HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 260

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

This document may incorporate amendments proposed by a committee, but not yet adopted, as well as amendments that have been adopted during the current legislative session. The document is a tool to show amendments in context and cannot be used for the purpose of adding amendments to legislation.

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT AND THE NEW MEXICO INSURANCE CODE TO PROHIBIT INSURERS FROM APPLYING LIMITATIONS ON COVERAGE FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES THAT ARE MORE RESTRICTIVE THAN LIMITATIONS ON COVERAGE FOR OTHER TYPES OF HEALTH CARE SERVICES; PROVIDING FOR INSURER COMPLIANCE **HAFC→~~;~~**

~~MAKING AN APPROPRIATION~~**←HAFC .**

.225449.2AIC March 3, 2023 (9:47am)

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = **→bold, blue, highlight←**
~~delete~~ = **→bold, red, highlight, strikethrough←**

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in Sections 1 through 9 of this 2023 act:

A. "generally recognized standards" means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or

disorders listed in the current edition of the American psychiatric association's *Diagnostic and Statistical Manual of Mental Disorders*, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act."

SECTION 2. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] BENEFITS REQUIRED.--Group coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care."

SECTION 3. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PARITY FOR COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.--

A. The office of superintendent of insurance shall ensure that an insurer complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. An insurer shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use

disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. An insurer shall not impose non-quantitative treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors, including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation to medical or surgical benefits in the classification."

SECTION 4. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PROVIDER NETWORK ADEQUACY.--

A. An insurer shall maintain an adequate provider network to provide mental health and substance use disorder services.

B. The superintendent of insurance shall ensure access to mental health and substance use disorder services providers, including parity with medical and surgical services provider access, through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. An insurer shall ensure that the process by

which reimbursement rates for mental health and substance use disorder services are determined is comparable and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates, an insurer shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. An insurer shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services is not reasonably available, an insurer shall provide access to out-of-network services with the same cost-sharing obligations to the insured as those required for in-network services."

SECTION 5. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] UTILIZATION REVIEW OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. An insurer shall, at least monthly, review and update the insurer's utilization review process to reflect the most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, an insurer shall apply criteria in accordance with generally recognized standards of care.

C. An insurer shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. An insurer shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health and substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or plan members."

SECTION 6. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] PROHIBITED EXCLUSIONS OF COVERAGE FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--An insurer shall not exclude provider proscribed coverage for mental health or substance use disorder services otherwise included in its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to an insured through a public benefit program; or

D. an insured has a concurrent diagnosis."

SECTION 7. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] LEVEL OF CARE DETERMINATIONS FOR THE PROVISION OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. An insurer shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing an insured into a medically necessary level of care.

B. Changes in level and duration of care shall be determined by the insured's provider in consultation with the insurer.

C. Level of care determinations shall include placement of an insured into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

D. Level of care services for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than arbitrary time limits."

SECTION 8. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] COORDINATION OF CARE.--An insurer may facilitate communication between mental health or substance use disorder services providers and the insured's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the insured."

SECTION 9. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] CONFIDENTIALITY PROVISIONS.--An insurer shall protect the confidentiality of an insured receiving mental health or substance use disorder services."

SECTION 10. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] EXCEPTIONS.--The provisions of Sections 1 through 9 of this 2023 act do not apply to short-term plans

subject to the Short-Term Health Plan and Excepted Benefit Act."

SECTION 11. A new section of the Prior Authorization Act is enacted to read:

"[NEW MATERIAL] PRIOR AUTHORIZATION RESCINDING OR MODIFYING PROHIBITED.--A health insurer shall not rescind or modify an authorization for mental health or substance use disorder services that has been authorized, after the provider renders the services pursuant to a determination of medical necessity, in good faith, except for cases of fraud or violation of the provider's contract with the health insurer."

SECTION 12. A new section of the Prior Authorization Act is enacted to read:

"[NEW MATERIAL] PRIOR AUTHORIZATION OR REFERRAL REQUIREMENT FOR IN-NETWORK MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES COVERAGE PROHIBITED.--

A. A health insurer shall not require prior authorization and referral requirements for the following mental health or substance use disorder services:

(1) acute or immediately necessary care;

(2) acute episodes of chronic mental health or substance use disorder conditions; or

(3) initial in-network inpatient or outpatient substance use treatment services.

B. Prior authorization shall be determined in

consultation with the insured's mental health or substance use disorder services provider for:

(1) continuation of services in chronic or stable conditions; or

(2) additional services.

C. Except in cases in which the insured terminates a plan, a health insurer shall not terminate coverage of services without consultation with the insured's mental health or substance use disorder services provider.

