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DELAWARE STATE SENATE  
153rd GENERAL ASSEMBLY

SENATE BILL NO. 22  
AS AMENDED BY  
HOUSE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO INSURANCE COVERAGE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and by redesignating accordingly:

§ 3343. Insurance coverage for ~~serious mental illness~~ mental health disorders and substance use disorders [For application of this section, see 81 Del. Laws, c. 29, § 3; and 82 Del. Laws, c. 199, § 3].

(a) Definitions. — For purposes of this section:

(1) “ASAM criteria” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of ~~patients~~ individuals with ~~addiction~~ a primary diagnosis of a substance use disorder established by the American Society of Addiction Medicine (“ASAM”) ~~for use in determining medically necessary treatment.~~

(3) “~~Drug and alcohol dependencies~~” means ~~substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16.~~

(6) “~~Medication-assisted treatment~~” means ~~the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of drug and alcohol dependencies.~~

(7) “~~Serious mental illness~~” means ~~any of the following biologically-based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders shall be utilized to determine whether a beneficiary of a health benefit plan is suffering from a serious mental illness.~~

( ) “Child and Adolescent Level of Care Utilization System / Service Intensity Instrument” or “CALOCUS-CASII” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of children and adolescents aged 6 to 18 with a primary diagnosis of a mental health disorder established by the American Association for Community Psychiatry (“AACCP”) and the American Academy of Child and Adolescent Psychiatry (“AACAP”).

( ) “Early Childhood Service Intensity Instrument” or “ECSII” means the latest version of the service planning tool established by AACAP for determination of the intensity of services for children and families with emotional, behavioral, or developmental needs, including those who are experiencing environmental stressors that may put them at risk for such problems.

( ) “Emergency care” means care provided to treat a mental health disorder or substance use disorder that meets the definition of an emergency medical condition as defined in § 3349 of this title.

( ) “Generally accepted standards of mental health disorder and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health disorder and substance use disorder care include published peer-reviewed scientific studies and medical literature and clinical practice guidelines and other recommendations of nonprofit health care professional associations.

( ) “Level of Care Utilization System” or “LOCUS” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of adults over 18 years of age with a primary diagnosis of a mental health disorder established by AACCP.

( ) “Medically necessary” means a service or product addressing the specific needs of a covered person, for the purpose of screening, preventing, diagnosing, managing or treating a mental health disorder or substance use disorder, including minimizing the progression of a disorder or its symptoms, in a manner that is all of the following:

- a. In accordance with the generally accepted standards of mental health disorder and substance use disorder care.
- b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
- c. Not primarily for the economic benefit of the carrier or for the convenience of the covered person, treating physician, or other health care provider.

( ) “Mental health disorders and substance use disorders” means a mental health disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

( ) “Nonprofit health care professional associations” means a not-for-profit health care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and that issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, and American Association for Community Psychiatry.

( ) “Serious mental illness” means any of the following mental health disorders: neurodevelopmental disorders; schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; anxiety disorders; obsessive-compulsive and related disorders; trauma- and stressor-related disorders; dissociative disorders; somatic symptom and related disorders; feeding and eating disorders; personality disorders; and disruptive, impulse-control, and conduct disorders. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders must be utilized to determine whether a beneficiary of a health benefit plan has a serious mental illness.

( ) “Urgent mental health disorder and substance use disorder care” means care that is delivered on an expedited basis for the treatment of an acute mental health disorder or substance use disorder with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health care-provider’s scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person’s or enrollee’s condition and prognosis.

( ) “Utilization review” means reviewing and approving, modifying, delaying, or denying, requests by health care providers, covered persons, or their authorized representatives for coverage of health care services, based in whole or in part on medical necessity, or for out-of-network services required pursuant to subsection (f) of this section.

( ) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

*(b) Coverage of ~~serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders. —*

(1) a. Carriers shall provide coverage for ~~serious mental illnesses and drug and alcohol dependencies~~ in all medically necessary services for mental health disorders or substance use disorders under all health benefit plans delivered or issued for delivery in this State. Coverage for ~~serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders must provide all of the following:

~~1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.~~

1. The levels of care described in the ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII.

2. Unlimited medically necessary treatment services for ~~drug and alcohol dependencies~~ mental health disorders and substance use disorders as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ~~ASAM criteria~~, in all of the following: ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII, including all of the following levels of care:

~~A. Treatment provided in residential setting.~~ Residential settings.

B. Intensive outpatient programs.

C. Inpatient settings, including withdrawal management.

3. Emergency services to treat mental health disorders and substance use disorders, including emergency transportation to an appropriate provider or facility for the purposes of stabilization, mobile crisis response teams, crisis receiving and stabilization services, and other services necessary to screen, evaluate, and stabilize an individual experiencing a mental health disorder or substance use disorder emergency.

4. For purposes of paragraph (b)(1)a.3. of this section, mobile crisis response services provided by a state-operated program or by a program authorized by the Division of Substance Abuse and Mental Health are considered emergency services. A carrier shall reimburse a state-operated or state-authorized mobile crisis program that submits claims for covered services consistent with this section. Nothing in this section requires a carrier to establish or duplicate a mobile crisis delivery system where the State operates or authorizes such services.

