SB 582

Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 582 (Senator Kelley, *et al.*)
Finance Health and Government Operations

Health Insurance - Federal Mental Health Parity and Addiction Equity Act - Utilization Review Criteria and Standards

This bill requires health insurance entities that provide for utilization review of health care services to ensure that the criteria and standards to be used in conducting utilization review for mental health and substance use benefits are in compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

Fiscal Summary

State Effect: Any additional workload on the Maryland Insurance Administration can be handled within existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Current Law: MHPAEA requires group health plans of large employers, as well as qualified health plans sold in health insurance exchanges and in the small group and individual markets as of January 1, 2014, to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways.

MHPAEA prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those imposed on other general medical benefits. Patients can no longer be denied insurance reimbursement when they reach a lifetime or annual spending cap imposed on mental health or substance use disorder care. MHPAEA also imposes

nondiscrimination standards on medical management practices, medical necessity determinations, and provider network and compensation practices ("nonquantitative treatment limitations"). While an employer is not required to offer any health insurance coverage for addiction or mental health care, the coverage of any service for these disorders – including a primary care practitioner's treatment of depression or the coverage of any medication for a mental or substance use disorder in a prescription drug formulary – renders the plan subject to MHPAEA.

Under MHPAEA, in determining medical necessity through utilization review, carriers are required to use medical management standards that are comparable to and applied no more stringently than the standards used to determine medical necessity for other medical and surgical services.

Under Maryland law, entities that propose to issue or deliver individual, group, or blanket health insurance policies or contracts in the State or to administer health benefit programs that provide for the coverage of health care services and the utilization review of those services must have a certificate of registration as a private review agent from the Insurance Commissioner or contract with a certified private review agent. A private review agent must certify to the Commissioner that the criteria and standards the private review agent uses to conduct utilization review are objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from norms when justified on a case-by-case basis. A private review agent may not use criteria and standards for utilization review that do not meet these requirements.

A private review agent who performs utilization review on behalf of a payor must (1) make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within two working days after receiving the information necessary to make the determination; (2) make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within one working day after receiving the necessary information; and (3) make all determinations on whether to authorize or certify an emergency inpatient admission or an admission for residential crisis services for treatment of a mental, emotional, or substance abuse disorder within two hours after receipt of the necessary information. The private review agent must promptly notify the health care provider of the determination. If a private review agent makes an initial determination not to authorize a health care service, the law provides a process for a health care provider to seek reconsideration.

If a course of treatment has been preauthorized or approved for a patient, a carrier or a private review agent may not retrospectively render an adverse decision regarding the services delivered to the patient, unless (1) the information submitted to the private review agent was fraudulent or intentionally misrepresentative; (2) critical information requested by the private review agent was omitted; or (3) the planned course of treatment that was approved for the patient was not substantially followed.

Background: Utilization review is the process by which a carrier determines whether proposed and delivered medical services are medically necessary and will be reimbursed. Parity violations may occur when utilization review criteria are applied inappropriately (*i.e.*, the clinical criteria and evaluation processes used to determine medical necessity hold mental health and substance use disorder services to higher clinical evidence standards than medical and surgical benefits).

Additional Information

Prior Introductions: None.

Cross File: HB 1252 (Delegate A. Kelly, *et al.*) - Health and Government Operations.

Information Source(s): *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, Ellen M. Weber, University of Maryland Francis King Carey School of Law, 2012; Maryland Insurance Administration; Department of Legislative Services

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