LEGAL ACTION CENTER

Health Insurance – Coverage for Mental Health Benefits and Substance Use Disorder Benefits – Treatment Criteria – HB 455
Health and Government Operations Committee Hearing
February 20, 2020
SUPPORT

Thank you for the opportunity to submit testimony **in support of HB 455** which would: (1) establish annual carrier compliance and data reporting standards to improve state enforcement of the Mental Health Parity and Addiction Equity Act of 2008 (Parity Act); and (2) inform consumers of their rights under the Parity Act when denied a service for mental health or substance use disorder treatment.

This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that fights discrimination against individuals with histories of substance use disorders, HIV/AIDs and criminal history records and promotes sound public policies to expand access to health services for these individuals. The Legal Action Center also leads the Parity at 10 Campaign in Maryland to improve enforcement of the Parity Act: **an 11-year old federal statute** that prohibits discriminatory coverage of and access to mental health (MH) and substance use disorder (SUD) benefits in state-regulated individual, small group and large group plans. The Parity Act provisions have been incorporated into Maryland's mandated MH and SUD benefit. *See* Ins. § 15-802.

Maryland's regulators, working with provider and consumer stakeholders, have taken important steps to enforce the Parity Act in private and public insurance. **But those efforts clearly point to the need for a carrier compliance reporting model to improve the state's enforcement strategies. Compliance reporting is needed to root out well-documented discriminatory practices so that consumers get the services they need, pay for, and are entitled to receive under state and federal law.**

I. Documented Discrimination in Insurance Coverage of Mental Health and Substance Used Disorder Benefits

The Maryland Insurance Administration (MIA), at the request of the Senate Finance Committee in 2015 and in connection with a previous compliance reporting bill (SB 586/HB 1010), has conducted three market conduct surveys to assess carrier compliance with the Parity Act. Although the third survey is not yet complete, the MIA has identified parity violations by virtually all the state's carriers in the area of network adequacy: the one plan feature that the MIA investigated in-depth for discriminatory plan practices. The MIA has issued a total of 9 finals orders and, in its second and third reports, identified practices that suggest violations of the Parity Act, even if not addressed in an order. The MIA's orders, investigative findings and penalties are summarized and provided in Attachment 1.

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The MIA's third report contains troublesome findings regarding the carriers' failure to (1) conduct the most basic compliance reviews required by the Parity Act and (2) document the reviews they claim to conduct. According to the MIA:

- Carriers that have delegated responsibility to another entity to administer MH and SUD benefits did not include Parity Act compliance requirements in their contracts.
- Carriers did not document their policies and process for conducting "as written" compliance reviews and failed to provide any documentation of their "as written" reviews.
- Carriers failed to conduct "in operation" compliance reviews and some had no teams to conduct audits.

A second source of Maryland carrier data – the July 2018 and 2019 network adequacy reports – also suggests underlying Parity Act violations. For the second network adequacy reporting period, only 1 of 6 carrier networks reported compliance with the State's appointment wait time metric of providing non-urgent MH and SUD care within 10 days for 95% of plan enrollees. COMAR § 31.10.44.05. *See* Attachment 2. Carrier compliance rates for MH and SUD services were far worse than compliance for somatic services. This gap in network provider panels points to underlying network admission practices, reimbursement rate standards and utilization management practices that likely constitute a Parity Act violation.

Maryland's consumers and providers cannot wait any longer for carrier accountability, which can only be achieved with the submission of a compliance and data report.

II. Legal Framework for Compliance Reporting and the MIA's Enforcement Process

The federal Parity Act regulations explicitly bar insurers from selling plans that do not comply with the Act's requirements (45 C.F.R. § 146.136(h); 29 C.F.R. § 2590.712(h)). **This means that carriers should already be conducting the parity compliance analysis that would be required under HB 455. The MIA's third market conduct findings unfortunately confirm that carriers are not conducting the required analyses.**

If carriers had any doubt about the scope of the analysis required under the Parity Act, the U.S. Departments of Labor (DOL) and Health and Human Services created a clear roadmap in its April 2018 *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act*. (Available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.). The DOL Self-Compliance Tool sets out an 11-step process that requires reporting and analysis of all financial requirements, quantitative treatment limitations, non-quantitative treatment limitations (NQTLs) and plan disclosure requirements. The NQTLs, which are the focus of the proposed compliance and data report in HB 455, are limitations on care access that are not expressed numerically, such as prior authorization and continuing authorization requirements, medical necessity criteria, network adequacy, reimbursement rates and prescription drug coverage.

The Self-Compliance tool is also crystal clear that health plans must be prepared to provide all the information on the above plan features, including "records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical as well as MH/SUD benefits to ensure they can demonstrate compliance with the law." Self-Compliance Tool at 20.

The MIA reviews several, **but not most**, of the required elements in the Self-Compliance Tool in its plan approval process. It annually examines plan compliance with financial requirements for individual and small group plans under the Parity Act, benefit coverage and exclusions, and ensures that lifetime and annual dollar limits are not imposed on plans in violation of the Affordable Care Act. Maryland Insurance Administration Bulletin 18-03 (Jan. 26, 2018) at 3. (Available at https://insurance.maryland.gov/Insurer/Documents/bulletins/18-03-2019-Affordable-Care-Act-Rate-and-Form-Filing.pdf.) **The MIA does not, however, investigate NQTLs** since those features are not evident on the face of plan documents. Apart from the required market conduct surveys, the MIA relies on consumer complaints or market conduct exams to identify standards that unfairly deny access to MH and SUD services. **To examine those critical plan features systematically, the MIA must request that information from carriers who have sole possession of that information and, as noted above, should have already gathered and analyzed for compliance.**

HB 455 tracks the DOL's compliance analysis and would also require carriers to submit quantitative data on 5 metrics that are needed to document the implementation of plan practices under the NQTL requirement. Under the Parity Act, the "rules" for establishing an NQTL must be comparable to and applied no more stringently for MH/SUD benefits that for medical/surgical benefits both "as written" in the policy and as implemented "in operation." (45 C.F.R. § 146.136(c)(4); 29 C.F.R. § 2590.712(c)(4)). The date metrics are essential to examine the implementation of the plan and uncover disparate practices that may reflect an underlying Parity Act violation.

The identification of disparate metrics was central to the New York Attorney General's enforcement actions against New York carriers that resulted **in 8 settlements with 7 different health plans, requiring them to change their practices, return $2 million to patients and pay $3 million in penalties.** New York State Office of the Attorney General, Health Care Bureau, Mental Health Parity: Enforcement by the New York State Office of the Attorney General (May 2018), https://ag.ny.gov/sites/default/files/hcb_mental_health_parity_report.pdf.

The proposed metrics track some of the information the MIA requested in its third market conduct survey and data that the DOL has identified as key to a compliance review. Self-Compliance Tool at 17.

III. Limitations of a Complaint Process to Uncover Parity Violations

The MIA relies heavily on complaints to uncover Parity Act violations and has encouraged MH and SUD providers to file complaints when carriers inappropriately deny services. **A complaint process, however, is ill-suited to uncover Parity violations.**

We know from the Attorney General's Annual Report on the Health Insurance Carrier Appeals and Grievances Process that a relatively small percentage of consumers file a grievance of a carrier's adverse MH or SUD decision. In 2019, carriers reported issuing 790 adverse decisions for MH/SUD services (1.05%) with 108 (1.26%) internal grievances filed; far fewer than the rate of internal grievances of adverse decisions for physician services (7.39%). Office of the Attorney General, Annual Report on the Health Insurance Carrier Appeals and Grievances Process: FY 2019 at 22, available at

http://www.marylandattorneygeneral.gov/CPD%20Documents/HEAU/Anual%20Reports/HEAUannrpt19.pdf. **This does not mean, however, that parity violations do not exist.**

The Parity at 10 Campaign conducted a survey in mid-2018 in five states, including Maryland, to evaluate whether consumers were aware of the Parity Act protections, including their right to challenge an adverse decision that denied or limited care. The survey results (based on a convenience sample and not randomized) suggest that consumers are not aware of their right to appeal an adverse decision, are more likely to file an appeal for a medical condition than a MH/SUD decision, and are more inclined to accept a carrier's decision for a MH or SUD denial than to appeal it. Among the survey respondents of 1,239 individuals, 545 (44%) of whom were Marylanders, 62% had employer-based insurance. The key findings are:

- Only half (49%) of consumers knew that a denial of a MH/SUD service can be appealed and 13% were not sure.
- 60% of consumers who had been denied care accepted their health plan's denial of care, and 33% reported filing an appeal with their insurance company.
- Nearly all consumers (93%) reported that they would "be likely" to challenge a denial of coverage for a medical service, but only 78% of consumers reported they would "be likely" to file a denial of coverage for a MH/SUD service.

Available on www.parityat10.org. Beyond a consumer's lack of knowledge about appeal rights and tendency to accept rather than appeal a carrier's denial, other factors contribute to the limited number of parity complaints.

- Neither the consumer nor the provider possesses the plan information that is required to determine whether a parity violation exists.
- Many practices that violate the Parity Act relate to plan practices that patients have no influence over, such as network adequacy and reimbursement rate setting, and cannot be appealed through a grievance process.
- In the midst of a crisis, family members are fighting to get the care needed to save the life of a loved one and most have no capacity to pursue a complaint.
- Most parity violations are systemic in nature and will not be rooted out through an individual complaint, even if one were filed.

HB 455 would improve a consumer's awareness of their rights under the Parity Act by including notification of those rights in adverse decision letters. **That alone will not root out parity violations: compliance reporting is needed.**

IV. Parity Enforcement in Other States: Compliance and Metric Reporting

In light of the limitations of plan review and consumer complaints, an increasing number of state regulators and legislatures have adopted compliance reporting requirements and many others are considering bills that would do so. HB 455's parity compliance reporting requirements are consistent with enforcement requirements that have been adopted in legislation by 5 other states, Colorado, Connecticut, Delaware, Illinois, New Jersey, and the District of Columbia. Each state's reporting provisions are set out in Attachment 3. Delaware and the

District of Columbia have begun collecting compliance reports, as of July 2019 and October 2019, respectively, and the other states will begin collecting reports in 2020 or 2021.