D. A health insurer shall not limit coverage for mental health or substance use disorder services up to the point of relief of presenting signs and symptoms or to short-term care or acute treatment.

E. The duration of coverage for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than on arbitrary time limits.

F. A health insurer may require a mental health or substance use disorder services provider to provide notification to the health insurer after the initiation of in-network mental health or substance use disorder treatment pursuant to Subsection A of this section.

G. If a provider fails to notify a health insurer pursuant to Subsection F of this section, a health insurer may perform appropriate utilization review.

H. A health insurer may require a mental health or substance use disorder services provider to develop and submit a treatment plan for an insured receiving in-network services in a manner that is compliant with federal law."

SECTION 13. A new section of the Prior Authorization Act is enacted to read:

"[NEW MATERIAL] PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS OR STEP THERAPY FOR SUBSTANCE USE DISORDER PROHIBITED.--

A. Coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of a substance use disorder, pursuant to a medical necessity determination, shall not be subject to prior authorization, except in cases in which a generic version is available.

B. A health insurer shall not impose step therapy requirements before authorizing coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of a substance use disorder, pursuant to a medical necessity determination, except in cases in which a generic version is available."

SECTION 14. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in Sections 14 through 22 of this 2023 act:

A. "generally recognized standards" means standards

of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's *Diagnostic and Statistical Manual of Mental Disorders*, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed

pursuant to the Counseling and Therapy Practice Act."

SECTION 15. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] BENEFITS REQUIRED.--A group health plan, other than a small group health plan or a blanket health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care."

SECTION 16. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PARITY FOR COVERAGE OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. The office of superintendent of insurance shall ensure that an insurer complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. An insurer shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. An insurer shall not impose non-quantitative

treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors, including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation with respect to medical or surgical benefits in the classification."

SECTION 17. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROVIDER NETWORK ADEQUACY.--

A. An insurer shall maintain an adequate provider network to provide mental health or substance use disorder services.

B. The superintendent shall ensure access to mental health or substance use disorder services providers, including parity with medical and surgical services provider access, through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. An insurer shall ensure that the process by which reimbursement rates for mental health and substance use disorder services are determined is comparable and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates,

an insurer shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. An insurer shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services is not reasonably available, an insurer shall provide access to out-of-network services with the same cost-sharing obligations to the insured as those required for in-network services."

SECTION 18. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] UTILIZATION REVIEW OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. An insurer shall, at least monthly, review and update the insurer's utilization review process to reflect the

most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, an insurer shall apply criteria in accordance with generally recognized standards of care.

C. An insurer shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. An insurer shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health or substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or plan members."

SECTION 19. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PROHIBITED EXCLUSIONS OF COVERAGE FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--An insurer shall not exclude provider proscribed coverage for mental health or substance use disorder services otherwise included in

its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to an insured through a public benefit program; or

D. an insured has a concurrent diagnosis."

SECTION 20. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] LEVEL OF CARE DETERMINATIONS FOR THE PROVISION OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. An insurer shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing an insured into a medically necessary level of care.

B. Changes in level and duration of care shall be determined by the insured's provider in consultation with the insurer.

C. Level of care determinations shall include placement of an insured into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment

program.

D. Level of care services for an insured with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the insured rather than arbitrary time limits."

SECTION 21. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COORDINATION OF CARE.--At the request of an insured, an insurer may facilitate communication between mental health or substance use disorder services providers and the insured's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the insured."

SECTION 22. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] CONFIDENTIALITY PROVISIONS.--An insurer shall protect the confidentiality of an insured receiving mental health or substance use disorder services."

SECTION 23. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] EXCEPTIONS.--The provisions of Sections 14 through 22 of this 2023 act do not apply to short-term plans subject to the Short-Term Health Plan and Excepted Benefit Act."

SECTION 24. Section 59A-23E-18 NMSA 1978 (being Laws

2000, Chapter 6, Section 1, as amended) is amended to read:

"59A-23E-18. REQUIREMENT FOR MENTAL HEALTH BENEFITS IN AN INDIVIDUAL OR GROUP HEALTH PLAN, OR GROUP HEALTH INSURANCE OFFERED IN CONNECTION WITH THE PLAN, FOR A PLAN YEAR OF AN EMPLOYER.--

A. A group health plan or group or individual health insurance shall not impose treatment limitations or financial restrictions, limitations or requirements on the provision of mental health benefits that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on coverage of benefits for other conditions.

