**HOUSE BILL XXX**

**54TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2019**

INTRODUCED BY

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FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; REQUIRING PARITY-COMPLIANCE REPORTS FROM INSURERS, HEALTH MAINTENANCE ORGANIZATIONS, AND NONPROFIT HEALTH CARE CORPORATIONS; PARITY IMPLEMENTATION SPECIFICATIONS FOR THE SUPERINTENDENT; INSURANCE COVERAGE REQUIREMENTS FOR MEDICATION-ASSISTED TREATMENT.

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

 SECTION 1. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

 "[NEW MATERIAL] PARITY REPORTING REQUIREMENTS.--

 A. An insurer that delivers, issues for delivery, or renews an individual health insurance policy, health care plan or certificate of health insurance or an insurer that offers, issues or renews an individual health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance shall submit an annual report to the superintendent on or before May 1st, that contains the following information:

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

 (2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits;

 (3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) and for each NQTL identified in paragraph (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL 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 medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of 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 evidence relied upon in designing each NQTL

 (c) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to 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 NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

 (d) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health and substance use disorder benefits are comparable to, and applied no more stringently 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 insurer that the results of the analyses above indicate that the insurer is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).”

SECTION 2. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

 "[NEW MATERIAL] PARITY REPORTING REQUIREMENTS.--

A. An insurer that delivers, issues for delivery, or renews a group health insurance policy, health care plan or certificate of health insurance or an insurer that offers, issues or renews a group health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance shall submit an annual report to the superintendent on or before May 1st, that contains the following information:

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

 (2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits;

 (3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) and for each NQTL identified in paragraph (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL 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 medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of 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 evidence relied upon in designing each NQTL

 (c) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to 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 NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

 (d) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health and substance use disorder benefits are comparable to, and applied no more stringently 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 insurer that the results of the analyses above indicate that the insurer is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).”

SECTION 3. A new section of the Health Maintenance Organization Law is enacted to read:

 "[NEW MATERIAL] PARITY REPORTING REQUIREMENTS.--

A. A health maintenance organization that delivers, issues for delivery, or renews an individual or group contract or a health maintenance organization that offers, issues or renews individual or group coverage in connection with a contract shall submit an annual report to the superintendent on or before May 1st, that contains the following information:

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

 (2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits;

 (3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) and for each NQTL identified in paragraph (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL 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 medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of 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 evidence relied upon in designing each NQTL

 (c) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to 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 NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

 (d) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health and substance use disorder benefits are comparable to, and applied no more stringently 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 health maintenance organization that the results of the analyses above indicate that the health maintenance organization is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).”

SECTION 4. A new section of the Nonprofit Health Care Plan Law is enacted to read:

 "[NEW MATERIAL] PARITY REPORTING REQUIREMENTS.--

A. A corporation that delivers, issues for delivery, or renews an individual or group nonprofit health care plan or a corporation that offers, issues or renews individual or group coverage in connection with a nonprofit health care plan shall submit an annual report to the superintendent on or before May 1st, that contains the following information:

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

 (2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits;

 (3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) and for each NQTL identified in paragraph (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL 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 medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of 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 evidence relied upon in designing each NQTL

 (c) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to 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 NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

 (d) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental health and substance use disorder benefits are comparable to, and applied no more stringently 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 corporation that the results of the analyses above indicate that the corporation is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).”

SECTION 5. A new section of Chapter 59A, Article 2 NMSA 1978 is enacted to read:

 "[NEW MATERIAL] PARITY IMPLEMENTATION REQUIREMENTS.--

 A. The superintendent shall implement and enforce applicable provisions of the 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 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3), includes:

 (1) Proactively ensuring compliance by each insurer, health maintenance organization, or corporation that delivers, issues for delivery, or renews an individual or group health insurance policy, health care plan, certificate of health insurance, contract or nonprofit health care plan or an insurer, health maintenance organization, or corporation that offers, issues or renews an individual or group health insurance policy, plan, certificate or coverage in connection with a health insurance policy, plan, certificate of health insurance, contract or nonprofit health care plan;

 (2) Evaluating all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations;

 (3) Performing parity compliance market conduct examinations of insurers, health maintenance organizations, or corporations that deliver, issue for delivery, or renew individual or group health insurance policies, health care plans, certificates of health insurance, contracts or nonprofit health care plans or insurers, health maintenance organizations, or corporations that offer, issue or renew individual or group health insurance policies, plans, certificates or coverage in connection with a health insurance policies, plans, certificates of health insurance, contracts or nonprofit health care plans, particularly market conduct examinations that focus on nonquantitative treatment limitations such as prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, and geographic restrictions, among other nonquantitative treatment limitations;

 (4) Requesting that insurers, health maintenance organizations, and corporations submit comparative analyses during the form review process demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental health and substance use disorder benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits; and

 (5) The superintendent may adopt rules, under section 9 of this Article, as may be necessary to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

 B. Not later than March 31st, 2020, the superintendent shall issue a report and educational presentation to the Legislature that shall:

 (1) Cover the methodology the superintendent is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and any federal regulations or guidance relating to the compliance and oversight of MHPAEA;

 (2) Cover the methodology the superintendent is using to check for compliance with 59A-23E-18 and 59A-23-6;

 (3) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations;

 (4) Detail any educational or corrective actions the superintendent has taken to ensure compliance with MHPAEA and 59A-23E-18 and 59A-23-6; and

 (5) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the superintendent finds appropriate, posting the report on the Internet website of the office of the superintendent of insurance.