Two states have imposed compliance reporting through regulatory agency actions. Since October 2013, Massachusetts has required carriers to submit an annual certification of Parity Compliance to the Division of Insurance and plan information regarding the implementation of medical necessity criteria and authorization processes to demonstrate compliance. Div. of Insurance Bulletin 2013-06 (May 31, 2013); M.G.L. ch. 26, § 8K. California's Dept. of Managed Health Care has required issuers to provide detailed pre-market parity compliance information for financial requirements, and quantitative and non-quantitative treatment limitations since late 2014. CAL. HEALTH & SAFETY § 1374.76.

Five states, including Colorado, Connecticut, Massachusetts, New York, and Vermont, and the District of Columbia also require carriers to submit compliance data consistent with the proposed data requirements in HB 455. *See* Attachment 4 for required State metrics. Delaware's Department of Insurance has also required carriers to submit audits of parity compliance that include data elements proposed in HB 455. *See* Attachment 4.

Maryland has been a leader is expanding access to mental health and substance use disorder services and protecting the Affordable Care Act standards that ensure insurance coverage for Marylanders who suffer from a mental health or substance use condition. But we can and must do more to stem the tide of our opioid and suicide crises and ensure the delivery of appropriate treatment services. **Insurance carriers must show that they are living up to non-discrimination standards that have been in place for over a decade and cover the services that consumers are paying for and are entitled to receive.**

We urge a favorable report on HB 455.

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ATTACHMENT 1

MIA Orders and Market Conduct Survey Findings: Parity Act Compliance

Carrier	Order/ Date	Violations	Penalty
Aetna/Coventry[i]	MIA-2015-12-035	• No in-network psychologists in all of Western Maryland • 2 counties with no in-network psychiatrists and 1 county had 1 • 1 county no in-network licensed professional counselors or licensed social workers • Statewide - 1 or no in-network methadone treatment programs	No Financial Penalty
CareFirst Blue Choice	MIA-2015-10-036	• Statewide - no in-network methadone treatment programs • Different reimbursement rates for MH/SUD network because used a separate vendor to manage MH/SUD benefits • Geofactors applied to somatic illnesses not applied to MH/SUD providers	Initial Financial Penalty of $30,000; Retracted Based on Consent Order
CareFirst GHMSI	MIA-2015-10-034	• Failure to meet network adequacy goals for neuropsychological doctors and geriatric psychiatrists	No Financial Penalty
Cigna[ii]	MIA-2015-10-007	• Additional screening requirement for MH/SUD credentialing • Requirement that MH/SUD applicants who had received treatment for SUD must be sober for 2 years • Imposed shorter response time for MH/SUD providers to submit requested credentialing information	$9,000 Financial Penalty

Evergreen	MIA- 2015-10-033	• Used 2 different vendors for MH/SUD services and somatic services and no coordination to ensure no more stringent credentialing requirements • Used different factors to set reimbursement rates for MH/SUD • 1 county - no in-network psychiatrists, psychologists, licensed social workers or professional counselors	No Financial Penalty
United Healthcare[iii]	MIA-2017-08-009	• Reviewed 5-year malpractice history for all MH/SUD facilities applying for credentialing but no malpractice review for med/surg facilities	$2,000 Financial Penalty
CareFirst BlueChoice, Inc. GHMSI (CareFirst BlueCrossBlueShield)	MIA-2018-01-023	• BlueChoice – on-line behavioral health directory failed to list 25 of 27 in-network MH hospitals and 5 of 7 MH non-hospital facilities • BC/BS Blue Preferred – online behavioral health directory failed to list any in-network inpatient MH facilities	$20,250 Financial Penalty against BlueChoice $4,725 Financial Penalty Against CareFirst BC/BS
Second Market Conduct Survey Other Findings	June 2017 MIA indicated carriers corrected issues during investigations. Carriers not identified	• Carrier limited disclosure of med/surg medical necessity criteria to 3 guidelines at a time to member/provider • Large group plan – financial testing did not account for all OP benefits • Carrier – on-line directory indicated no in-network inpatient MH facilities • Carrier's credentialing documents for MH/SUD	

		providers required site visit but not for med/surg providers • Carrier reported different authorization practices in notices for inpatient MH/SUD treatment and med/surg treatment.	
Second Market Conduct Survey Other Findings	June 2017 Carriers with inadequate networks not identified	• 6 counties – no in-network non-hospital facilities for opioid use disorders[iv] • 11 counties – no in-network non-hospital facilities for treatment of bi-polar disorders[v] • 4 counties – no in-network opioid providers[vi] • 7 counties – no in-network providers of bi-polar disorders[vii]	No Financial Penalties or Other Actions Taken
Aetna	MIA-2018-10-037	• Required MH/SUD outpatient and inpatient facilities to complete detailed Personnel Review for credentialing; medical facilities not required to complete Personnel Review	$1,500 Financial Penalty
Cigna	MIA-2019-06-012	• Denied credentialing for 5 of 13 SUD treatment facilities based on "no network need identified." Admitted all 122 medical facilities even though "no network need identified."	$25,000 Financial Penalty
Third Market Conduct Survey Other Findings	Sept. 18, 2019 MIA indicated that carriers corrected issues during investigations but investigation was not complete.	• 1 carrier imposed prior authorization requirements on all MH/SUD services but not all medical services • 1 carrier's standards for submitting malpractice history during credentialing differs for	No Financial Penalties or Other Actions Taken

	Carriers not identified	MH/SUD facilities and med/surg facilities • 1 carrier imposed 7-day cap on the number of days for inpatient MH/SUD authorization, but no cap on inpatient medical services	
Third Market Conduct Survey Other Findings	Sept. 18, 2019 Carriers not identified.	• All carriers reported that non-network MH/SUD services are accessed more frequently than non-network med/surg services • Some carriers took longer to credential MH/SUD facilities than med/surg facilities • Carriers have not assessed "in operation" compliance; some carriers have no team to conduct compliance audits • Some carriers have no policies for conducting review of plan compliance and some have no documentation of reviews • Contracts with entities that manage MH/SUD benefits do not address Parity requirements.	

[i] Includes Aetna Health Inc., Aetna Life Insurance Co., Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Co.
[ii] Includes Cigna Health and Life, Insurance Co. and Connecticut General Life Insurance Company.
[iii] Includes MAMSI Life and Health Insurance Company, Optimum Choice, Inc,. UnitedHealthcare Insurance Company, All Savers Insurance Company and UnitedHealthcare of the Mid-Atlantic, Inc.
[iv] Calvert, Charles, St. Mary's, Allegany, Garrett and Washington Counties had no in-network opioid treatment facilities.
[v] Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worchester and Talbot Counties had no in-network non-hospital facilities for bi-polar disorder treatment.
[vi] Garrett, Queen Anne's and Worchester Counties had no in-network opioid treatment providers.
[vii] Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester Counties had no in-network providers for bipolar-disorders.

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June 29, 2016

The Honorable Thomas McLain Middleton
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015 - Final Summary of Survey One Analysis

Dear Senator Middleton:

In light of testimony and discussion of Senate Bill 586 (2015), the Maryland Insurance Administration ('MIA") was requested to (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with MHPAEA and applicable State mental health and addiction parity laws and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division sent a survey to carriers issuing fully-insured group and individual qualified health benefit plans on the Maryland Health Benefit Exchange (*See* Attachment A). All carriers responded, and subsequent investigations were opened. As all the pending hearings and matters have been resolved, we now can provide the committee with a summary of the 2014 survey results.

Responses were requested and provided from the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Company,
- CareFirst- including CareFirst BlueChoice, Inc. ("BlueChoice"), CareFirst of Maryland, Inc. and Group Hospitalization & Medical Services ("CareFirst/GHMSI'),
- Cigna ("Cigna")- including Cigna Health and Life, Insurance Company, and Connecticut General Life Insurance Company,
- Evergreen Health Cooperative Inc. ("Evergreen"),

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser"),
- United Healthcare ("United Healthcare")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., United Healthcare Insurance Company, All Savers Insurance Company , and United Healthcare of the Mid-Atlantic, Inc., and
- Freedom Life Insurance Company of America ("Freedom").

The MIA issued six administrative orders based on its investigation findings. Three of the carriers did not contest the orders (Cigna, Aetna/Coventry and Evergreen), and three carriers requested hearings (BlueChoice, CareFirst/GHMSI, and Kaiser). Copies of the orders are attached (*See* Attachment B).

The MIA provides the following summary of the findings, actions taken, and outcome for each carrier referenced above:

Aetna/Coventry:

Coventry's responses revealed the following:

- Aetna/Coventry had no in network psychologists in all of Western Maryland (including Garrett, Allegheny, Washington and Frederick counties). Coventry only had one in-network psychiatrist in Washington County, and no in-network psychiatrists in either Garrett or Allegheny counties. Additionally, there were no in-network licensed professional counselors or licensed clinical social workers in Garrett County.
- There were no in-network methadone treatment centers in the state for Coventry, and only one in-network for Aetna.

The MIA found Aetna's/Coventry's network was insufficient. As a result of these findings, Order# MIA-2015-12-035 was issued to Coventry by the MIA. The MIA directed Coventry to provide quantitative goals for psychiatrists, psychologists, licensed professional counselors and licensed clinical social workers for Garrett County within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days demonstrating in-network access to methadone treatment. Coventry provided the required follow-up documentation. It indicated that Coventry conducted a thorough review of all clinic locations and in-network providers and identified 12 additional in-network methadone treatment clinics. Additionally Coventry provided analysis demonstrating that they met their network accessibility standards with regards to the other provider types.

CareFirst:

For CareFirst, who insured the most Marylanders, the MIA analyzed the responses for both BlueChoice and CareFirst/GHMSI.

BlueChoice's responses revealed the following:

- There were no in-network methadone treatment centers in the state for BlueChoice.
- BlueChoice used a separate vendor to manage the mental health/substance abuse disorder network and therefore there were concerns that reimbursement rates were different than for somatic illness providers.
- Geofactors applied to somatic illness providers were not applied to mental health/substance abuse disorder providers.

The MIA found BlueChoice's network was insufficient. As a result of these findings, Order# MIA-2015-10-036 was issued to BlueChoice by the MIA. The MIA directed BlueChoice to provide documentation within 90 days demonstrating in-network access to methadone treatment, to provide documentation within 90 days outlining the underlying factors used to calculate reimbursement rates for all types of providers, and imposed an administrative penalty of $30,000.00. BlueChoice requested a hearing.