5. Nothing in this subsection requires a carrier to cover non-clinical placements or supports, including foster care or recovery residences that are not licensed or certified as behavioral treatment programs under Delaware law; provided, however, that if a carrier provides coverage for such services or settings, the carrier shall apply the requirements of this section to that coverage and shall cover medically necessary clinical services, including services delivered in residential treatment settings, as required under paragraph (b)(1)a.2. of this section.

b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan that does any of the following:

1. containing Contains terms that place a greater financial burden on ~~an insured a~~ covered person for covered services provided in the diagnosis and treatment of a ~~serious mental illness and drug and alcohol dependency~~ mental health disorder or substance use disorder than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

2. Discriminates, in its benefit design or implementation of its benefit design, against covered persons because of their history of, present, or predicted mental health disorder or substance use disorder.

(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of ~~serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary ~~treatment services of serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

b. Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

c. Coverage provided under this paragraph (b)(2) of this section may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the

health benefit plan and in compliance with the Mental Health Parity and Addiction Equity Act's financial requirements; provided, however, a health benefit plan must not impose an additional copayment or coinsurance on a covered person who received an emergency supply of the same medication in the same 30-day period in which the emergency supply of medication was dispensed.

d. This paragraph (b)(2) of this section does not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a 30-day supply of such medication, provided that the total sum of copayments or coinsurance for an entire 30-day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a 30-day supply of such medication.

(3) A health benefit plan that provides coverage for prescription drugs must place at least 1 formulation of ~~a medication-assisted treatment~~ each FDA-approved medication to treat one or more substance use disorders, regardless of whether the prescription drug is formulary, non-formulary, or excluded, on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

- a. Buprenorphine.
- b. Naltrexone.
- c. Naloxone.
- d. A product containing both buprenorphine and naloxone.
- e. Disulfiram.
- f. Acamprosate.

(4) A health benefit plan that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an opioid treatment program as defined under 42 C.F.R. § 8.2.

(c) *Eligibility for coverage.* — (1) Subject to the limitations under subsection (d) of this section, a health benefit plan may condition coverage of services provided in the diagnosis and treatment of a ~~serious mental illness and drug and alcohol dependency~~ mental health disorder or substance use disorder on any of the following requirements:

a. That the services must be rendered by a mental health disorder or substance use disorder professional licensed or certified by the State Board of Licensing, ~~including, but not limited to,~~ psychologists, psychiatrists, social workers, and other such mental health professionals, or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health disorder or substance use disorder facility licensed by the State

or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse as set forth in Chapter 22 of Title 16, or substantially similar licensing entities in other states. Nothing in this paragraph (c)(1)a. of this section affects a health benefit plan's obligation to cover medically necessary team-based services, including Coordinated Specialty Care and Assertive Community Treatment, of a mental health disorder or substance use disorder so long as such services are supervised by a licensed or certified professional.

b. That the services must be medically necessary.

c. That the services must be covered services subject to any administrative requirements of the health benefit plan.

(2) A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a ~~serious mental illness and drug and alcohol dependency~~ mental health disorder or substance use disorder in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions include precertification and referral requirements.

(d) *Benefit management.* — (1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder ~~serious mental illness and drug and alcohol dependency~~ to those services that are deemed medically necessary as follows:

a. The management of benefits for ~~serious mental illnesses and drug and alcohol dependencies~~ mental health disorders or substance use disorders may be by methods used for the management of benefits provided for other medical conditions, ~~or may be by management methods unique to mental health benefits, including pre-admission screening, prior authorization of services, including~~ utilization review, and the development and monitoring of treatment plans.

b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary ~~treatment services of drug and alcohol dependencies~~ serious mental illnesses or substance use disorders, including inpatient treatment or on a prescription medication under paragraph (b)(3) of this section. No other provision of this section may be construed to expand the prohibition in this paragraph to mental health disorder benefits not subject to this paragraph.

c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally

recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient, ~~including the periodic consultation with the carrier to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by the American Society of Addiction Medicine (“ASAM”) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient,~~ and conduct periodic assessments using ASAM, LOCUS, CALOCUS-CASII, or ECSII as appropriate to the covered person’s age and primary diagnosis, to determine continued stay, transfer or discharge to ensure that the inpatient treatment is medically necessary for the patient covered person.

d. Any utilization review of treatment provided under paragraph (b)(1) of this section may include a review of all ~~services~~ non-emergency care provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management; provided, however, the carrier may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that such ~~treatment~~ non-emergency care was not medically necessary if such inpatient treatment was contrary to the ~~evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by ASAM or, if applicable, any state-specific ASAM criteria.~~ ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII.

e. A carrier must ensure that a covered person does not have any financial obligation to the facility an in-network provider for any treatment under paragraph (b)(1) of this section other than any copayment, coinsurance, or deductible otherwise required under the health benefit plan.

