result in significant detriment to a carrier if the information were made available to the public.

5. Repeal. This section is repealed April 30, 2028.

Sec. 5. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of 0092

Initiative: Provides funding for one Senior Market Conduct Examiner position and related All Other costs to evaluate consumer or provider complaints concerning mental health and substance use disorder coverage for federal parity violations, to facilitate new annual

mental health and substance use disorder parity reporting requirements from insurers and to conduct market conduct examinations of carriers for compliance with federal parity law.

OTHER SPECIAL REVENUE FUNDS	**2021-22**	**2022-23**
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$102,269
All Other	$0	$10,472
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$112,741