The MIA and BlueChoice negotiated a Consent Order (*See* Attachment C). In response to the Order, BlueChoice entered into a contract with a methadone treatment provider with multiple locations as of December 2015. BlueChoice also provided a notice explaining that mental health/substance use disorder providers are treated as in-network providers for the purpose of reimbursement of this benefit. Finally, it was determined that BlueChoice's policy to apply geofactors on reimbursement rates to providers treating somatic illness and not to mental health/substance abuse disorder providers actually benefitted Maryland consumers. The application of the geofactors would be detrimental and result in lower reimbursement rates for mental health/substance abuse disorder providers, which may discourage new providers to join BlueChoice's network.

CareFirst/GHMSI responses revealed the following:

- CareFirst/GHMSI's availability plan filed with the MIA identified that they had not met the stated goals for network adequacy in two mental health/substance abuse disorder provider groups.

As a result of this finding, Order# MIA-2015-10-034 was issued to CareFirst/GHMSI by the MIA to bring them into compliance. The MIA directed CareFirst/GHMSI to provide documentation within 90 days demonstrating an increase in the number of both neuropsychological doctors, and geriatric psychiatrists in its provider panel, to provide a written update in six months of CareFirst/GHMSI's effort to contract with additional providers.

The MIA entered into a Consent Order (*See* Attachment D), which required CareFirst/GHMSI to provide an updated availability plan that showed members were able to obtain the mental health benefits despite not meeting standards in the identified provider groups. The MIA received the necessary information and has determined that CareFirst/GHMSI is now in compliance.

Cigna:

Cigna's responses revealed the following:

- While Cigna was using the Uniform Credentialing Application for both somatic illness and mental health/substance use disorder providers, they also were requiring screening interviews for the mental health/substance use disorder providers Section 15-112.1(b) of the Insurance Article requires that the Uniform Credentialing Form be the sole application to become credentialed.
- Additionally, Cigna required mental health/substance use disorder provider applicants who had undergone treatment for substance abuse, to be sober for two years. This was not required for somatic illness providers. This information was captured outside of the Uniform Credentialing Application, which does not require such information.
- Cigna required mental health/substance use disorder providers shorter response timeframes to respond to inquiries as opposed to their somatic illness provider counterparts. This finding also indicated that the credentialing was more burdensome for mental health/substance abuse disorder providers.

The MIA found the credentialing differences were more burdensome for providers of mental health/substance abuse disorders. As a result of these findings, Order# MIA-2015-10-007 was issued to Cigna by the MIA. The Order required corrective action within ten (10 days) to eliminate the practice of screening interviews for providers, to allow mental health/substance abuse disorder providers the same amount of time (30 days) to respond to written requests as somatic illness providers, and to pay an administrative penalty of $9,000.00. Cigna filed a corrective action plan, providing documentation that they made the changes to their credentialing standards, removed the prescreening form from the credentialing policy and procedure, revised their policy to allow behavioral practitioners 30 days to respond to written requests for additional information consistent with medical/surgical providers, and paid the administrative penalty.

Evergreen:

Evergreen's responses revealed the following:

- Evergreen utilized two vendors; one vendor for somatic illness providers, and one for mental health/substance abuse disorder providers.
- There was no coordination between the two vendors to ensure that credentialing standards were no less stringent for their somatic illness vendors than their mental health/substance abuse disorder vendors.
- Evergreen did not use the same factors when setting reimbursement rates. Providers who treated somatic illnesses were treated consistently, with reimbursement pricing generally based on a percentage of Medicare rates. Mental health/substance abuse disorder provider reimbursement pricing included a factor relating to a CPT code which was not factored into the reimbursement rate in the same manner for providers who treated somatic illnesses.
- Evergreen reported no in-network psychiatrists, psychologists, licensed clinical social workers or certified professional counselors in Garrett County, Maryland, which demonstrated that their network was insufficient.

As a result of these findings, Order# MIA-2015-10-033 was issued to Evergreen by the MIA. The MIA directed Evergreen to provide a quantitative goal for in-network providers for mental health and substance use disorder benefits within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days of changes to their methodology for provider credentialing and provider reimbursement to comply with the MHPAEA.

The MIA received documentation from Evergreen that their behavioral health provider network (Beacon) includes providers whose offices are located within the required geographical proximity of members who reside in Garrett County. Evergreen permitted members who were unable to access a participating provider within the required geographic proximity, to be treated by an out-of-network provider while utilizing in-network benefits. The mental health vendor contacted 15 mental health/substance use disorder providers within Garrett County in an effort to enlarge the number of in-network providers, with limited success. They also reported that while their two vendors use different methodologies to negotiate rates with providers, they apply the same reimbursement factors in the same fashion. The MIA received the information it requested from Evergreen.

Kaiser:

Kaiser's initial responses indicated the following:

- Kaiser had 28 in-network licensed professional counselors for their entire Maryland service area which resulted in a provider to member ratio of 1/5,927. This ratio was less favorable to members than for other mental health/substance abuse disorder provider types within Kaiser's network.

As a result, Order#MIA-2015-10-035 was issued by the MIA to Kaiser. The MIA directed Kaiser to provide numeric goals for in-network licensed professional counselors within 90 days to ensure an adequate network, and to provide a written update whether the goal had been met in six months. Kaiser provided the MIA additional information that illustrated that there was no unreasonable delay to receive care. The MIA concluded that Kaiser's network was not insufficient. The MIA rescinded its Order.

United Healthcare:

The MIA's review of United Healthcare's practices revealed no MHPAEA violations based on the Maryland Insurance Article.

Freedom:

In its response to Survey One, Freedom disclosed that it did offer qualified health plans in the individual or group markets in Maryland. The survey questions were therefore not applicable to Freedom and the Administration closed its investigation.

We hope this summary information is helpful and we would be glad to provide any further information about the results of Survey One upon request.

In addition, you asked that the MIA monitor and update the committee on efforts in other states, in particular California. California's Department of Managed Health Care ("DMHC") requires full service health plans (that offer commercial coverage for individuals, small groups, or large groups in 2015) to submit filings that demonstrate their compliance with the MHPAEA. In 2014, the DMHC provided insurers with detailed instructions that required them to complete worksheets that compare their behavioral health coverage to other medical coverage, and required them to complete another worksheet comparing their application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

In 2013, the DMHC fined Kaiser $4 million, in part, because the DMHC found Kaiser and its providers were informing consumers that certain mental health services were not covered, which was in direct violation of the parity sections of California's state laws. In this follow-up report the DMHC determined that Kaiser had not adequately corrected this violation. The Department found that while Kaiser had corrected this information on its website and in its explanation of benefits documents, its providers were still telling consumers that certain medically necessary services were not covered, like long-term therapy. The report indicated that the Department is considering further disciplinary action.

In 2014, the DMHC reached a settlement with Health Net of California for $300,000 after initially issuing a cease and desist order in November 2013. Among other accusations, Health Net was accused of "failure to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions." This was in violation of the parity provisions within the Health and Safety Code.

Several fines were levied due to carriers' behavioral health coverage practices, notably: Oregon's Department of Consumer and Business Services fined Health Net of Oregon $5,000 dollars for denying coverage for behavioral health services because the patients did not get prior authorization from Health Net; Missouri's Department of Insurance, Financial Institutions and Professional Registration reached a $4.5 million settlement with Aetna for its continued failure to provide coverage for autism services in compliance with state law; the Connecticut Insurance Department recovered $1.3 million for consumers from insurance plans after investigating complaints about health insurance coverage - some of these complaints were about behavioral health coverage, and Vermont's Department of Financial Regulation fined Cigna Behavioral Health $392,500 after it was found that Cigna had used the recommendations of "unlicensed review agents" in making coverage determinations.

Other states are initiating other action, including:

- Connecticut is creating a short consumer guide and a behavioral health consumer toolkit to help consumers navigate the appeals process and better understand how to get quality behavioral healthcare through their insurance plans,

- Rhode Island's Office of the Health Insurance Commissioner, after receiving complaints from consumers that insurance plans were not covering needed behavioral health services, initiated market conduct examinations on four insurers to see if they are violating parity laws, and
- the Massachusetts Division of Insurance ("DOI") commissioned a report that found that behavioral health patients on average have to wait much longer for follow-up care than non-behavioral health patients, and, although the delays were not necessarily caused by federal or state parity law violations, the report recommended that the DOI should create standards for the detail required in insurance company records about follow-up care so that it is easier to see if there are differences in the utilization management process for behavioral health patients versus non-behavioral health patients. We are monitoring this action.

We hope this information is helpful.

Finally, you asked that the MIA examine the extent to which contract and plan benefit design features, financial requirements, treatment limitations, and utilization review requirements, as well as carrier processes, standards, and factors used to administer benefits, change from year-to-year to evaluate the feasibility of the prospective reporting that would have been required under SB 586. Please note that MIA staff reviews annually on a prospective basis many of the items listed in SB 586. Under MHPAEA, the financial requirements are required to be based on assumptions for the next year, so annual verification is needed and is performed during the annual contract review in the individual and small group markets. Also, due to the filing requirements under the Affordable Care Act, we are seeing new cost-sharing requirements for benefits being filed for the individual and small group markets annually so that the plans can continue to meet to required metal levels. Therefore, for contract review, MIA staff is already reviewing prospectively contracts for approval, including the contract and plan benefit designs, financial requirements, and permissible exclusions and limitations.

The MIA worked with the various interested parties to develop a second survey to address additional concerns regarding compliance with MHPAEA. Survey Two was sent to the health insurance carriers on October 20, 2015. (*See* Attachment E.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Two analysis once it has been completed. We will be working with interested parties to develop a third survey to be sent out this year.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Peter A. Hammen, Chairman, House Health and Government Operations Committee
Cc: Patrick Carlson, Senate Finance Committee Staff
Cc: Linda Stahr, HGO Committee Staff
Cc: Nancy J. Egan, Esq., Director of Government Relations, MIA
Attachments: (5)

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

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AL REDMER, JR.
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Deputy Commissioner

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January 26, 2018

Sent Via Certified and Electronic Mail

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with the final results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

On June 30, 2017, the MIA submitted a summary of the 2015 Survey findings to your attention. *See* Attachment A. That summary explained that investigations were ongoing for UnitedHealthcare ("UHC" including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.) and CareFirst (including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI")). The MIA has completed those investigations, as detailed below. Information about UHC, BlueChoice, CareFirst of Maryland Inc., and GHMSI's provider networks that was received during the 2015 Survey was included in the letter the Administration sent to your attention on June 30, 2017. *See* Attachment A, Section "Provider and Facility In-Network Adequacy."