f. A carrier must authorize coverage of prescription medicine without imposing a step therapy requirement for at least 1 formulation of each prescription medication for ~~medication-assisted~~ the treatment of mental health disorder or substance use disorder that is on each tier of the drug formulary developed and maintained by the carrier. A carrier may impose a step therapy requirement for a prescription medication only to require use of a therapeutically equivalent generic drug that is rated as therapeutically equivalent (AB-rated) by the United States Food and Drug Administration and has the same active ingredient, dosage form, and strength as the prescribed medication. Notwithstanding any step

therapy requirement permitted under this subsection, a carrier shall authorize coverage of the prescribed dosage form or formulation of the prescribed medication when the prescribed formulation is reasonably expected to provide clinical benefit for the covered person.

g. Utilization review and utilization review criteria may not deviate from current generally accepted standards of mental health disorder and substance use disorder care. In conducting utilization review, a carrier shall apply the relevant, age-appropriate criteria or guidelines set forth in the most recent version of treatment criteria or guidelines developed by the nonprofit health care association for the relevant clinical specialty and shall not apply different, additional, conflicting, or more restrictive utilization review criteria. In conducting utilization review permitted by this subsection relating to service intensity or level of care placement, continued stay, or transfer or discharge, the carrier shall apply the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII, as applicable, and shall authorize placement at the service intensity and level of care consistent with that criteria. If the carrier's application of the applicable patient placement criteria is not consistent with the service intensity or level of care placement requested by the covered person or the covered person's provider, any adverse benefit determination notice must include full details of the carrier's assessment under the applicable criteria to the provider and the covered person.

h. Notwithstanding paragraph (d)(1)g. of this subsection, the Commissioner, in consultation with the Division of Substance Abuse and Mental Health, may designate a specific edition or version of the ASAM criteria, LOCUS, CALOCUS-CASII, ECSII, or other nonprofit health care professional association treatment criteria or guidelines required under paragraph (d)(1)g. of this subsection during a transition from one edition or version to a subsequent edition or version to ensure alignment with state licensure standards.

~~(2) This section shall not be interpreted to require a carrier to employ the same benefit management procedures for serious mental illnesses and drug and alcohol dependencies that are employed for the management of other illnesses or diseases covered by the health benefit plan or to require parity or equivalence in the rate, or dollar value of, claims denied.~~

(e) *Exclusions.* — This section does not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a) of this section.

~~(f) *Out-of-network Availability of in-network services.* — Where a health benefit plan provides benefits for the diagnosis and treatment of serious mental illnesses and drug and alcohol dependencies within a network of providers and~~

where a beneficiary of the health benefit plan obtains services consisting of diagnosis and treatment of a serious mental illness and drug and alcohol dependency outside of the network of providers, this section shall not apply. The health benefit plan may contain terms and conditions applicable to out of network services without reference to this section.

(1) A carrier shall maintain an adequate network in each of its health benefit plans to ensure timely access to non-urgent mental health disorder and substance use disorder services within 10 business days and to urgent mental health disorder and substance use disorder services within 24 hours. If a covered person requests assistance to obtain medically necessary services and the carrier fails to secure the delivery of those services from an appropriate in-network provider within applicable network adequacy standards established under state or federal law, the carrier shall, in a timely manner, execute a single-case agreement that allows the covered person to receive medically necessary services, including any follow-up services to complete a course of treatment, from an appropriate out-of-network provider. If the carrier identifies an appropriate in-network provider who can deliver medically necessary services within the applicable network adequacy standards and the covered person declines those services, the carrier has satisfied its obligation under this subsection. For the purposes of this subsection, "appropriate provider" includes providers who have the training and experience necessary to provide age- and condition-appropriate services to treat the covered person under the requirements of this section.

(2) The single-case agreement executed pursuant to this subsection shall do all of the following:

- a. Reimburse the out-of-network provider for covered services at a rate negotiated by the provider and the carrier.
- b. Apply no greater cost-sharing requirements than would apply if the services were provided by an in-network provider, with such cost-sharing amounts accruing toward the in-network deductible and out-of-pocket maximum.
- c. Specify the duration, scope, and services covered under the agreement.
- d. Treat services provided pursuant to the agreement as covered services under the health benefit plan for the duration of the agreement.
- e. Specify that the provider shall accept payment from the carrier and the covered person's in-network cost sharing as payment in full.

(3) If the Commissioner determines that the carrier failed to execute a single-case agreement under this section in a timely manner, the Commissioner may order the carrier to hold the covered person harmless for any costs in excess of in-network cost-sharing that the covered person incurred to obtain medically necessary services from an out-of-network provider.

(4) A carrier shall disclose, in the health benefit plan policy and on the carrier's publicly accessible website, a covered person's rights under this subsection and the process by which a covered person may request assistance from the carrier in obtaining medically necessary services from an appropriate in-network provider within applicable network adequacy standards, including a telephone number and a dedicated webpage or electronic submission mechanism to make such requests, and the circumstances under which the carrier must enter into a single-case agreement with an out-of-network provider, with no greater cost-sharing than would apply if the services were provided by an in-network provider.

*(g) Reporting requirements. —*

Each carrier must submit a report to the Delaware Health Information Network in conjunction with the Commissioner on or before July 1 2019, and any year thereafter during which the carrier makes significant changes to how it designs and applies its medical management protocols; the report must contain the following information:

(1) A description of the process used to develop or select the ~~medical necessity utilization review~~ criteria for ~~mental illness and drug and alcohol dependencies~~ mental health disorder and substance use disorder benefits and the process used to develop or select the ~~medical necessity utilization review~~ criteria for medical and surgical benefits.