SECTION 6. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

 "[NEW MATERIAL] MEDICATION-ASSISTED TREATMENT REQUIREMENTS.--

 A. Each insurer that delivers, issues for delivery, or renews an individual health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews an individual health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance use disorders.

 B. Each insurer that delivers, issues for delivery, or renews an individual health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews an individual health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall not impose any step therapy requirements before the insurer will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

 C. Each insurer that delivers, issues for delivery, or renews an individual health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews an individual health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall place all prescription medications approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the insurer.

 D. Each insurer that delivers, issues for delivery, or renews an individual health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews an individual health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

SECTION 7. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

 "[NEW MATERIAL] MEDICATION-ASSISTED TREATMENT REQUIREMENTS.--

 A. Each insurer that delivers, issues for delivery, or renews a group health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews a group health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance use disorders.

 B. Each insurer that delivers, issues for delivery, or renews a group health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews a group health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall not impose any step therapy requirements before the insurer will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

 C. Each insurer that delivers, issues for delivery, or renews a group health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews a group health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall place all prescription medications approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the insurer.

 D. Each insurer that delivers, issues for delivery, or renews a group health insurance policy, health care plan or certificate of health insurance that provides substance use disorder prescription drug benefits or an insurer that offers, issues or renews a group health insurance policy, plan or certificate in connection with a health insurance policy, plan or certificate of health insurance that provides substance use disorder prescription drug benefits shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

SECTION 8. A new section of the Health Maintenance Organization Law is enacted to read:

 "[NEW MATERIAL] MEDICATION-ASSISTED TREATMENT REQUIREMENTS.--

A. Each health maintenance organization that delivers, issues for delivery, or renews an individual or group contract that provides substance use disorder prescription drug benefits or a health maintenance organization that offers, issues or renews individual or group coverage in connection with a contract that provides substance use disorder prescription drug benefits shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance use disorders.

 B. Each health maintenance organization that delivers, issues for delivery, or renews an individual or group contract that provides substance use disorder prescription drug benefits or a health maintenance organization that offers, issues or renews individual or group coverage in connection with a contract that provides substance use disorder prescription drug benefits shall not impose any step therapy requirements before the health maintenance organization will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

 C. Each health maintenance organization that delivers, issues for delivery, or renews an individual or group contract that provides substance use disorder prescription drug benefits or a health maintenance organization that offers, issues or renews individual or group coverage in connection with a contract that provides substance use disorder prescription drug benefits shall place all prescription medications approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the health maintenance organization.

 D. Each health maintenance organization that delivers, issues for delivery, or renews an individual or group contract that provides substance use disorder prescription drug benefits or a health maintenance organization that offers, issues or renews individual or group coverage in connection with a contract that provides substance use disorder prescription drug benefits shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

SECTION 9. A new section of the Nonprofit Health Care Plan Law is enacted to read:

 "[NEW MATERIAL] MEDICATION-ASSISTED TREATMENT REQUIREMENTS.--

A. Each corporation that delivers, issues for delivery, or renews an individual or group nonprofit health care plan that provides substance use disorder prescription drug benefits or a corporation that offers, issues or renews individual or group coverage in connection with a nonprofit health care plan that provides substance use disorder prescription drug benefits shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance use disorders.

 B. Each corporation that delivers, issues for delivery, or renews an individual or group nonprofit health care plan that provides substance use disorder prescription drug benefits or a corporation that offers, issues or renews individual or group coverage in connection with a nonprofit health care plan that provides substance use disorder prescription drug benefits shall not impose any step therapy requirements before the corporation will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

 C. Each corporation that delivers, issues for delivery, or renews an individual or group nonprofit health care plan that provides substance use disorder prescription drug benefits or a corporation that offers, issues or renews individual or group coverage in connection with a nonprofit health care plan that provides substance use disorder prescription drug benefits shall place all prescription medications approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the corporation.

 D. Each corporation that delivers, issues for delivery, or renews an individual or group nonprofit health care plan that provides substance use disorder prescription drug benefits or a corporation that offers, issues or renews individual or group coverage in connection with a nonprofit health care plan that provides substance use disorder prescription drug benefits shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.