UnitedHealthcare ("UHC")

UHC's responses to the MIA's 2015 survey and resulting investigation revealed that UHC's managed behavioral health organization United Behavioral Health Inc., under the brand Optum, reviewed a five year malpractice history for all mental health/substance use disorder facilities applying to be credentialed. UHC collected but did not review a malpractice history for any medical/surgical facilities.

As a result of finding that UHC applied more stringent credentialing requirements to behavioral health facilities than to medical/surgical facilities, Consent Order # MIA-2017-08-009 was issued to UHC by the MIA to bring UHC into compliance. *See* Attachment B. The MIA directed UHC to pay a fine of $2,000.00 for the four behavioral health facilities affected by this practice, and to submit, within 30 days, a corrective action plan. UHC has paid the fine and has removed the requirement to review a five year malpractice history for mental health/substance use disorder facilities.

CareFirst

On May 1, 2017, the MIA became aware that CareFirst BlueChoice, Inc.'s ("BlueChoice") online provider directory for behavioral health listed only two of the 27 in-network mental health hospitals and two of the seven mental health non-hospital facilities that the Respondents had reported were in-network during the MIA's investigation. The MIA was informed that the 27 hospitals include acute care/general hospitals that were listed under the medical/surgical portion of the provider directory. Additionally, two of the non-hospital facilities that were reported were listed only under the medical/surgical portion of the provider directory. The remaining three non-hospital facilities that were reported were not listed anywhere in the provider directory. In response to the MIA's investigation, BlueChoice corrected the error with its online provider directory. All reported facilities are now listed in the behavioral health provider directory as well as the medical/surgical directory if the facilities provide both services.

On May 1, 2017, the MIA also became aware that CareFirst BlueCross BlueShield's Blue Preferred online behavioral health provider directory did not list any in-network inpatient mental health facilities. The MIA was informed that the inpatient mental health facilities appeared in the directory under the medical/surgical portion of the provider directory. In response to the MIA's investigation, CareFirst BlueCross BlueShield corrected the error with the Blue Preferred online behavioral health provider directory to reflect that there were seven in-network facilities.

As a result of the inaccuracies in BlueChoice and CareFirst BlueCross BlueShield's online provider directories, Consent Order # MIA- was issued to CareFirst by the MIA to bring CareFirst into compliance. *See* Attachment C. The MIA directed BlueChoice to pay an administrative penalty of $20,250.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. BlueChoice has paid the fine and corrected its directory as of December 11, 2017. The same consent order directed CareFirst BlueCross BlueShield to pay an administrative penalty of $4,725.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. CareFirst BlueCross BlueShield has paid the fine on January 5, 2018, and corrected its directory as of May 5, 2017.

Survey Three

The MIA worked with various interested parties to develop a third survey to address additional concerns regarding compliance with MHPAEA. Survey Three was sent to the health insurance carriers on October 6, 2017. (*See* Attachment C.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Three analysis once it has been completed.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chair, House Health and Government Operations Committee
Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

- Attachment A -

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

AL REDMER, JR.
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NANCY GRODIN
Deputy Commissioner

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June 30, 2017

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with an update on the results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and addiction parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully-insured group and individual health benefit plans ("2014 Survey"). (*See* Attachment A). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (*See* Attachment B).

In preparation for developing and issuing the second survey ("2015 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 26, 2015. The 2015 Survey was sent to the carriers on October 20, 2015, and is attached for your review. (*See* Attachment C). All of the carriers responded.

Responses were requested of and provided by the following carriers:[1]

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI");
- Cigna Health and Life Insurance Company ("Cigna");
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ("Kaiser);
- United Healthcare ("UHC")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.; and
- Freedom Life Insurance Company of America ("Freedom").

In October, 2016, the MIA was awarded a federal grant which funded an extra staff member to continue the second MHPAEA survey analysis and to conduct investigations of possible violations. The MIA has completed its review of the survey results for Aetna, Cigna, Kaiser, and Freedom. A review of Aetna's, Cigna's and Kaiser's practices revealed no violations of the MHPAEA or applicable state mental health and substance use disorder parity laws. In its response to the 2015 Survey, Freedom disclosed that it did not offer qualified health plans in the individual or group markets in Maryland. The survey questions therefore were not applicable to Freedom and the Administration closed its investigation.

The MIA has not yet completed its review of UHC and CareFirst. The MIA will provide you with its findings when these reviews are completed.

Issues Corrected During the Investigation

As a result of the survey, a number of issues were identified and corrected during the Administration's investigation. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents and/or no harm to consumers was identified. The following errors were corrected:

- Internal medical review policy limited disclosure of the medical/surgical medical necessity guidelines to three guidelines at a time to a provider/member. The carrier believed that its licensing agreement for the guidelines required it to limit disclosure of the guidelines. As a result of the MIA's investigation, the carrier reviewed its licensing agreement and determined that the limitation was not in the agreement. The carrier removed the limitation from its internal medical review policy. The carrier informed the MIA that it was not aware of any requests for the guidelines that had been denied or limited because of the internal policy.

- Financial testing for a large group plan did not account for all of its outpatient benefits in the "all other outpatient" category nor preventative benefits in the out-of-network outpatient office visits category. As a result of the MIA's investigation, the carrier corrected its financial testing and

[1] Evergreen Health Cooperative Inc., was also surveyed and provided a response to the 2015 Survey. Due to the Company's ongoing efforts to remain viable in the marketplace during the span of the 2015 Survey, Evergreen was removed from examination. As a result, no further investigation was conducted following Evergreen's initial survey response. The MIA will consider reopening investigations upon commencement of the third parity survey.

demonstrated that the exclusions of certain benefits did not change the results of the cost-sharing that could be applied to mental health/substance use disorder benefits in those classifications.

- An online provider directory indicated that it did not have any in-network inpatient facilities that could treat mental health illnesses. As a result of the MIA's investigation, the carrier corrected its online directory to reflect that there are in-network inpatient facilities to treat mental health illnesses.

- A publically available document demonstrating compliance with MHPAEA ("MHPAEA Summary") provided that the carrier's credentialing process for medical/surgical providers required the provider to agree to a site visit *if* required by the credentialing committee. In contrast, the carrier's managed behavioral health organization ("MBHO") *required* a site visit for each mental health/substance use disorder provider applying to be credentialed. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to site visits for credentialing. The carrier and MBHO confirmed that they do not require site visits as part of credentialing for their commercial networks. As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to reflect this information.

- The MHPAEA Summary also provided that for out-of-network inpatient scheduled admissions there are two different notice requirements to obtain prior authorization, (1) "as soon as possible" and (2) "5 days before receiving the benefit." The MHPAEA Summary stated that all scheduled admissions for inpatient mental health/substance use disorder treatment must obtain prior authorization "as soon as possible." In contrast, the only example of a medical/surgical treatment that was held to that requirement was transplants. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to out-of-network inpatient prior authorization requirements. The carrier confirmed that all scheduled out-of-network admissions for medical/surgical and mental health/substance use disorder benefits were required to obtain prior authorization "as soon as possible." As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to accurately reflect its procedure.

Provider and Facility In-Network Adequacy

In the 2015 Survey, the MIA requested responses to the following questions regarding in-network providers for inpatient and outpatient treatment of heroin and opioid abuse disorders, diabetes, stroke, and bipolar disorders:

a) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.

b) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).

c) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.

d) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.

Some carriers reported that they do not have in-network non-hospital facilities for the treatment of heroin/opioid abuse disorders and bipolar disorder in certain counties of Maryland.[2] Other plans did not have any in-network inpatient hospitals, inpatient non-hospital facilities, or intensive outpatient treatment for substance use disorder treatment or bipolar disorder treatment in certain counties.[3]

As a result of the MIA's investigation, some carriers entered into new contracts with facilities located in counties lacking in-network providers. However, carriers advised the MIA that although they continue efforts to recruit providers and facilities in these counties, there do not appear to be any licensed non-hospital based behavioral health inpatient facilities that are willing to contract with managed care plans in many counties. Some carriers also provided information demonstrating that they meet their network accessibility standards with regards to all provider and facility types despite the lack of in-network facilities in certain counties. Other carriers address the shortage of in-network providers by (1) allowing members to access out-of-network providers at their in-network cost-sharing rate and (2) authorizing continued acute inpatient care until it is safe to transition the patient to partial hospitalization or intensive outpatient treatment.

Other State MHPAEA Compliance Efforts

California.

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that California's Department of Managed Health Care ("DMHC") required full service health plans (that offer commercial coverage for individuals, small groups, or large groups) to submit filings in 2014 that demonstrate the carriers' compliance with the MHPAEA for health plans sold in 2015.[4] In 2014 and 2015, the DMHC penalized two insurers for violations of state and federal parity laws. Those actions were addressed in more detail in the MIA's Summary Letter for the 2014 Survey, included as an attachment for your convenience. (*See* Attachment B). Additionally, the DMHC conducted a desk audit to review the filings. The desk audit resulted in 24 plans out of 25 lowering MH/SUD cost-sharing in one or more products; 3 plans eliminating impermissible day or visit limits on MH/SUD benefits; 12 plans modifying or clarifying prior or concurrent authorization requirements; and all 25 plans revising their evidence of coverage text to more clearly describe MH/SUD benefits.

On April 1, 2016, following the desk audit, the DMHC began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC is also looking at plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.[5]

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[2] Counties reportedly lacking in-network heroin/opioid treatment facilities: Calvert, Charles, St. Mary's, Allegany, Garret, and Washington counties. Counties lacking in-network bipolar treatment facilities: Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worchester and Talbot counties.

[3] Counties reportedly lacking in-network heroin/opioid providers: Garrett, Queen Anne's and Worchester counties. Counties lacking in-network bipolar disorder providers: Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester counties.

[4] New Hampshire and the federal Center for Medicare and Medicaid Services have used the workbooks developed by DMHC when conducting their own market conduct exams.