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to ~~mental illness and drug and alcohol dependencies benefits~~ mental health disorder or substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to ~~mental illness and drug and alcohol dependencies~~ mental health disorder or substance use disorder benefits that do not also 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 (g)(1) of this section and for each NQTL identified in paragraph (g)(2) of this section, 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 illness and drug and alcohol dependencies benefits~~ mental health disorder or 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, ~~for mental illness and drug and alcohol dependencies~~ mental health disorder or 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, for 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 illness and drug and alcohol dependencies~~ mental health disorder or 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.

e. Disclose the specific findings and conclusions reached by the carrier that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136, 45 C.F.R. 147.160, and any other related federal regulations found in the Code of Federal Regulations.

(4) Any information submitted to the Delaware Health Information Network and the Commissioner by a carrier that is ~~considered proprietary by the carrier~~ a trade secret or confidential or privileged commercial or financial information shall not be made public record.

(5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private right of action.

(h) Nothing in this section shall be construed to: limit

(1) Limit or reduce any benefit, entitlement, or coverage conferred by § 3366 of this title including, ~~but not limited to,~~ provider and service eligibility.

(2) Prohibit exclusions for experimental or investigational services that comply with the parity requirements of this section.

(3) Require a carrier to switch to the latest version of the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII criteria, or diagnostic manuals or classifications during a plan year when a new version of the criteria or manuals is released after a plan year has begun.

(i) This section does not apply to plans of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act, 42 U.S.C. §§ 1395 et seq., 1396 et seq., and 1397aa et seq., known as Medicare, Medicaid, or any other coverage under a state or federal government plan.

(j) Disclosure of nonquantitative treatment limitation parity compliance analyses.

(1) A health care provider, a current covered person, or a prospective covered person may request of a carrier any nonquantitative treatment limitation parity compliance analysis (NQTL parity compliance analysis) that a carrier is required to have completed by 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 37 300gg-26.

(2) Within 30 days of receiving a request pursuant to paragraph (j)(1) of this section, a carrier must provide a copy of the requested NQTL parity compliance analysis to the requesting person, free of charge.

(3) Every health benefit plan policy and mental health disorder and substance use disorder provider contract must disclose the following information:

a. A notification of the right to request an NQTL parity compliance analysis.

b. Instructions for how to request an NQTL parity compliance analysis.

(k) The provisions published at 89 Federal Register 77586 et seq. on September 23, 2024, are incorporated into this section in their entirety and apply as state law. This incorporation remains in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(l) Under all health benefit plans delivered or issued for delivery in this State, if a carrier provides any benefits for a mental health disorder or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health disorder or substance use disorder in every classification in which medical or surgical benefits are provided. For purposes of this subsection, "core treatments" means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health disorder or substance use disorder care. For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the carrier provides benefits for one or more medical conditions or surgical procedures. A carrier does not provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the carrier provides benefits for core treatments for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health disorder or substance use disorder with respect to a classification, the carrier is not required to provide benefits for core treatments for such condition or disorder in that classification, but must provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(m) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, a carrier may not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health disorder or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health disorder or substance use disorder benefits as compared to medical or surgical benefits.

(n) A nonquantitative treatment limitation applicable to mental health disorder or substance use disorder benefits in a classification may not be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical or surgical benefits in the classification. To test compliance with this subsection, a carrier shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health disorder or substance use disorder benefits and medical or surgical benefits and carefully consider the impact as part of the plan's evaluation. As part of its evaluation, the carrier may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, those differences will be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, the carrier must take reasonable action to address the material differences to ensure compliance and must document the actions that have been or are being taken by the carrier to address material differences in access to mental health disorder or substance use disorder benefits, as compared to medical or surgical benefits.

Section 2. Amend Chapter 35, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and by redesignating accordingly:

§ 3571U. Mental Health Parity and Addiction Equity Act ~~reporting~~ requirements.

(a) Each health insurer offering group health insurance coverage that provides ~~mental illness and drug and alcohol dependencies~~ mental health disorder or substance use disorder benefits must submit a report to the Delaware Health Information Network and Commissioner on or before July 1 2019, and any year thereafter during which the insurer makes

significant changes to how it designs and applies its medical management protocols; the report must contain the following information:

(1) A description of the process used to develop or select the ~~medical necessity utilization review~~ criteria for ~~mental illness and drug and alcohol dependencies~~ mental health disorder and substance use disorder benefits and the process used to develop or select the ~~medical necessity utilization review~~ criteria for medical and surgical benefits.

(2) Identification of all nonquantitative treatment limitations (NQTLs) that are applied to ~~mental illness and drug and alcohol dependencies~~ mental health disorder or substance use disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to ~~mental illness and drug and alcohol dependencies~~ mental health disorder or substance use disorder benefits that do not also apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the ~~medical necessity utilization review~~ criteria described in paragraph (1) of this ~~section~~ subsection and for each NQTL identified in paragraph (2) of this ~~section~~ subsection, 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 illness and drug and alcohol dependencies~~ mental health disorder or 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, for ~~mental illness and drug and alcohol dependencies~~ mental health disorder or 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, for 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 illness and~~

~~drug and alcohol dependencies~~ mental health disorder or 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.

e. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(4) Any information submitted to the Delaware Health Information Network and Commissioner by a carrier that is ~~considered proprietary by the carrier~~ a trade secret or confidential or privileged commercial or financial information shall not be made public record.

