Health Insurance – Utilization Review – Revisions (SB 791)
Senate Finance Committee
February 21, 2024
FAVORABLE WITH AMENDMENTS

Thank you for the opportunity to submit testimony in favor of SB 791 with amendments which, among other revisions, would require private review agents to use uniform utilization review standards in making medical necessity determinations for all medical conditions including mental health and substance use disorders. This testimony is submitted by the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV and AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health and substance use disorder services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance. Utilization review (UR) standards are at the core of whether Marylanders get access to the care they need and pay for through their insurance plan, and those standards must comply with the Parity Act.

We support SB 791 to ensure that private review agents (PRA) (1) use the right medical necessity standards when making authorization and payment decisions for mental health (MH) and substance use disorder (SUD) treatment and (2) provide more detailed information about the basis for adverse decisions. We urge the Committee to adopt two amendments that would apply to authorization decisions for MH and SUD care, as proposed in SB 93: requiring PRAs to make level of care determinations based on the patient's underlying chronic condition and requiring PRAs to explain the criteria it believes the patient has not satisfied prior to issuing a denial.

1. **Mandatory Use of Evidence-Based Medical Necessity Standards Developed by Professional Medical and Clinical Societies.**

SB 791 would require private review agents to use the medical necessity and level of care standards that have been developed by the non-profit medical and clinical specialty society for the relevant medical condition, unless a professional society does not have criteria for a specific condition. The proposed standard is consistent with the American Medical Association's Prior Authorization and Utilization Management Reform Principles, which recommends that UR entities "standardize criteria across the industry to promote uniformity and reduce administrative burden." (Principle #18). As the AMA explained, the lack of standardization and extensive use of proprietary forms imposes significant administrative burden on providers. For purposes of patient care, "any clinically based utilization management criteria should be similar – if not identical – across utilization review entities."

Maryland has required the use of standardized evidence-based UR standards for SUD care – the American Society of Addiction Medicine (ASAM) Criteria since 2019 Ins. § 15-802(d)(5). SB 791 would extend the same statutory protection to MH care, benefitting both consumers and providers. Regardless of a consumer's insurance plan, access to care would be based on standardized professional care guidelines that address the patient's full medical condition and psychosocial needs. A patient and their practitioner will have greater control over their health care because the UR criteria will be developed by a professional medical society that has no financial stake in the authorization of patient care. Receiving the right level of care at the initiation of treatment

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facilitates recovery and reduces the likelihood that the individual will cycle needlessly through more costly episodes of care.

Equally important, providers will spend less time challenging denials that have been based on proprietary standards that are inconsistent with professional society standards. We know that some MH providers do not participate in carrier networks because the administrative burden associated with addressing denials of patient care is far too onerous. The proposed UR standard, if implemented with fidelity, will, over time, improve patient care and practitioner participation in networks.

2. **Two Additional UR Protections Will Ensure Access to the Right Level of Care for Individuals with Mental Health and Substance Use Disorders.**

We urge the Committee to adopt two requirements, set out in SB 93, that would address unique barriers to more intensive levels of MH and SUD care. **First, PRAs must authorize treatment to address the patient's underlying chronic condition rather than make care determinations based on the patient's acute symptoms alone.** Like many medical conditions, an individual with a MH or SUD may present both acute symptoms (e.g. an overdose, psychotic episode, suicidal ideation) and an underlying condition (e.g. major depression, an alcohol or opioid use disorder), both of which must be treated through a range of services of varying degrees of intensity and/or medications. Health plans commonly deny authorization for medically necessary subacute care that is required for the treatment of the patient's chronic MH or SUD by using UR standards that require on-going acute symptoms. While the use of the professional society UR will begin to address this problem, the PRAs must also implement those standards with fidelity. Essentially, a PRA should not selectively apply the criteria in a way that prevents the patient from getting the care they need to recover – such as covering treatment for their withdrawal management from the substance but denying ongoing care at the appropriate to address the underlying SUD. To prevent this misapplication or selective application of the "right" criteria, we urge the Committee to require the PRA to make all decisions consistent with the required criteria for chronic care treatment and not limit treatment to services for acute care.

We also urge the Committee to adopt a second safeguard against erroneous denials of MH and SUD care by requiring the PRA to explain to the treating provider the specific criteria a patient does not meet ***before issuing the denial*** to allow for immediate corrective action. While SB 791 would appropriately require PRAs to provide more detailed information in their denial notices, a pre-denial explanation is important for MH and SUD care because Marylanders rarely challenge those adverse decisions. Only **one-half of one percent (0.59%)** of MH and SUD adverse decisions are challenged in a grievance process – a much lower rate than for other medical adverse decisions – even though **one-third (37%) of challenged decisions are overturned by the carrier.** Office of Attorney General, Health Education and Advocacy Unit, Annual Report on the Health Insurance Carrier Appeals and Grievances Process for FY 2023. Clearly many Marylanders who do not challenge their adverse decision are being denied insurance coverage to which they are entitled and need. The proposed amendment would reduce the burden on both patients who do not have the support or capacity to challenge an adverse decision as well as practitioners who must spend significant time engaging in post-denial discussions.

Thank you for considering our views. We urge the Committee to issue a favorable report with amendments on SB 791.

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