

# MAINE STATE LEGISLATURE

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**LAWS**  
**OF THE**  
**STATE OF MAINE**

**AS PASSED BY THE**

**ONE HUNDRED AND THIRTIETH LEGISLATURE**

**SECOND SPECIAL SESSION**  
**September 29, 2021**

**SECOND REGULAR SESSION**  
**January 5, 2022 to May 9, 2022**

**THE GENERAL EFFECTIVE DATE FOR**  
**SECOND SPECIAL SESSION**  
**NON-EMERGENCY LAWS IS**  
**DECEMBER 29, 2021**

**THE GENERAL EFFECTIVE DATE FOR**  
**SECOND REGULAR SESSION**  
**NON-EMERGENCY LAWS IS**  
**AUGUST 8, 2022**

**PUBLISHED BY THE REVISOR OF STATUTES**  
**IN ACCORDANCE WITH THE MAINE REVISED STATUTES ANNOTATED,**  
**TITLE 3, SECTION 163-A, SUBSECTION 4.**

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**Augusta, Maine**  
**2022**

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

**PUBLIC SAFETY, DEPARTMENT OF  
Gambling Control Board Z002**

Initiative: Provides allocation for one Public Safety Inspector I position and associated All Other costs.

OTHER SPECIAL REVENUE FUNDS	2021-22	2022-23
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$75,161
All Other	\$0	\$8,389
OTHER SPECIAL REVENUE FUNDS TOTAL	\$0	\$83,550

**Emergency clause.** In view of the emergency cited in the preamble, this legislation takes effect when approved.

Effective April 20, 2022.

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**CHAPTER 637**

**H.P. 1309 - L.D. 1758**

**An Act Regarding Access to  
Telehealth Behavioral Health  
Services during Public Health  
Emergencies**

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

**Sec. 1.** 22 MRSA §51 is enacted to read:

**§51. Exemption to written informed consent requirement for mental health services and substance use disorder treatment during public health emergency**

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Licensed facility" means a facility licensed under Title 5, section 20005, subsection 6, paragraph B or Title 34-B, section 1203-A.

B. "Public health emergency" means a federal public health emergency declared pursuant to 42 United States Code, Section 247d or a state public health emergency declared pursuant to section 802 or Title 37-B, chapter 13, subchapter 2.

**2. Informed consent.** The department may not require a licensed facility to obtain written informed consent from a person receiving mental health services or substance use disorder treatment from the licensed facility during a public health emergency. A licensed facility shall obtain consent from a person receiving mental health services or substance use disorder treatment

during a public health emergency; such consent may be obtained through verbal, electronic or written means.

**3. Rulemaking.** The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

**Sec. 2. Department of Health and Human Services to amend certain licensing rules.** No later than January 1, 2023, the Department of Health and Human Services shall amend its rules in 14-193 C.M.R. Chapter 6, Licensing of Mental Health Facilities, and 14-118 C.M.R. Chapter 5, Regulations for Licensing and Certifying of Substance Abuse Treatment Programs, to allow a facility licensed under the Maine Revised Statutes, Title 5, section 20005, subsection 6, paragraph B or Title 34-B, section 1203-A to obtain consent through verbal, electronic or written means from a person during a public health emergency in accordance with Title 22, section 51. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

See title page for effective date.

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**CHAPTER 638**

**H.P. 1355 - L.D. 1822**

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

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

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

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

for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

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

**3-B. Parity in cost sharing for primary care and behavioral health office visits; group health plan.** A group health plan, other than a small group health plan subject to subsection 3-A, with an effective date on or after January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year. After the first behavioral health office visit, a health plan may not apply a copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a

high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

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

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

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

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

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

C. Performing parity compliance market conduct examinations of carriers that execute, deliver, issue for delivery, continue or renew individual policies or individual and group health care contracts, particularly market conduct examinations that focus on nonquantitative treatment limitations, including, but not limited to, prior authorization, concur-

rent review, retrospective review, step therapy, network admission standards, reimbursement rates and geographic restrictions; and

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

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

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

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

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

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

within the corresponding classification of benefits. At a minimum, the results of the analysis must:

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

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

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

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

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

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

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

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

**PROFESSIONAL AND FINANCIAL  
REGULATION, DEPARTMENT OF**

**Insurance - Bureau of 0092**

Initiative: Provides funding for one Senior Market Conduct Examiner position and related All Other costs to evaluate consumer or provider complaints concerning mental health and substance use disorder coverage for federal parity violations, to facilitate new annual mental health and substance use disorder parity reporting requirements from insurers and to conduct market conduct examinations of carriers for compliance with federal parity law.

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

See title page for effective date.

**CHAPTER 639**

**H.P. 1377 - L.D. 1867**

**An Act To Codify MaineCare  
Rate System Reform**

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

**Sec. 1. 5 MRSA §12004-I, sub-§36-F** is enacted to read:

**36-F.**

Human Services	<u>MaineCare Rate Reform</u>	<u>Not Authorized</u>	<u>22 MRSA</u>
	<u>Expert Technical Advisory Panel</u>		<u>§3173-J, sub-§5</u>

**Sec. 2. 22 MRSA §3173-J** is enacted to read:

**§3173-J. Rate-setting system for development and maintenance of sustainable, efficient and value-oriented MaineCare payment models and rates**

This section establishes a rate-setting system for the development and maintenance of MaineCare payment models and rates that comply with the requirement in 42 United States Code, Section 1396a that rates be consistent with efficiency, economy and quality of care; that are adequate to support MaineCare member access to services; and that are equitable and data-driven.

**1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Alternative payment model" means a health care payment model that uses financial incentives to promote or leverage greater value for patients, purchasers, payers or providers and that connects at least a portion of reimbursement to performance on defined quality measures.

B. "MaineCare section of policy" means a set of MaineCare-covered services, as categorized by the department through the adoption of rules that specify the parameters for coverage.

C. "Rate determination" means a process conducted by the department to establish the reimbursement rate methodology, base rate amount or payment model for a MaineCare section of policy or for a specific covered service, whether through adoption or adaptation of a benchmark rate from another payer or development through a rate study.

D. "Rate study" means an analysis conducted by the department or its contracted vendor to develop a recommended rate methodology and resulting base rate amount and payment model based on the service model and cost components for the service.

**2. Rate-setting system principles and processes.**

The department shall establish MaineCare provider reimbursement rates, including those paid through fee-for-service and alternative payment models. The rates must be established in accordance with the following principles and processes and adopted through rulemaking as described in subsection 3. The department shall:

A. Develop annually a schedule of rate determination by MaineCare section of policy in consultation with the MaineCare Rate Reform Expert Technical Advisory Panel established under subsection 5 as follows:

(1) Post the rate determination schedule on its publicly accessible website;

(2) Provide an opportunity for the public to review and comment on the rate determination schedule and make available a summary of these comments on its publicly accessible website; and

(3) Conduct off-schedule rate determinations as the department finds appropriate;

B. Conduct or contract for, every 4 years, a comprehensive benchmarking report to compare MaineCare rates for all services to those paid by Medicare, at least 5 comparison Medicaid states and any appropriate Maine commercial payers. The department shall provide public notice of the initiation of the comprehensive benchmarking process, provide an opportunity for the public to review and comment on the draft report and make available a summary of these comments alongside the final report;