(5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private cause of action.

(b) Disclosure of nonquantitative treatment limitation parity compliance analyses.

(1) A health care provider, a current covered person, or a prospective covered person may request of a carrier any nonquantitative treatment limitation parity compliance analysis (NQTL parity compliance analysis) that a carrier is required to have completed by 29 U.S.C. Sec. 1185a or 42 U.S.C. Sec. 37 300gg-26.

(2) Within 30 days of receiving a request pursuant to paragraph (b)(1) of this section, a carrier must provide a copy of the requested NQTL parity compliance analysis to the requesting person, free of charge.

(3) Every health benefit plan policy and mental health disorder and substance use disorder provider contract must disclose the following information:

a. A notification of the right to request an NQTL parity compliance analysis.

b. Instructions for how to request an NQTL parity compliance analysis.

(c) The provisions published at 89 Federal Register 77586 et seq. on September 23, 2024, are incorporated into this section in their entirety and apply as state law. This incorporation remains in effect notwithstanding any subsequent amendment, repeal, or nonenforcement of the referenced federal provisions.

(d) Under all health benefit plans delivered or issued for delivery in this State, if a carrier provides any benefits for a mental health disorder or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health disorder or substance use disorder in every classification in which medical or surgical benefits are provided. For purposes of this subsection, "core treatments" means standard treatments or courses of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health disorder or substance use disorder care.

For purposes of this subsection, whether the benefits provided are considered "meaningful benefits" is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the carrier provides benefits for one or more medical conditions or surgical procedures. A carrier does not provide meaningful benefits under this subsection unless it provides benefits for core treatments for that condition or disorder in each classification in which the carrier provides benefits for core treatments for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health disorder or substance use disorder with respect to a classification, the carrier is not required to provide benefits for core treatments for such condition or disorder in that classification, but must provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

(e) For the purposes of determining comparability and stringency for nonquantitative treatment limitations, a carrier may not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health disorder or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health disorder or substance use disorder benefits as compared to medical or surgical benefits.

(f) A nonquantitative treatment limitation applicable to mental health disorder or substance use disorder benefits in a classification may not be more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical or surgical benefits in the classification. To test compliance with this subsection, a carrier shall collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health disorder or substance use disorder benefits and medical or surgical benefits and carefully consider the impact as part of the plan's evaluation. As part of its evaluation, the carrier may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits. To the extent the relevant data evaluated suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, those differences will be considered a strong indicator of a noncompliant nonquantitative treatment limitation. Where the relevant data suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health disorder or substance use disorder benefits as compared to medical or surgical benefits in a classification, the carrier must take reasonable action to address the material differences to ensure compliance and must document the actions that have been or are being taken by the carrier to address

material differences in access to mental health disorder or substance use disorder benefits, as compared to medical or surgical benefits.

§ 3571X. ~~Medication-assisted treatment for drug and alcohol dependencies.~~ Medications for mental health disorders and substance use disorders.

~~(a) For purposes of this section, “medication-assisted treatment” means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of drug and alcohol dependencies.~~

~~(b) (a) If group health insurance coverage provides prescription medication benefits for the treatment of mental illness and drug and alcohol dependencies~~ a mental health disorder or substance use disorder, as defined by §3578 of this title, a health insurer must place at least 1 formulation of a medication-assisted treatment each FDA-approved medication to treat 1 or more substance use disorders, regardless of whether the prescription drug is formulary, non-formulary, or excluded, on the lowest tier of the drug formulary developed and maintained by the carrier, including each of the following:

- (1) Buprenorphine.
- (2) Naltrexone.
- (3) Naloxone.
- (4) A product containing both buprenorphine and naloxone.
- (5) Disulfiram.
- (6) Acamprosate.

~~(e) (b) A health insurer that provides coverage for prescription drugs must cover the fees associated with the administration or dispensing of methadone dispensed at an opioid treatment program as defined under 42 C.F.R. § 8.2.~~

~~(d) (c) A health insurer shall provide benefits under this section as follows:~~

- (1) Not impose a prior authorization requirement.
- (2) Must authorize coverage of prescription medicine without imposing a step therapy requirement for at least 1 formulation of each ~~prescription medication for medication-assisted treatment~~ FDA-approved medication to treat 1 or more substance use disorders that is on each tier of the drug formulary developed and maintained by the health insurer. A health insurer may impose a step therapy requirement for a prescription medication only to require use of a therapeutically equivalent generic drug that is rated as therapeutically equivalent (AB-rated) by the United States Food and Drug Administration and has the same active ingredient, dosage form, and strength as the prescribed medication. Notwithstanding any step therapy requirement permitted under this subsection, a health

insurer shall authorize coverage of the prescribed dosage form or formulation of the prescribed medication when the prescribed formulation is reasonably expected to provide clinical benefit for the covered person.

