HB 455

Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 455 (Delegate Kelly, *et al.*)
Health and Government Operations Finance

Health Insurance - Mental Health Benefits and Substance Use Disorder Benefits - Reports on Nonquantitative Treatment Limitations and Data

This bill requires insurers, nonprofit health service plans, health maintenance organizations, and any other person or organization that provides health benefit plans in the State (collectively known as carriers) to submit two specified reports to the Insurance Commissioner, by March 1, 2022, and March 1, 2024, to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (Parity Act, also known as MHPAEA) and conduct a specified comparative analysis. By December 31, 2021, the Commissioner must create two forms for entities to submit or post to their websites a summary of the required reports and adopt regulations to implement the reporting requirements. **The bill terminates September 30, 2026.**

Fiscal Summary

State Effect: No effect in FY 2021. Maryland Insurance Administration (MIA) special fund expenditures increase by $55,100 in FY 2022 for contractual staff, as discussed below. MIA special fund revenues increase by an indeterminate amount from the $125 rate and form filing fee and any carrier penalties. No effect on the State Employee and Retiree Health and Welfare Benefits Program. Future years reflect ongoing costs, elimination of one-time costs, and elimination of the contractual position in FY 2026.

(in dollars)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
SF Revenue	$0	-	-	-	-
SF Expenditure	$0	$55,100	$51,500	$53,200	$54,900
Net Effect	$0	($55,100)	($51,500)	($53,200)	($54,900)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: "Parity Act classification" means inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits.

Compliance Report

By March 1, 2022, and March 1, 2024, each carrier that delivers or issues a health benefit plan in the State must identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets and submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act. The report must include the following information for the five health benefit plans identified:

- a description of the process used to develop or select the medical necessity criteria for mental health, substance use disorder (SUD), and medical and surgical benefits;
- for each Parity Act classification, identification of nonquantitative treatment limitations that are applied to mental health, SUD, and medical and surgical benefits;
- identification of the description of the nonquantitative treatment limitations in the carrier's plan documents and instruments under which the plan is established or operated; and
- the results of a specified comparative analysis.

Comparative Analysis

A carrier must conduct a comparative analysis for the nonquantitative treatment limitations identified in the compliance report as those limitations are written and in operation. The comparative analysis must demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health and SUD benefits in each Parity Act classification are comparable to, and are applied no more stringently than, those used for medical and surgical benefits.

A carrier must (1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit; (2) identify and define the specified evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation; (3) include the results of specified audits, reviews, and analyses performed on nonquantitative treatment limitations; (4) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations;

(5) disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with the Parity Act; and (6) identify the process used to comply with the Parity Act disclosure requirements for mental health, SUD, and medical/surgical benefits.

Benefits Report

By March 1, 2022, and March 1, 2024, each carrier that delivers or issues a health benefit plan in the State must submit a report to the Commissioner for the five health benefit plans identified in the compliance report on the following data for the immediately preceding calendar year for mental health, SUD, and medical/surgical benefits by Parity Act classification:

- the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health, SUD, and medical and surgical benefits in each Parity Act classification; and
- the number of claims submitted for mental health, SUD, and medical and surgical benefits in each Parity Act classification and the number, rates of, and reasons for denials of claims.

Submission of Reports

Both reports must (1) be submitted on a standard form developed by the Commissioner; (2) be submitted by the carrier that issues or delivers the health benefit plan; (3) be prepared in coordination with any entity the carrier contracts with to provide mental health and SUD benefits; (4) contain a signed statement attesting to the accuracy of the report; (5) be available to plan members and the public on the carrier's website in a summary form (developed by the Commissioner) that removes confidential or proprietary information; and (6) exclude any identifying information of any plan member.

Public Information Act Requests

A carrier submitting a report may submit a written request to the Commissioner that disclosure of specific information included in the report be denied under the Public Information Act. If so, the carrier must identify the particular information the disclosure of which the carrier requests be denied and cite the statutory authority that authorizes denial. The Commissioner may review a request submitted by a carrier and notify the carrier before granting access to information that was the subject of the request.