[5] Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

The DMHC finished its first round of audits in early 2017. It plans to issue reports to the carriers in the first half of 2017.[6] Preliminary findings released by the DMHC include continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

Beginning in 2016, the California Department of Insurance (CA DOI) required carriers to complete Parity Workbooks as part of each carrier's 2017 plan filling. The Workbook provides insurers with detailed instructions that require them to complete worksheets that compare financial and quantitative treatment limitations applied to their behavioral health coverage to other medical coverage. Another required worksheet compares the insurers' application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

Checklists and Carrier Attestations.

Many states, including Maryland, rely on checklists and carrier attestations that plans are complying with state and federal parity laws.[7] These checklists and attestations are required as a part of a state DOI form review prior to the plan being sold on the market. Some checklists are simple, merely stating that the plan must comply with state and federal parity laws and providing a box in which the carrier is meant to cite to the form page that supports this requirement. Others require more in-depth information be provided including a narrative description of the methodology used to determine plan parity compliance and completed worksheets demonstrating parity compliance for financial and quantitative treatment limitations.[8] Fewer states conduct a comprehensive review of non-quantitative treatment limitations during form review.

Data Collection and Targeted Market Conduct Examinations.

Nine states undertake targeted market conduct examinations ("MCEs") focused on behavioral health benefits and initiated as the result of consumer complaints or information collected during form review.[9] These MCEs have resulted in penalties and corrective action plans.[10] Some states have completed MCEs focusing on compliance with federal and state parity laws. Notably, New Hampshire's DOI completed

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[6] The DMHC will make final reports available to the public on the DMHC's website. The DMHC intends to complete the remaining 20 surveys in June 2017.

[7] States with this requirement include Alabama, Alaska, California, Colorado, Connecticut, Delaware, Indiana, Maine, Maryland, Massachusetts, Nebraska, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, and Washington.

[8] California, Connecticut, Maryland, Massachusetts, Rhode Island.

[9] California, Connecticut, New Hampshire, New York, North Dakota, Pennsylvania, Rhode Island, Washington, West Virginia.

[10] In 2011, West Virginia's Office of the Insurance Commissioner fined insurance plans $115,305.79 for violations related to the state parity law discovered during market conduct exams. In 2014, North Dakota DOI determined that its BlueCross BlueShield improperly denied 63 MH/SUD claims because it failed to comply with utilization review guidelines, medical necessity guidelines, and/or its contracts and state law. BCBS agreed to correct its procedures. In 2015, Connecticut DOI fined United Behavioral Health $8,500 and required United to submit a plan for compliance within 90 days after a MCE determined that 2 appeal determinations were not reviewed by an appropriate clinical peer for the service requested. Other MCE and resulting fines were detailed in the MIA's 2014 Survey Summary, attached for your convenience. (*See* Attachment B).

three MCEs of Anthem Health Plans of New Hampshire, Inc. ("Anthem"), Cigna Life and Health Insurance Company ("Cigna"), and Harvard Pilgrim Health Care of New England, Inc. ("Harvard Pilgrim").[11] These targeted MCEs included review of issuer compliance with MHPAEA and focused on substance use disorder benefits. In 2017, the New Hampshire DOI ordered Anthem, Cigna, and Harvard Pilgrim to correct various issues including inadequate provider networks for MH/SUD services, inaccurate provider directories, and accessibility problems. As a result, Anthem added 100 new MH/SUD provider contacts and developed the Aware Recovery Care Program, a team-based approach to treat substance use disorder. Additionally, Anthem and Harvard's improper dosage limitation on Evizo, the naloxone auto-injector used to prevent overdoses, was highlighted for correction. New Hampshire's DOI plans to open targeted MCEs into Anthem's credentialing criteria and an additional follow up examination of Harvard's reimbursement methodology and rates.

Another developing method used by states to monitor parity compliance is data collection and examination.[12] The data is examined for patterns that may indicate an underlying parity violation that should be investigated through an MCE. There were two states that had significant findings. In 2016, New Hampshire's DOI used its all-payer claims database to analyze provider reimbursement rates for substance use disorder services for 2014 and 2015. New Hampshire determined that commercial carriers consistently paid health care providers less than Medicare rates for treating patients with substance use disorders. The New York Office of the Attorney General ("NY OAG") examined denial rate data as part of its investigations into carrier compliance with state and federal parity laws. The denial rate data showed that carriers denied some behavioral health claims up to seven times as often as medical/surgical claims in the same category.[13] Based in part on the data it reviewed, the NY OAG issued an order against Excellus Health Plan, Inc. ("Excellus") finding, among other parity violations, that it "applies more rigorous—and frequent—utilization review for inpatient substance use disorder treatment than for inpatient medical/surgical treatment." The NY OAG made the same determination about ValueOptions' utilization review practices, finding that it issued denials for behavioral health claims twice as often and addiction recovery services four times as often as medical/surgical claims. At least four New York health plans subcontract with ValueOptions to administer their member's behavioral health benefits. Between 2014 and 2015, the NY OAG reached settlements with six health insurance carriers, ordering corrective action and assessing approximately $4.6 million dollars in fines and penalties.

Massachusetts requires carriers to annually submit data that compares MH/SUD services and M/S services in areas including number of requests for authorization of services and type of services; authorization requests approved, modified, and denied; the number of internal appeals and outcome; and number of appeals sent to external review and outcome. Representatives of the Massachusetts Department of Insurance advised the MIA that the data is being used to track areas of concern for future MCEs.

Utilization and Medical Necessity Review Criteria.

There is an emerging trend in the states focused on standardizing utilization review criteria for substance use disorder benefits. At least four states now require carriers to use the nationally recognized

[11] In order to conduct these MCE, New Hampshire DOI contracted with an IRO and a pharmacist to assist with review of medical necessity denials and prescription formularies.
[12] States that have employed this method include Connecticut, Massachusetts, New Hampshire, New York, and Vermont.
[13] Excellus Health Plan, Inc. issued denials in 48% of the inpatient substance use disorder treatment reviews it conducted for preauthorization compared to less than 20% of the inpatient medical/surgical requests. Additionally, 29% of outpatient behavioral health services were denied compared to 13% of outpatient medical/surgical services.

American Society of Addiction Medicine ("ASAM") utilization review criteria and medical necessity review criteria when managing substance use disorder benefits for private insurance products.[14] Connecticut also requires carriers to use criteria established by the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument when reviewing requests/claims for child/adolescent mental disorder services, and the American Psychiatric Association Guidelines or Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare for adult mental disorder services.[15] The Connecticut law does allow carriers to develop their own criteria or purchase criteria from other qualified vendors approved by the DOI in order to address advancements in technology/types of care that are not covered in the most recent guidelines/criteria listed in the statute.

Future Plans.

The MIA is currently developing a template for future parity MCEs by drawing from its own experience with the parity surveys and investigations, other states' MCEs, and the NAIC's Market Regulation Handbook. A third parity survey is also under development. The MIA intends to invite interested parties to a meeting on August 21, 2017, to engage in a discussion regarding the third survey.

If you have any questions about this summary letter or any other activities undertaken by the MIA with reference to the parity surveys, please call me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee
Linda Stahr, Committee Counsel
Partick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

[14] Connecticut, Illinois, New Hampshire, Rhode Island.
[15] S.B. No. 372, effective January 1, 2017 and codified at § 38a0591c of Connecticut's insurance law.

LAWRENCE J. HOGAN, JR.
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BOYD K. RUTHERFORD
Lt. Governor

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September 18, 2019

The Honorable Delores G. Kelley
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015- Summary of Survey Three Analysis

Dear Senator Kelley:

The purpose of this letter is to provide you with an update on the results from the third survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and substance use disorder parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and substance use disorder parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully insured group and individual health benefit plans ("2014 Survey"). (*See* Attachment A). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (*See* Attachment B).

In October 2015, the second survey was sent to carriers. (*See* Attachment C). The second survey revealed violations and the MIA issued two administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 30, 2017, and January 26,

2018, the MIA submitted summaries of the 2015 Survey findings to your attention. (*See* Attachment D and E).

In preparation for developing and issuing the third survey ("2017 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 21, 2017. The 2017 Survey was sent to the carriers on October 6, 2017, and is attached for your review. (*See* Attachment F). All of the carriers responded.

Responses were requested of and provided by the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst ("CareFirst")- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI");
- Cigna Health and Life Insurance Company ("Cigna");
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ("Kaiser);
- United Healthcare ("UHC")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.

The MIA has completed its review of the survey results for all of the above listed carriers. The Administration did not identify any violations of MHPAEA or the applicable state mental health and substance use disorder parity laws during its investigations of Kaiser and CareFirst. The investigation of UHC is ongoing and the results of that investigation will be reported when complete.

Orders Issued

Aetna

Aetna's responses revealed the following:

- Aetna's internal policy document governing the assessment and credentialing of organizational providers required inpatient and outpatient behavioral health facilities to complete detailed Personnel Review assessments that were not required to be completed by Medical/Surgical inpatient and outpatient facilities.

The MIA asked Aetna to explain the difference in the credentialing requirements for behavioral health and M/S facilities. Aetna responded that it agreed there was a discrepancy and that Aetna would add a Personnel Review section to the Medical/Surgical facility assessments. The MIA found that Aetna's written policy did not comply with MHPAEA. As a result of these findings, Consent Order # MIA-2018-10-037 was issued to Aetna by the MIA. The MIA directed Aetna to provide a correct internal policy document including a Personnel Review section for credentialing Medical/Surgical facilities simultaneously with executing the consent order. Additionally, the MIA fined Aetna $1,500 for the three

behavioral health facilities that have undergone the more burdensome Personnel Review assessment as a part of Aetna's facility credentialing process since the final MHPAEA rules went into effect. Aetna paid the fine and submitted a corrected policy to the MIA, resolving the consent order.

Cigna

Cigna's responses revealed the following:

- In 2017, Cigna denied five of the thirteen behavioral health facilities that applied to join its network for the reason that "no network need identified." Cigna did not deny any of the 122 medical/surgical facilities that applied from 2015-2017 for that reason.