§ 3578. Insurance coverage for ~~serious mental illness~~ mental health disorders and substance use disorders [For application of this section, see 81 Del. Laws, c. 29, § 3].

(a) Definitions. — For the purposes of this section, the following words and phrases shall have the following meanings:

(1) “ASAM criteria” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of ~~patients~~ individuals with ~~addiction~~ a primary diagnosis of a substance use disorder established by the American Society of Addiction Medicine (“ASAM”) for use in determining medically necessary treatment.

(3) “~~Drug and alcohol dependencies~~” means substance abuse disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of Title 16.

(5) “~~Serious mental illness~~” means any of the following biologically based mental illnesses: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual shall be utilized to determine whether a beneficiary of a health benefit plan is suffering from a serious mental illness.

( ) “Child and Adolescent Level of Care Utilization System / Service Intensity Instrument” or “CALOCUS-CASII” means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of children and adolescents aged 6 to 18 with a primary diagnosis of a mental health disorder established by the American Association for Community Psychiatry (“AACP”) and the American Academy of Child and Adolescent Psychiatry (“AACAP”).

( ) “Early Childhood Service Intensity Instrument” or “ECSII” means the latest version of the service planning tool established by AACAP for determination of the intensity of services for children and families with emotional, behavioral, or developmental needs, including those who are experiencing environmental stressors that may put them at risk for such problems.

( ) “Emergency care” means care provided to treat a mental health disorder or substance use disorder that meets the definition of an emergency medical condition as defined in § 3349 of this title.

( ) “Generally accepted standards of mental health disorder and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant

clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health disorder and substance use disorder care include published peer-reviewed scientific studies and medical literature and clinical practice guidelines and other recommendations of nonprofit health care professional associations.

() "Level of Care Utilization System" or "LOCUS" means the latest version of comprehensive set of guidelines for placement, continued stay, and transfer or discharge of adults over 18 years of age with a primary diagnosis of a mental health disorder established by AACP.

() "Medically necessary" means a service or product addressing the specific needs of a covered person, for the purpose of screening, preventing, diagnosing, managing, or treating a mental health disorder or substance use disorder, including minimizing the progression of a disorder or its symptoms, in a manner that is all of the following:

- a. In accordance with the generally accepted standards of mental health disorder and substance use disorder care.
- b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
- c. Not primarily for the economic benefit of the carrier, purchaser, or for the convenience of the covered person, treating physician, or other health care provider.

() "Mental health disorders and substance use disorders" means a mental health disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.

() "Nonprofit health care professional association" means a not-for-profit health care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and that issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, and American Association for Community Psychiatry.

( ) “Serious mental illness” means any of the following mental health disorders: neurodevelopmental disorders; schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; anxiety disorders; obsessive-compulsive and related disorders; trauma- and stressor-related disorders; dissociative disorders; somatic symptom and related disorders; feeding and eating disorders; personality disorders; and disruptive, impulse-control, and conduct disorders. The diagnostic criteria set out in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders must be utilized to determine whether a beneficiary of a health benefit plan has a serious mental illness.

( ) “Urgent mental health disorder and substance use disorder care” means care that is delivered on an expedited basis for the treatment of an acute mental health disorder or substance use disorder with symptoms of sufficient severity pursuant to a determination by a licensed treating health-care provider, operating within the health-care provider's scope of practice and professional expertise, that the failure to provide the service is likely to result in serious, long-term health complications or a material deterioration in the covered person's or enrollee's condition and prognosis.

( ) “Utilization review” means reviewing and approving, modifying, delaying, or denying, requests by health care providers, covered persons, or their authorized representatives for coverage of health care services, based in whole or in part on medical necessity, or for out-of-network services required pursuant to subsection (f) of this section.

( ) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

(b) Coverage of ~~serious mental illness and drug and alcohol dependency;~~ mental health disorders and substance use disorders. —

(1) a. Carriers shall provide coverage for ~~serious mental illnesses and drug and alcohol dependencies in all medically necessary services for mental health disorders or substance use disorders under all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders must provide all of the following:

~~1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.~~

1. The levels of care described in the ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII.

2. Unlimited medically necessary ~~treatment services for drug and alcohol dependencies~~ mental

health disorders and substance use disorders as required by the Mental Health Parity and Addiction

Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, in all

of the following: ASAM criteria, LOCUS, CALOCUS-CASII, and ECSII, including all of the following levels of care:

- A. Treatment provided in residential settings.
- B. Intensive outpatient programs.
- C. Inpatient settings, including withdrawal management.

3. Emergency services to treat mental health disorders and substance use disorders, including emergency transportation to an appropriate provider or facility for the purposes of stabilization, mobile crisis response teams, crisis receiving and stabilization services, and other services necessary to screen, evaluate, and stabilize an individual experiencing a mental health or substance use disorder emergency.

4. For purposes of paragraph (b)(1)a.3. of this section, mobile crisis response services provided by a state-operated program or by a program authorized by the Division of Substance Abuse and Mental Health are considered emergency services. A carrier shall reimburse a state-operated or state-authorized mobile crisis program that submits claims for covered services consistent with this section. Nothing in this section requires a carrier to establish or duplicate a mobile crisis delivery system where the State operates or authorizes such services.