[~~B. A group health plan or group or individual health insurance offered in connection with that plan, may:~~

~~(1) require pre-admission screening prior to the authorization of mental health benefits whether inpatient or outpatient; or~~

~~(2) apply limitations that restrict mental health benefits provided under the plan to those that are medically necessary.~~

~~C.~~] B. As used in this section, "mental health benefits" means mental health benefits as described in the group health plan or group health insurance offered in connection with the plan [~~but does not include benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction~~]."

SECTION 25. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in Sections 25 through 33 of this 2023 act:

A. "generally recognized standards" means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American

psychiatric association's *Diagnostic and Statistical Manual of Mental Disorders*, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act."

SECTION 26. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] BENEFITS REQUIRED.--A health maintenance organization, other than a small group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care."

SECTION 27. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PARITY FOR COVERAGE OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. The office of superintendent of insurance shall ensure that a carrier complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. A carrier shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use

disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. A carrier shall not impose non-quantitative treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors, including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation with respect to medical or surgical benefits in the classification."

SECTION 28. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] PROVIDER NETWORK ADEQUACY.--

A. A carrier shall maintain an adequate provider network to provide mental health or substance use disorder services.

B. The superintendent shall ensure access to mental health or substance use disorder services providers, including parity with medical and surgical services provider access, through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. A carrier shall ensure that the process by which reimbursement rates for mental health and substance use disorder services are determined is comparable and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates, a carrier shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. A carrier shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services are not reasonably available, a carrier shall provide access to out-of-network services with the same cost-sharing obligations to an enrollee as those required for in-network services."

SECTION 29. A new section of the Health Maintenance

Organization Law is enacted to read:

"[NEW MATERIAL] UTILIZATION REVIEW OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. A carrier shall, at least monthly, review and update the carrier's utilization review process to reflect the most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, a carrier shall apply criteria in accordance with generally recognized standards of care.

C. A carrier shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. A carrier shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health or substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or enrollees."

SECTION 30. A new section of the Health Maintenance

Organization Law is enacted to read:

"[NEW MATERIAL] PROHIBITED EXCLUSIONS OF COVERAGE FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--A carrier shall not exclude provider proscribed coverage for mental health or substance use disorder services otherwise included in its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to an enrollee through a public benefit program; or

D. an enrollee has a concurrent diagnosis."

SECTION 31. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] LEVEL OF CARE DETERMINATIONS FOR THE PROVISION OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. A carrier shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing an enrollee into a medically necessary level of care.

B. Changes in level and duration of care shall be determined by the enrollee's provider in consultation with the

carrier.

C. Level of care determinations shall include placement of an enrollee into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

D. Level of care services for an enrollee with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the enrollee rather than arbitrary time limits."

SECTION 32. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] COORDINATION OF CARE.--At the request of an enrollee, a carrier may facilitate communication between mental health or substance use disorder services providers and the enrollee's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the enrollee."

SECTION 33. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] CONFIDENTIALITY PROVISIONS.--A carrier shall protect the confidentiality of an enrollee receiving mental health or substance use disorder treatment."

SECTION 34. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] EXCEPTIONS.--The provisions of Sections 25 through 33 of this 2023 act do not apply to short-term plans subject to the Short-Term Health Plan and Excepted Benefit Act."

SECTION 35. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in Sections 35 through 43 of this 2023 act:

A. "generally recognized standards" means standards of care and clinical practice, established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including:

(1) psychiatry;

(2) psychology;

(3) social work;

(4) clinical counseling;

(5) addiction medicine and counseling; or

(6) family and marriage counseling; and

B. "mental health or substance use disorder services" means:

(1) professional services, including inpatient and outpatient services and prescription drugs, provided in

accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's *Diagnostic and Statistical Manual of Mental Disorders*, including substance use disorder; or

(2) professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act."

SECTION 36. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] BENEFITS REQUIRED.--A health care plan, other than a small health care plan, that is delivered, issued for delivery or renewed in this state shall provide coverage for all mental health or substance use disorder services required by generally recognized standards of care."

SECTION 37. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PARITY FOR COVERAGE OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. The office of superintendent of insurance shall ensure that a health care plan complies with federal and state laws, rules and regulations applicable to coverage for mental health or substance use disorder services.

B. A health care plan shall not impose quantitative treatment limitations, financial restrictions, limitations or requirements on the provision of mental health or substance use disorder services that are more restrictive than the predominant restrictions, limitations or requirements that are imposed on substantially all of the coverage of benefits for other conditions.

C. A health care plan shall not impose non-quantitative treatment limitations for the treatment of mental health or substance use disorders or conditions unless factors, including the processes, strategies or evidentiary standards used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to and are applied no more restrictively than the factors used in applying the limitation with respect to medical or surgical benefits in the classification."