The MIA asked Cigna to explain what factors and evidentiary standards it used to determine "no network need identified," for behavioral health facility applications and to demonstrate that those factors and evidentiary standards were applied comparably and just as stringently to medical/surgical facility applications. Cigna was not able to provide support for why five behavioral health facilities but no medical/surgical facilities were denied for this reason, based on the factors that Cigna considers when admitting a facility to its network. Cigna stated that its decision to admit or deny a facility entrance to its network is based in part on discretion. The MIA found that Cigna more stringently applied discretion in determining that "no network need identified" for five behavioral health facilities that applied to join its network in 2017.

As a result of these findings, Consent Order # MIA-2019-06-012 was issued to Cigna by the MIA. The MIA directed Cigna to provide a corrective action plan for its review and admission of facility applications to its network that demonstrates that behavioral health and medical/surgical facilities are reviewed in a parity compliant manner. That corrective action plan is due to the MIA in September 2019. Additionally, the MIA fined Cigna $25,000 for having a process that violated MHPAEA. Cigna signed the Consent Order and paid the fine.

Issues Corrected During the Investigation

As a result of the survey and resulting investigations, a number of issues were identified and corrected. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents. The following errors were corrected:

- An internal concurrent review policy stated that for Indemnity and Traditional Choice plans, "[c]oncurrent review is not a requirement for medical inpatient admissions. Behavioral health inpatient and residential admissions for [carrier] members do include concurrent review." The carrier explained that "[t]his policy statement was in error and was not in keeping with operational practices. . .both medical/surgical and behavioral health [] perform concurrent review if notified of an inpatient admission." The carrier provided a copy of the updated policy with the correction and data supporting that

concurrent review did occur for medical/surgical inpatient admissions for Indemnity and Traditional Choice plans during the examination period.

- An internal policy which contained a list of services that require pre-authorization stated that "All Behavior [sic] Health Services" required pre-authorization. There was no similar requirement of pre-authorization for all medical/surgical services. The carrier explained that the policy was misleading and that pre-authorization requirements are identical for medical/surgical and behavioral health services. All inpatient services require pre-authorization (with the exception of emergency services). Outpatient services require pre-authorization depending on the product the member purchased and the network with which the provider participates, not based on the services provided. The carrier corrected its internal policy to clarify that medical/surgical and behavioral health services have identical pre-authorization requirements.
- An internal policy describing when an exception will be approved to access care out-of-network under Maryland Insurance Article § 15-830(d) did not include an exception for when an appropriate provider is not available without unreasonable delay. The carrier explained that it does consider this fact when granting out-of-network exceptions and supported its position by providing data that showed the number of exception requests granted for the reason that an appropriate provider was not available without unreasonable delay during the examination period. The carrier corrected its internal policy document to include this exception.
- An internal policy describing the requirements and standards for facility credentialing of MH/SUD facilities stated that all such facilities would be interviewed as a part of the credentialing process. No similar interview requirement was included in the internal policy document describing the requirements and standards for facility credentialing of M/S facilities. The carrier explained that the MH/SUD should not have had an interview requirement as that does not accurately reflect the credentialing process. The carrier attested that both MH/SUD and M/S facilities are contacted during contracting to clarify the services the facility provides for reimbursement purposes. The carrier corrected its internal policy document to remove all mention of an interview requirement.
- An internal policy describing the requirements and standards for facility credentialing of MH/SUD facilities did not include a similar process for obtaining an exception to the requirements of submitting a malpractice history or meeting the liability insurance requirements as are contained in the M/S facility credentialing policy. The carrier explained that this was inadvertent and that the exception processes are similarly available for all facility types. The carrier provided a corrected facility credentialing policy for MH/SUD facilities that included descriptions of the exception process. The carrier noted that the exception process is not disclosed to the facilities in the credentialing application; therefore, no facilities were unfairly notified of the availability of an exception process. The carrier confirmed that most facilities utilized the exception process for disclosing malpractice history based on advice of legal counsel and zero facilities utilized the exception process for the liability insurance requirements during the survey period.
- An internal concurrent review form for inpatient mental health services contained an authorization guideline that stated the maximum number of days the clinical reviewer could approve was 7 days per utilization review. No similar maximum day cap was mentioned in any of the provided internal utilization review forms for medical/surgical

services. The carrier explained that there is no actual cap on the number of days the clinical reviewer can approve at one time for any behavioral health inpatient services. The carrier attested that both the M/S inpatient Goal Length of Stay and MH/SUD inpatient limit to a maximum number of days that can be approved are developed based on evidence based treatment guidelines. Both are guidelines and not rules, and exceptions to both M/S and MH/SUD suggested number of inpatient days can be made when the individual member's circumstances demonstrate that a different number of days are medically necessary. There is no operational/computer barrier to approving more than the maximum number of days suggested for MH/SUD inpatient services.

Internal Review Process for MHPAEA Compliance

In the 2017 Survey, the MIA asked carriers about the delegation of development/management of behavioral health benefits to another entity, the oversight the carrier exercised over that entity, the audits the carrier conducted to determine compliance with nonquantitative treatment limitation (NQTL) rules, specifically utilization management standards, both as written and in operation.[1]

All of the carriers who reported delegating the management of behavioral health services to another entity provided the delegation agreements which established routine audits of the delegate's internal policies and processes. None of these delegation agreements specifically addressed assessing MHPAEA compliance.

All of the carriers reported at least an annual review of plan documents and internal policies and procedures for MHPAEA compliance. However, the stringency of the MHPAEA review varied between carriers. Some carriers reported MHPAEA assessments but were not able to provide any written policies establishing such an assessment or any written reports documenting the results of such an assessment. Other carriers produce an annual MHPAEA document, focusing on a side-by-side comparison of medical/surgical and behavioral health NQTLs based on review of plan documents and internal policies and procedures. However, most of those carriers were not able to provide any written policies establishing the processes undertaken to produce this side-by-side comparison and lacked any review of MHPAEA compliance in operation. A couple of the carriers attested that the companies were working to establish a team to conduct MHPAEA audits, focusing on determining whether NQTLs were no more stringent in operation, which has not yet been assessed by most carriers. One carrier does have a team that conducts at least annual MHPAEA compliance review of written policy documents and reviews operational data to determine whether NQTLs are applied more stringently in operation.

Denial and Appeal Rates

The MIA asked the carriers to provide data on utilization review denials and appeals based on medical necessity between January 1, 2015 and December 31, 2017. *See* Attachment F, Question 6.

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[1] *See* Attachment F, Questions 1 and 2.

Overall, the data carriers provided demonstrated that the number of MH/SUD utilization review requests is significantly lower than the number of M/S utilization review requests at every level of care. For example, one carrier reported that behavioral health utilization review requests made up only .2% of utilization review for all outpatient services.

The data provided by most of the carriers demonstrated comparable rates of utilization review denials within a particular classification of benefits,[2] or, the percentage and number of MH/SUD denials were significantly lower than M/S denials. One carrier did report data that demonstrated that a higher percent of MH/SUD (more frequently SUD) services in the inpatient classification were denied based on medical necessity than M/S services in the same classification. However, overall, MH/SUD utilization review requests for that carrier were denied far less frequently than M/S utilization review requests. The MIA conducted a thorough review of the carrier's internal policies and procedures regarding utilization review and development of medical necessity criteria and did not identify any MHPAEA violations. Although this data may indicate a more stringent application of utilization review to inpatient MHPAEA services in operation, federal guidance on MHPAEA cautions that "[d]isparate results alone do not mean that the NQTLs in use do not comply with [MHPAEA] requirements."[3] However, the most recent guidance released by the federal Department of Labor explains, "[w]hile outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance."[4] The Administration has taken this guidance into consideration for future focused examinations of the carrier.

Credentialing Data

Some carriers reported data that demonstrated that it took longer to credential a MH/SUD facility than a M/S facility between 2015 and 2017. When asked to explain why this occurs, carriers provided the following reasons:

- Agreements with MH/SUD providers each require individual negotiation based on the unique set of services offered by that provider. Each MH/SUD provider's program varies based on the credentials of the individuals providing services (i.e., MD, LSW, RN, etc.), the ratio of providers to patients (i.e., individual versus group and size of group), and the program length of time. Accordingly, unlike for medical/surgical providers who predominantly provide the same type, credentials, ratio and program length, there is little to no industry standard reimbursement rates available for these MH/SUD services. Provider-specific rate negotiations are therefore required and may extend the negotiation period.
- MH/SUD facilities did not submit complete applications.
- MH/SUD facilities required site visits because the facility was not accredited.

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[2] MHPAEA dictates that the parity analysis be conducted with each of six classifications: in-patient in-network; in-patient out-of-network, out-patient in-network, out-patient out-of-network, emergency, and pharmacy. 45 C.F.R. § 146.136(c)(2)(ii).

[3] 78 FR 68245.

[4] *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, U.S. Dep't of Labor, Spring 2018, page 17, available at, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf

Importantly, there was not a unanimous trend of carriers taking longer to credential MH/SUD facilities than M/S facilities. Some carriers took far longer to credential M/S facilities than MH/SUD facilities.

As a part of the MIA's work on the Finance Subcommittee for the Governor's Commission to Study Mental and Behavioral Health, the MIA is looking at all aspects of network inadequacies, including barriers to providers and facilities credentialing with carriers. The MIA plans to incorporate what it learned from this survey into the work of the Subcommittee and hopes to address timeliness of credentialing for behavioral health facilities through its work on the Commission.

Out-of-Network Utilization

All of the carriers reported data demonstrating that members accessed behavioral health services out-of-network more frequently than medical/surgical services between 2015 and 2017. Tables showing the top three services and top three diagnoses, for each carrier, that accessed care out-of-network are included in Appendix A. When asked about the higher out-of-network utilization for behavioral health, the carriers provided the following reasons:

- Despite best efforts, MH/SUD providers are less likely to want to join any commercial carrier network than M/S providers. This is a national problem (citing JAMA Psychiatry, 2014 Feb; 71(2): 176-188 as supporting that nationally approximately 50 percent of psychologists do not contract with any insurer, including Medicare).
- Mental Health practices tend to be smaller and do not have the administrative support to file claims or the capacity to accept new patients for extended periods of time, therefore, they do not contract with any insurer.
- Many of the out-of-network claims are laboratory tests.
- There has been growth of a significant industry of SUD providers who offer out-of-network services that are not evidence based treatment and who engage in recruitment practices that prey on vulnerable populations and lure them out-of-network.
- Members may have out-of-network benefits and choose to seek treatment from an out-of-network provider.