A carrier must disclose to a member on request any plan information contained in a report that is required to be disclosed to that member under federal or State law.

Insurance Commissioner Review of Reports and Penalties

The Commissioner must (1) review each report to assess each carrier's compliance with the Parity Act; (2) notify a carrier in writing of any noncompliance before issuing an administrative order; and (3) within 90 days after the notice of noncompliance is issued, allow the carrier to submit a compliance plan to MIA and reprocess any claims that were improperly denied because of the noncompliance.

If the Commissioner finds that the carrier failed to submit a complete report, the Commissioner may impose any penalty or take any authorized action, including issuing an administrative order that requires the carrier (or an entity delegated by the carrier) to cease the noncompliant conduct or practice or provide a payment that has been denied improperly because of noncompliance. The Commissioner must consider the late filing of a report and any parity violation to be a serious violation with a significantly deleterious effect on the public.

The Commissioner must also submit an interim report (by December 1, 2023) and a final report (by December 1, 2025) to the General Assembly summarizing findings after reviewing the carrier reports. In those reports, the Commissioner must make recommendations related to the value of and need for ongoing compliance and data reporting, among other items.

Current Law: Maryland's mental health parity law (§ 15-802 of the Insurance Article) prohibits discrimination against an individual with a mental illness, emotional disorder, or SUD by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply for the diagnosis and treatment of physical illnesses. Carriers are required to submit a demonstration of mental health parity compliance when they submit their form filings in the individual, small group, or large group fully insured markets. Self-insured plans are not required to submit documentation to MIA but rather are subject to federal fines and penalties for failure to comply.

MHPAEA (referred to in the bill as the Parity Act) 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 SUD benefits than those imposed on other general medical benefits. MHPAEA also imposes nondiscrimination standards on medical necessity determinations.

Background: At least six states (Colorado, Delaware, Illinois, Minnesota, New York, and Tennessee) have enacted legislation intended to help enforce existing mental health parity laws by requiring health plans to improve their reporting practices on the subject.

State Fiscal Effect: Under the bill, the Commissioner must develop standard and summary forms for carriers to submit their compliance and benefits reports to MIA (standard forms) and make the reports available on the carrier's website (summary forms), as well as regulations to implement the reporting requirements. Carriers must submit both reports (on the standard form) to the Commissioner by March 1, 2022, and March 1, 2024. The Commissioner must review each report to assess compliance, notify a carrier of noncompliance, require the carrier to address noncompliance, require reimbursement to members and beneficiaries for costs incurred as a result of noncompliance, and impose specified penalties.

MIA special fund revenues, therefore, increase from both the $125 rate and form filing fee for each carrier submission and from any penalty assessed on a carrier.

To implement the bill's requirements, special fund expenditures increase by $55,095 in fiscal 2022, which accounts for the bill's October 1, 2020 effective date. This estimate reflects the cost to hire one contractual mental health parity analyst, beginning July 1, 2021. The analyst will assist in developing forms, regulations, and report submission procedures by December 31, 2021; review carrier reports for compliance, notify carriers of noncompliance, and assess penalties as necessary for the reports due by March 1, 2022, and March 1, 2024; and assist in preparing the interim and final reports to the General Assembly. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Contractual Position	1.0
Salary and Fringe Benefits	$47,070
One-time Start-up Costs	4,890
Ongoing Operating Expenses	3,103
Total FY 2022 State Expenditures	**$55,095**

Future year expenditures reflect a full salary with annual increases and employee turnover and ongoing operating expenses. The contractual position is assumed to terminate December 31, 2025, after the final report to the General Assembly.

This estimate does not include any health insurance costs that could be incurred for specified contractual employees under the State's implementation of the federal Patient Protection and Affordable Care Act.

Additional Information

Prior Introductions: As introduced, SB 631 and HB 599 of 2019 were similar; both bills were amended and then enacted as Chapters 357 and 358 of 2019.

Designated Cross File: SB 334 (Senators Augustine and Hester) - Finance.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services - Office of Legislative Audits

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