SECTION 38. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PROVIDER NETWORK ADEQUACY.--

A. A health care plan shall maintain an adequate provider network to provide mental health or substance use disorder services.

B. The superintendent shall ensure access to mental health or substance use disorder services providers, including parity with medical and surgical services provider access,

through regulation and review of claims processing, provider reimbursement procedures, network adequacy and provider reimbursement rate adequacy.

C. A health care plan shall ensure that the process by which reimbursement rates for mental health and substance use disorder services are determined is comparable and no more stringent than the process for reimbursement of medical or surgical benefits. In developing provider reimbursement rates, a health care plan shall demonstrate that it has performed a comparability analysis of provider:

(1) reimbursement rates in surrounding states;

(2) reimbursement rates between mental health and substance use disorder providers and medical or surgical providers; and

(3) credentialing processes for mental health and substance use disorder providers and medical or surgical providers.

D. A health care plan shall undertake all efforts, including increasing provider reimbursement rates through the processes and strategies described in Subsection C of this section, to ensure state-mandated network adequacy for the provision of mental health or substance use disorder services.

E. When in-network access to mental health or substance use disorder services are not reasonably available, a health care plan shall provide access to out-of-network

services with the same cost-sharing obligations to a subscriber as those required for in-network services."

SECTION 39. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] UTILIZATION REVIEW OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. A health care plan shall, at least monthly, review and update the health care plan's utilization review process to reflect the most recent evidence and generally recognized standards of care.

B. When performing a utilization review of mental health or substance use disorder services, including level of care placement, continued stay, transfer and discharge, a health care plan shall apply criteria in accordance with generally recognized standards of care.

C. A health care plan shall provide utilization review training to staff and contractors undertaking activities related to utilization review.

D. A health care plan shall:

(1) develop utilization review policies regarding quantitative and non-quantitative limitations for mental health or substance use disorder services coverage that are no more restrictive than the utilization review policies regarding quantitative and non-quantitative limitations for medical and surgical care; and

(2) make utilization review policies available to providers or subscribers."

SECTION 40. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] PROHIBITED EXCLUSIONS OF COVERAGE FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--A health care plan shall not exclude provider proscribed coverage for mental health or substance use disorder services otherwise included in its coverage when:

A. it is available pursuant to federal or state law for individuals with disabilities;

B. it is otherwise ordered by a court or administrative agency;

C. it is available to a subscriber through a public benefit program; or

D. a subscriber has a concurrent diagnosis."

SECTION 41. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] LEVEL OF CARE DETERMINATIONS FOR THE PROVISION OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES.--

A. A health care plan shall provide coverage for all in-network mental health or substance use disorder services, consistent with generally recognized standards of care, including placing a subscriber into a medically necessary

level of care.

B. Changes in level and duration of care shall be determined by the subscriber's provider in consultation with the insurer.

C. Level of care determinations shall include placement of a subscriber into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility or an outpatient treatment program.

D. Level of care services for a subscriber with a mental health or substance use disorder shall be based on the mental health or substance use disorder needs of the subscriber rather than arbitrary time limits."

SECTION 42. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] COORDINATION OF CARE.--At the request of a subscriber, a health care plan may facilitate communication between mental health or substance use disorder services providers and the subscriber's designated primary care provider to ensure coordination of care to prevent any conflicts of care that could be harmful to the subscriber."

SECTION 43. A new section of the Nonprofit Heath Care Plan Law is enacted to read:

"[NEW MATERIAL] CONFIDENTIALITY PROVISIONS.--A health care plan shall protect the confidentiality of a subscriber

receiving mental health or substance use disorder treatment."

SECTION 44. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] EXCEPTIONS.--The provisions of Sections 35 through 43 of this 2023 act do not apply to short-term plans subject to the Short-Term Health Plan and Excepted Benefit Act."

SECTION 45. [NEW MATERIAL] REPORTING.--The office of superintendent of insurance shall report annually to the legislative health and human services committee and the legislative finance committee regarding the implementation, regulation, compliance and enforcement of the provisions of this 2023 act.

HAFC→~~SECTION 46. APPROPRIATION.--One million dollars ($1,000,000) is appropriated from the general fund to the office of superintendent of insurance for expenditure in fiscal year 2024 and subsequent fiscal years to hire staff to regulate, monitor compliance and enforce the provisions of this act. Any unexpended or unencumbered balance remaining at the end of a fiscal year shall not revert to the general fund.~~←HAFC

SECTION HAFC→~~47.~~←HAFC HAFC→46.←HAFC APPLICABILITY.--The provisions of this act are applicable to group health insurance policies, health care plans or certificates of health insurance, other than small group health plans, that are delivered, issued for delivery or renewed in this state on or

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after January 1, 2024.

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