On December 8, 2017, the Administration published final regulations for network sufficiency standards.[5] These regulations require carriers to annually report to the Administration how their various networks meet the standards as detailed in the regulations. The regulation includes standards for behavioral health facilities and providers.[6] The standards became effective on January 1, 2018, and the Administration is hopeful that these requirements for behavioral health providers and facilities will address the concerns about inadequate networks for behavioral health services. The Administration plans to continue working on this issue through its enforcement of the Network Adequacy regulations.

[5] http://www.mdinsurance.state.md.us/Documents/newscenter/legislativeinformation/31.10.44-NetworkAdequacy-FinalPublished1282017.pdf
[6] COMAR 31.10.44.04-06.

Utilization Management and Prescription Drugs

All of the carriers surveyed demonstrated compliance with Md. Ins. Art. §§ 15-850 and 851, by providing coverage for at least one formulation of an opioid antagonist without prior authorization and not having prior authorization requirements for any prescription included in the carrier's formulary that is used to treat opioid use disorder and contains methadone, buprenorphine or naltrexone.

The Administration asked the carriers to provide data from 2015- 2017 regarding prior authorization requirements and denials for SUD, MH, and M/S prescriptions. Additionally, the carriers were asked for data reflecting how many prescription requests were dispensed as a different medication than the medication described. Some carriers provided data that indicated that a higher percentage of SUD prescriptions were subject to utilization review than M/S prescriptions. The instances of utilization review plummeted in 2017, as a result of §§ 15-850 and 15-851, to below or equal to the frequency of M/S prescription utilization review.

One carrier reported data that demonstrated that MH prescriptions were more frequently dispensed as alternate medications than M/S or SUD. This number changed in 2017 to be more equitable between M/S, MH and SUD. The carrier explained that it had moved from an open formulary to a closed formulary and it took providers some time to learn to prescribe medications contained in the closed formulary. The carrier maintained that this is why the numbers leveled out in 2017.

The Administration has reviewed the carriers' utilization review policies for their pharmacy benefits and found that the carriers use the same processes for developing the utilization review requirements and implementing those requirements for M/S and MH/SUD benefits. Although the frequency of SUD prescription utilization review appears to have been corrected by §§ 15-850 and 15-851, further investigation of utilization review files with the assistance of a pharmacist with experience in behavioral health would be necessary to determine if the carrier applied utilization review requirements more stringently to behavioral health medications in operation. The Administration is working on a Request for Proposals to contract with a clinician group who can provide clinical expertise on a variety of Administration examinations, including further review of this issue.

Other State MHPAEA Compliance Efforts

California

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that on April 1, 2016, following a desk audit, California's Department of Managed Health Care ("DMHC") began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC also looked at

plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.[7]

The DMHC finished its first round of plan audits in early 2017. It issued reports to the carriers in the fall of 2017 and spring of 2018.[8] Preliminary findings released by the DMHC included continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

The Administration reviewed seventeen reports issued by DMHC. Of those seventeen reports, five noted potential MHPAEA violations that were addressed with the company. All of the concerning practices noted involved a carrier that delegated the utilization management of its behavioral health benefits to a third party. The issues included (1) using different definitions of medical necessity for M/S and MH/SUD services, (2) using varied medical necessity criteria for M/S services but only one set of criteria for MH/SUD services, (3) use of prior authorization and/or concurrent review for outpatient MH/SUD office visits but not for M/S office visits, (4) auto-authorization for M/S inpatient services but not for MH/SUD inpatient services, (5) no concurrent review for skilled nursing stays but requiring concurrent review for MH/SUD residential treatment stays, and (6) visit limits per authorization on MH/SUD office visits but not M/S visits.

The identification of these issues led some of the companies to correct the criteria, processes or utilization review requirements applied to behavioral health services. Other companies failed to make corrections and DMHC noted in the reports that review of the companies for corrective action addressing these issues would be conducted at the plan's next routine survey. None of the carriers were fined for violations of MHPAEA as a result of the surveys that were available for the Administration's review.

Other States

A number of other states are conducting comprehensive market conduct examinations to determine compliance with MHPAEA. Many of these examinations include the assistance of clinicians.

In 2018, Pennsylvania released two examination reports, one of Blue Cross of Northeastern Pennsylvania ("BCNP") d/b/a First Priority Health Insurance, Co., and one of Aetna.[9] *See* Attachment G. The BCNP report identified issues of parity coverage for behavioral

[7] Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

[8] The DMHC has been making the final reports available to the public on the DMHC's website.

[9] The Aetna examination included Aetna Health Insurance Company, Aetna Health, Inc., Health America, Inc., Health Assurance PA, Inc., and Aetna Life Insurance Company.

health services, as well as coverage issues for substance use disorder inpatient detox, nonhospital residential treatment and outpatient services. BCNP paid restitution and took corrective action. The Aetna report identified issues with coverage for autism spectrum disorder and substance use disorder. Pennsylvania concluded that Aetna used confusing policy language that implied there was no coverage for certain substance use disorder services. Aetna also applied incorrect copays, coinsurance and visit limits and had violations for prior authorization requirements and step therapy. Pennsylvania ordered restitution, corrective action and payment of a fine.

In August 2018, Rhode Island released its examination report of Blue Cross Blue Shield of Rhode Island ("BCBS"). *See* Attachment H. With the assistance of clinicians, Rhode Island assessed BCBS's behavioral health benefits for compliance with a variety of Rhode Island laws and regulations as well as the federal MHPAEA. The targeted examination focused on non-quantitative treatment limitations and utilization review policies, procedures and their implementation. The examination found that BCBS was using clinically inappropriate utilization review criteria for behavioral health service, which was also applied inappropriately. The examination also found that BCBS's utilization review was applied more stringently to behavioral health services and coverage exclusions applied to behavioral health services that were found to be in violation of MHPAEA. Rhode Island instructed BCBS to revise its behavioral health utilization review criteria, establish revised policies and procedures for utilization review of behavioral health services, and revise and narrow the scope of behavioral health services subject to prior authorization.

The Massachusetts Office of the Attorney General brought legal action against Aetna claiming violations of state law by maintaining inaccurate and deceptive provider directories and inadequacy provider networks. *See* Attachment I. Additionally, the AG alleged that Aetna violated state law by unfairly denying or impeding member coverage for substance use disorder treatments. In December 2018, Aetna entered into a settlement whereby it agreed to a number of terms, including covering specific medically necessary substance use disorder services and not requiring members to obtain preauthorization for specific substance use disorder services.

The Administration will submit the final results of the investigations into UnitedHealthcare entities upon their conclusion.

If you have any further questions, do not hesitate to contact me.

Sincerely,

Al Redmer, Jr.
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee and Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

ATTACHMENT 2

Appointment Wait Time for Non-Urgent MH/SUD Services 2018-2019 Comparison and Member Enrollment

Carrier	2018 Report[1]	2019 Report	Enrollment Individual Market[2] (7.31.19)	Enrollment Small Group Market[2] (7.31.19)
Aetna Health Ins.	82% (in 14 days)	89%	NA	166
Aetna Life Ins. Co.	82% (in 14 days)	89%	NA	629
CareFirst	95%	57.5%	11,493 (combined with GHMS)	22,158 (combined with GHMS)
CareFirst BlueChoice	95%	57.5%	108,301	168,248
CareFirst GHMS	95%	57.5%	11,493 (combined with CareFirst)	22,158 (combined with CareFirst)
Cigna Life and Health Ins. Co.	Missing data	76%	NA	NA
Connecticut Gen. Life Ins. Co.	Missing data	76%	NA	NA
Golden Rule Ins. Co.	72%	96%	NA	NA
Kaiser Found. Health Plan of Mid-Atlantic States	89.3%	84.3%	70,686	10,344
Kaiser Permanente Ins. Co.	Missing data	28%	NA	NA
MAMSI Life and Health Ins. Co.	72%	96%	NA	21,092
Optimum Choice Inc.	72%	96%	NA	17,205
United Healthcare Ins. Co. Choice Plus	72%	96%	NA	23,895[3]
United Healthcare Ins. Co. (CORE)	NA	96%	NA	
United Healthcare of the Mid-Atlantic Inc. (CORE)	72%	96%	NA	5,079[4]
United Healthcare of the Mid-Atlantic Inc. (Choice)	72%	96%	NA	

1. Reports are available at https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations-Information.aspx and the Legal Action Center submitted an analysis of compliance to the MIA in September 2018. See Letter from Ellen Weber, Legal Action Center, to Robert Morrow, Assoc. Comm. Life & Health Maryland Insurance Administration, Sept. 18, 2018 (on file with the Legal Action Center).
2. Hogan Administration Announces Second Consecutive Decrease in Health Insurance Premiums, Sept. 19, 2019, available at https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2019236.
3. The enrollment data does not distinguish between United Healthcare Ins. Co's CORE and Choice plans.
4. The enrollment data does not distinguish between United Healthcare of the Mid-Atlantic CORE and Choice plans.