5. Nothing in this subsection requires a carrier to cover non-clinical placements or supports, including foster care or recovery residences that are not licensed or certified as behavioral health treatment programs under Delaware law; provided, however, that if a carrier provides coverage for such services or settings, the carrier shall apply the requirements of this section to that coverage and shall cover medically necessary clinical services, including services delivered in residential treatment settings, as required under paragraph (b)(1)a.2. of this section.

b. Subject to subsections (a) and (c) through (g) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan that does any of the following:

- 1. containing Contains terms that place a greater financial burden on an insured a covered person for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency mental health disorder or substance use disorder than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan. By way of example, such terms include deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits or limits in the coverage of prescription medicines.

2. Discriminates, in its benefit design or implementation of its benefit design, against covered persons because of their history of, present, or predicted mental health disorder or substance use disorder.

(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of ~~serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary ~~treatment services of serious mental illnesses and drug and alcohol dependencies~~ mental health disorders and substance use disorders where an emergency medical condition, as defined in § 3565(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

b. Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

c. Coverage provided under this paragraph (b)(2) of this section may be subject to copayments, coinsurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan and in compliance with the Mental Health Parity and Addiction Equity Act's financial requirements; provided, however, a health benefit plan must not impose an additional copayment or coinsurance on a covered person who received an emergency supply of the same medication in the same 30-day period in which the emergency supply of medication was dispensed.

d. This paragraph (b)(2) of this section does not preclude the imposition of a copayment or coinsurance on the initial emergency supply of medication in an amount that is less than the copayment or coinsurance otherwise applicable to a 30-day supply of such medication, provided that the total sum of copayments or coinsurance for an entire 30-day supply of the medication does not exceed the copayment or coinsurance otherwise applicable to a 30-day supply of such medication.

(c) Eligibility for coverage. — Subject to the limitations set forth in subsection (d) of this section, a health benefit plan may condition coverage of services provided in the diagnosis and treatment of a ~~serious mental illness and drug and alcohol dependency~~ mental health disorder or substance use disorder on any of the further requirements that the service or services:

(1) Must be rendered by a mental health disorder or substance use disorder professional licensed or certified by the State Board of Licensing, including, ~~but not limited to,~~ psychologists, psychiatrists, social workers

and such other mental health professionals, or a drug and alcohol counselor who has been certified by the Delaware Certified Alcohol and Drug Counselors Certification Board, or in a mental health disorder or substance use disorder facility licensed by the State or in a treatment facility approved by the Department of Health and Social Services or the Bureau of Alcoholism and Drug Abuse as set forth in Chapter 22 of Title 16 or substantially similar licensing entities in other states; . Nothing in this paragraph (c)(1) of this section affects a health benefit plan's obligation to cover medically necessary team-based services, including Coordinated Specialty Care and Assertive Community Treatment, of a mental health disorder or substance use disorder so long as such services are supervised by a licensed or certified professional.

(2) Must be medically ~~necessary~~; and necessary.

(3) Must be covered services subject to any administrative requirements of the health benefit plan.

A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a ~~serious mental illness and drug and alcohol dependency~~ mental health disorder or substance abuse disorder in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions may include, by way of example and not by way of limitation, precertification and referral requirements.

(d) Benefit management. —

(1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a mental health disorder or substance use disorder ~~serious mental illness and drug and alcohol dependency~~ to those ~~services that are deemed medically necessary~~ as follows:

a. The management of benefits for ~~serious mental illnesses and drug and alcohol dependencies~~ mental health disorders or substance use disorders may be by methods used for the management of benefits provided for other medical conditions, ~~or may be by management methods unique to mental health benefits~~. Such ~~may include, by way of example and not limitation, pre-admission screening, prior authorization of services, including~~ utilization review and the development and monitoring of treatment plans.

b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary ~~treatment, services of serious mental illnesses or substance use disorders, including in-patient treatment, of drug and alcohol~~

~~dependencies, treatment. Nothing in § 3571U of this title may be construed to expand the prohibition in this paragraph to mental health disorder benefits not subject to this paragraph.~~

c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient, ~~including the periodic consultation with the carrier to ensure that the facility is using the evidence-based and peer-reviewed clinical review tool utilized by the carrier which is designated by the American Society of Addiction Medicine (“ASAM”) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient, and conduct periodic assessments using ASAM, LOCUS, CALOCUS-CASII, or ECSII, as appropriate to the covered person’s age and primary diagnosis, to determine continued stay, transfer, or discharge to ensure that the inpatient treatment is medically necessary for the patient covered person.~~

d. Any utilization review of treatment provided under paragraph (b)(1) of this section may include a review of all ~~services~~ non-emergency care provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management; provided, however, the carrier may only deny coverage for any portion of the initial 14-day inpatient treatment on the basis that such ~~treatment~~ non-emergency care was not medically necessary if such inpatient treatment was contrary to the ~~evidence-based and peer-reviewed clinical review tool utilized by the carrier which is designated by ASAM or, if applicable, any state-specific ASAM criteria.~~ ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII.

e. A carrier must ensure that a covered person does not have any financial obligation to the facility an in-network provider for any treatment under paragraph (b)(1) of this section other than any copayment, coinsurance, or deductible otherwise required under the health benefit plan.

