CHAPTER 29
FORMERLY
SENATE BILL NO. 41
AS AMENDED BY
SENATE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO COVERAGE FOR SERIOUS MENTAL ILLNESS AND DRUG AND ALCOHOL DEPENDENCY.

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

Section 1. Amend § 3343, Title 18 of the Delaware Code as follows:

§ 3343. Insurance coverage for serious mental illness.

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

(1) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, carrier includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

"Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity, or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in subparagraph b. of this paragraph.

b. The certification required in subparagraph a. of this paragraph shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender, or other factors) charged for such policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the

information and statement required in subparagraph b. of this paragraph at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(3) "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.

(4) “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.

(b) *Coverage of serious mental illnesses and drug and alcohol dependencies. —*

(1)a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide:

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

2. Unlimited medically necessary treatment for drug and alcohol dependencies provided in residential settings as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

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 containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency 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, co-insurance 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)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 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 of serious mental illnesses and drug and alcohol dependencies 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, co-insurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan; provided, however, a health benefit plan must not impose an additional copayment

or co-insurance 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 co-insurance on the initial emergency supply of medication in an amount that is less than the copayment or co-insurance otherwise applicable to a 30 day supply of such medication, provided that the total sum of copayments or co-insurance for an entire 30 day supply of the medication does not exceed the copayment or co-insurance 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 on the further requirements that the service(s):

(1) Must be rendered by a mental health 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 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;

(2) Must be medically necessary; and

(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 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 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 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, 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, including in-patient treatment, of drug and alcohol dependencies.

c. The benefit prescribed by subsection (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 healthcare accrediting organization or the Division of Substance Abuse and Mental Health, 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, to ensure that the inpatient treatment is medically necessary for the patient.

d. Any utilization review of treatment provided under subsection (b)(1) of this section may include a review of all services provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment; provided, however, the carrier may only deny coverage for any portion of the initial 14 day inpatient treatment on the basis that such treatment 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.

e. A covered person does not have any financial obligation to the facility for any treatment under subsection (b)(1) of this section other than any copayment, co-insurance, or deductible otherwise required under the health benefit plan.

(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 not apply to plans or policies not within the definition of health benefit plan, as set out in subsection (a)(2) 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, 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.

(g) Nothing in this section shall be construed to limit or reduce any benefit, entitlement, or coverage conferred by § 3366 of this title including, but not limited to, provider and service eligibility.

Section 2. Amend § 3578, Title 18 of the Delaware Code as follows:

§ 3578 Insurance coverage for serious mental illness.

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

(1) "Carrier" means any entity that provides health insurance in this State. For the purposes of this section, carrier includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, credit, dental, vision, Medicaid plans, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

"Health benefit plan" shall not include policies or certificates or specified disease, hospital confinement indemnity, or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

a. The carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in paragraph (a)(2)b. of this section.

b. The certification required in paragraph (a)(2)a. of this section shall contain the following:

1. A statement from the carrier certifying that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

2. A summary description of each policy or certificate described in this paragraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this State.

c. In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this State on or after January 1, 1999, the carrier files with the Commissioner the information and statement required in paragraph (a)(2)b. of this section at least 30 days prior to the date such a policy or certificate is issued or delivered in this State.

(3) "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.

(4) “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.

(b) *Coverage of serious mental illness and drug and alcohol dependency. —*

(1)a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide:

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

2. Unlimited medically necessary treatment for drug and alcohol dependencies provided in residential settings as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a).

c. 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 containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency 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, co-insurance 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)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 that include 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 of serious mental illnesses and drug and alcohol dependencies 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, co-insurance, and annual deductibles that are consistent with those imposed on other benefits within the health benefit plan; provided, however, a health benefit plan must not impose an additional copayment or co-insurance 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 co-insurance on the initial emergency supply of medication in an amount that is less than the copayment or co-insurance otherwise applicable to a 30 day supply of such medication, provided that the total sum

of copayments or co-insurance for an entire 30 day supply of the medication does not exceed the copayment or co-insurance 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 on the further requirements that the service or services:

(1) Must be rendered by a mental health 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 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;

(2) Must be medically necessary; and

(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 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 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 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, 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, including in-patient treatment, of drug and alcohol dependencies.

c. The benefit prescribed by subsection (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 healthcare accrediting organization or the Division of Substance Abuse and Mental Health, 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, to ensure that the inpatient treatment is medically necessary for the patient.

d. Any utilization review of treatment provided under subsection (b)(1) of this section may include a review of all services provided during such inpatient treatment, including all services provided during the first 14 days of such inpatient treatment; provided, however, the carrier may only deny coverage for any portion of the initial 14 day inpatient treatment on the basis that such treatment 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.

e. A covered person does not have any financial obligation to the facility for any treatment under subsection (b)(1) of this section other than any copayment, co-insurance, or deductible otherwise required under the health benefit plan.

(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 not apply to plans or policies not within the definition of health benefit plan, as set out in paragraph (a)(2) 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.

(g) Nothing in this section shall be construed to limit or reduce any benefit, entitlement, or coverage conferred by § 3570A of this title including, but not limited to, provider and service eligibility.

Section 3. Applicability Date. This Act applies to all individual and group health benefit plans issued or renewed on or after January 1, 2018.

Approved May 30, 2017