f. Utilization review and utilization review criteria may not deviate from current generally accepted standards of mental health disorder and substance use disorder care. In conducting utilization review, a carrier shall apply the relevant, age-appropriate criteria or guidelines set forth in the most recent

versions of treatment criteria or guidelines developed by the nonprofit professional association for the relevant clinical specialty and shall not apply different, additional, conflicting, or more restrictive utilization review criteria. In conducting utilization review permitted by this subsection relating to service intensity or level of care placement, continued stay, or transfer or discharge, the carrier shall apply the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII, as applicable, and shall authorize placement at the service intensity and level of care consistent with that criteria. If the carrier's application of the applicable patient placement criteria is not consistent with the service intensity or level of care placement requested by the covered person or the covered person's provider, any adverse benefit determination notice must include full details of the carrier's assessment under the applicable criteria to the provider and the covered person.

g. Notwithstanding paragraph (d)(1)f. of this subsection, the Commissioner, in consultation with the Division of Substance Abuse and Mental Health, may designate a specific edition or version of the ASAM criteria, LOCUS, CALOCUS-CASII, ECSII, or other nonprofit health care professional association treatment criteria or guidelines required under paragraph g. of this subsection during a transition from one edition or version to a subsequent edition or version to ensure alignment with state licensure standards.

~~(2) This section shall not be interpreted to require a carrier to employ the same benefit management procedures for serious mental illnesses and drug and alcohol dependencies that are employed for the management of other illnesses or diseases covered by the health benefit plan or to require parity or equivalence in the rate, or dollar value of, claims denied.~~

(e) Exclusions. —

This section ~~shall~~ does not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a) of this section.

~~(f) Out of network services. Where a health benefit plan provides benefits for the diagnosis and treatment of serious mental illnesses and drug and alcohol dependencies within a network of providers and where a beneficiary of the health benefit plan obtains services consisting of diagnosis and treatment of a serious mental illness and drug and alcohol dependency outside of the network of providers, the provisions of this section shall not apply. The health benefit plan may contain terms and conditions applicable to out of network services without reference to the provisions of this section.~~

(f) Availability of in-network services.

(1) A carrier shall maintain an adequate network in each of its health benefit plans to ensure timely access to non-urgent mental health disorder and substance use disorder services within 10 business days and to urgent mental health disorder and substance use disorder services within 24 hours. If a covered person requests assistance from the carrier to obtain medically necessary services and the carrier fails to secure the delivery of those services from an appropriate in-network provider within applicable network adequacy standards established under state or federal law, the carrier shall, in a timely manner, execute a single-case agreement that allows the covered person to receive medically necessary services, including any follow-up services to complete a course of treatment, from an appropriate out-of-network provider. If the carrier identifies an appropriate in-network provider who can deliver medically necessary services within the applicable network adequacy standards and the covered person declines those services, the carrier has satisfied its obligation under this subsection. For purposes of this subsection, "appropriate provider" includes providers who have the training and experience necessary to provide age- and condition-appropriate services to treat the covered person under the requirements of this section.

(2) The single-case agreement executed pursuant to this subsection shall do all of the following:

a. Reimburse the out-of-network provider for covered services at a rate negotiated by the provider and the carrier.

b. Apply no greater cost-sharing requirements than would apply if the services were provided by an in-network provider, with such cost-sharing amounts accruing toward the in-network deductible and out-of-pocket maximum.

c. Specify the duration, scope, and services covered under the agreement.

d. Treat services provided pursuant to the agreement as covered services under the health benefit plan for the duration of the agreement.

e. Specify that the provider shall accept payment from the carrier and the covered person's in-network cost sharing as payment in full.

(3) If the Commissioner determines that the carrier failed to execute a single-case agreement under this section in a timely manner, the Commissioner may order the carrier to hold the covered person harmless for any costs in excess of in-network cost-sharing that the covered person incurred to obtain medically necessary services from an out-of-network provider.

(4) A carrier shall disclose, in the health benefit plan policy and on the carrier's publicly accessible website, a covered person's rights under this subsection and the process by which a covered person may request assistance from the carrier in obtaining medically necessary services from an appropriate in-network provider within

applicable network adequacy standards, including a telephone number and a dedicated webpage or electronic submission mechanism to make such requests, and the circumstances under which the carrier must enter into a single-case agreement with an out-of-network provider, with no greater cost-sharing than would apply if the services were provided by an in-network provider.

(g) Nothing in this section shall be construed to: ~~limit~~

(1) Limit or reduce any benefit, entitlement, or coverage conferred by § 3570A of this title including, ~~but not limited to,~~ provider and service eligibility.

(2) Prohibit exclusions for experimental or investigational services that comply with the parity requirements of § 3571U of this title.

(3) Require a carrier to switch to the latest version of the ASAM criteria, LOCUS, CALOCUS-CASII, or ECSII criteria, or diagnostic manuals or classifications during a plan year when a new version of the criteria or manuals is released after a plan year has begun.

Section 3. Effective Date. This Act applies to all health insurance policies, contracts, or certificates issued, renewed, modified, altered, amended or reissued in this state after December 31, 2027.