ATTACHMENT 3

Legal Action Center (2.10.20)
Carrier Compliance Reporting Requirements

	Maryland Bill	U.S. D.O.L.[i]	Delaware[ii]	Illinois[iii]	Colorado[iv]	New Jersey[v]	Connecticut[vi]	D.C.[vii]
Frequency	Annual	Annual	Once and subsequent for significant changes	Annual	Annual	Annual	Annual	Annual
List benefits and classifications	Sec. (C)(2)(I)	Step 1 at p. 14	18 Del. Admin. Code § 1410 App. A, A-1					
List all excluded benefits, reason	Sec. (C)(2)(II)							
Process for developing or selecting medical necessity criteria			§ 3343(g)(1); § 3571U(1)	215 ILCS § 5/ 370c.1(k)(4)	C.R.S.A. § 10-16-147(2)(b)(I)	N.J. Rev. Stat. § 26:2S-10.8(c)(1)	C.G.S.A. P.A. 19-159 § 1(b)(1)	D.C. Code § 31-3175.03(a)(2)
Identify all NQTLs	Sec. (C)(2)(III)	Step 1 at p. 13	§ 3343(g)(2); § 3571U(2) App. A-3; DDI Guidance Step 1[viii]	215 ILCS § 5/ 370c.1(k)(5)	C.R.S.A. § 10-16-147(2)(c)	N.J. Rev. Stat. § 26:2S-10.8 (c)(2)	C.G.S.A. P.A. 19-159 § 1(b)(2)	D.C. Code § 31-3175.03(a)(3)
Identify factors considered in designing NQTLs	Sec. (C)(2)(IV)	Step 2 at p. 14; Compliance tips at pp. 14 and 15 for subparts	§ 3343(g)(3)(a); § 3571U(3)(a) App. A-3; DDI Guidance Step 2,3, 4[ix]	215 ILCS § 5/ 370c.1(k)(6)(A)	C.R.S.A. § 10-16-147 (2)(d)(II)(A)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(a)	C.G.S.A. P.A. 19-159 § 1(b)(3)(A)	D.C. Code § 31-3175.03 (a)(4)(A)
Identify sources used to define/ establish NQTLs	Sec. (C)(2)(V)	Step 3 at p. 15; Compliance tip at 15 for subparts.	§ 3343(g)(3)(b); § 3571U(3)(b) App. A-3; DDI Guidance Step 2, 3, 4	215 ILCS § 5/ 370c.1(k)(6)(B)	C.R.S.A. § 10-16-147 (2)(d)(II)(B)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(b)	C.G.S.A. P.A. 19-159 § 1(b)(3)(B)	D.C. Code § 31-3175.03 (a)(4)(B)
Comparative Analysis of parity "as written"	Sec. (C)(2)(VI)	Step 4 at p. 16; Compliance tips at p. 16; p. 20 for audit.	§ 3343(g)(3)(c), (e); § 3571U(3)(c), (e) App. A-3; DDI Guidance Step 4[x]	215 ILCS § 5/ 370c.1(k)(6)(C), (E)	C.R.S.A. § 10-16-147 (2)(d)(II)(C), (E)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(c), (e)	C.G.S.A. P.A. 19-159 § 1(b)(3)(C), (E)	D.C. Code § 31-3175.03 (a)(4)(C), (E)
Comparative Analysis of parity "in operation"	Sec. (C)(2)(VII)	Step 4 at 16; Compliance tips at pp. 16 and 17; p. 20 for audit.	§ 3343(g)(3)(d), (e); § 3571U(3)(d), (e) App. A-3; DDI Guidance Step 5[xi]	215 ILCS § 5/ 370c.1(k)(6)(D), (E)	C.R.S.A. § 10-16-147 (2)(d)(II)(D), (E)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(d), (e)	C.G.S.A. P.A. 19-159 § 1(b)(3)(D), (E)	D.C. Code § 31-3175.03 (a)(4)(D), (E)
Process to comply with disclosure	Sec. (C)(2)(VIII)	Section G			C.R.S.A. § 10-16-113(3)(c)[xii]			

[i] U.S. DOL, Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (2018), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.

[ii] DE Code § 3343; 3571U; 18 Del. Admin. Code § 1410 and App. 1; DDI Guidance Concerning Providing the Information Required on the NQTL Portion of the Data Collection Tool for Mental Health Parity Analysis, https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/06/NQTL-Guidance-and-Worksheet-FINAL.pdf; SB 230 (2018), https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocumentEngrossment?engrossmentId=13202&docTypeId=6. (Overlap: Aetna, BC/BS [Highmark], and United)

[iii] 215 ILCS § 5/370c.1; SB 1707 (2018), http://www.ilga.gov/legislation/publicacts/100/PDF/100-1024.pdf. **(Overlap: BC/BS and Cigna).**

[iv] Colo. Rev. Stat. Ann. § 10-16-147; HB 19-1269 (2019), http://leg.colorado.gov/sites/default/files/2019a_1269_signed.pdf. (Overlap: Aetna, BC/BS, Kaiser, and United)

[v] N.J. Rev. Stat. § 26:2S-10.8; AB 2031 (2019), https://legiscan.com/NJ/text/A2031/2018. **(Overlap: BC/BS [Horizon]).**

[vi] Conn. Gen. Stat. Ann. Pub. Act 19-159 (2019), https://www.cga.ct.gov/2019/ACT/pa/pdf/2019PA-00159-R00HB-07125-PA.pdf. **(Overlap: Aetna, BC/BS [Anthem], Cigna, and United)**.

[vii] D.C. Code § 31-3175.03; B22-0597 (2019), http://lims.dccouncil.us/Download/39262/B22-0597-SignedAct.pdf. **(Overlap: Aetna, CareFirst, Kaiser, and United).**

[viii] The Delaware Dept. of Insurance Guidance states that "each managed care organization and *its vendors (if applicable)* should refer to this document for full context regarding completing each step in the NQTL spreadsheet." (emphasis added). (p. 1). In addition, DDI's Step 4 comparative analysis of "written standards" identifies a review of "delegation contracts." (p. 3). The DDI's requirements are consistent with the HB 455/SB 334 provisions, VI(2) and VII(2), to identify measures that the carrier use to ensure that its **delegated entity** uses comparable design and application standards.

[ix] The Delaware Dept. of Insurance Guidance, Step 4, identifies, as part of the comparative analysis of the NQTLs as written, "the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved…." (p. 3). The DDI requirement is consistent with the HB 455/SB 334 provision, IV(1), regard title and qualification of employees making NQTL decisions.

[x] The Delaware Dept. of Insurance Guidance, Step 4, identifies a non-exhaustive list of internal reviews and analyses to support the plan's "as written" comparative analysis. See p. 3-4. The DDI requirement is consistent with the HB 455/SB334 provision, VI(1), requiring identification of the plan's analyses, audits or methods.

[xi] The Delaware Dept. of Insurance Guidance, Step 5, identifies a non-exhaustive list of audits to support the plan's "in operation" comparative analysis. Among the audits listed are: frequency of and reasons for reviews for the extension of initial authorization decision; audit results that demonstrate the frequency of reviews for MH/SUD and med/surg benefits were of equivalent stringency; audit/review of denial and appeal rates (both medical and administrative); analysis of out-of-network utilization; analysis of provider in-network participation. (pp. 4-5). The DDI requirements are consistent with the HB 455/SB334 provisions related to denial rates, (VII)(3), and data reporting requirements, Sec. D.

[xii] The statute mandates how plans comply with disclosure requirements, rather than asking plans to describe how they comply.

ATTACHMENT 4

Legal Action Center (2.10.20)
Carrier Data Collection Requirements

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
Frequency	Annual	Annual	Annual	Annual	Annual	Annual	Once, and subsequent for significant changes	Annual
MH/SUD Service Utilization	Total number and percentage of members who received MH/SUD benefits by level of care	Total number and percentage of members who received MH/SUD services by level of care	Total number of times patients/ providers requested MH, SUD, and Med/Surg services and the amount of services requested (number of visits, inpatient days)	Total number and percentage of members who received MH/SUD benefits by level of care		Number of beneficiaries treated for opioid use disorder		
Utilization Management Requests and Requirements	Number and percentage of utilization review requests and plan decisions related to prior authorization and concurrent review by parity classification	Number of utilization review requests for MH, SUD, and Med/Surg		Average length of stay for inpatient treatment; average number of sessions for outpatient treatment	Rates of utilization review and outcome for MH, SUD, and Med/Surg by parity classification; number of prior or concurrent authorization requests	Frequency with which plans required prior authorization	Audit to demonstrate that the frequency of all types of utilization review are comparable; frequency and reasons for review of extension on initial decisions	Data on parity compliance for adverse decisions regarding claims for MH and SUD services including total number of adverse decisions for such claims

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	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
Denials and Appeals	Number and percentage of denials and appeals of adverse and coverage decisions by parity classification	Number and rate of utilization requests denied and reason; number and rate of internal appeals and their outcomes; number and rate of external appeals and their outcomes	Number of service and outcomes; number of internal appeals and their outcomes; number of external appeals and their outcomes	Number and percentage of members denied prior and concurrent authorization; number of appeals by members and providers	Number of denials for MH, SUD, and Med/Surg by parity classification; rates of appeals and outcomes	The rates and reasons for denial of claims by parity classification	Audit/review of denial and appeal rates (medical and admin.) by service type or benefit category	
Network Utilization	Number and percentage of claims paid for in-network and out-of-network services by level of care	Number of providers (primary care, specialists, hospitals, and pharmacies) located in each county and the percentage that were board certified; procedures used to credential providers; provider-to-patient ratio	An explanation of any differences in the standards for granting authorization for out-of-network services; rates of provider disenrollment and reasons for disenrollment		Percentage of claims paid for in-network and out-of-network services; number and type of providers who are in-network; percentage of providers who remained in-network; any other data to evaluate network adequacy	List of in-network providers that prescribe opioid use disorder medications and type of medication; description of effort to ensure in-network capacity meets needs of insurer's beneficiaries	Analysis of out-of-network and emergency utilization; Wait times for appointments, volume of claims filed, and types of services provided by in-network providers; market analysis of factors to establish provider reimbursement rates: supply	

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
							and need for provider type or specialty; analysis of provider in-network participation rate	
Claim Reimbursement	Claim expenses per member per month for MH, SUD, and Med/Surg; other data to evaluate reimbursement practices	Claims expenses per member per month for MH, SUD, and Med/Surg, by level of care; and a written statement of the types of financial arrangements with providers			Comparison of cost-sharing requirements and benefit limitations; any other data to evaluate reimbursement practices between MH/SUD and Med/Surg for in-network and out-of-network providers		Analysis of health plan's paid claims; internal review of published information identifying increasing costs	
Misc.		Discharge rates, average lengths of hospital stays, and percentage of patients who remained engaged in treatment after ED visits for MH/SUD or initiating treatment		Discharge rates from inpatient MH and SUD treatment, readmission rates; level of patient satisfaction with quality of MH and SUD care and treatment provided		Certification of comprehensive review of administrative practices for compliance with parity		

	MD Bill	CT[i]	MA[ii]	VT[iii]	NY[iv]	DC[v]	DE[vi]	CO[vii]
				under the insurance plan				

[i] CONN. GEN. STAT. §§ 38a-478c, 38a-478l; Conn. Dept. of Insurance, "Consumer Report Card On Health Insurance Carriers in Connecticut" (Oct. 2019), available at https://portal.ct.gov/-/media/CID/1_Reports/2019-ConsumerReportCard.pdf?la=en. **(Overlap: Aetna, BC/BS [Anthem], Cigna, and United).**

[ii] M.G.L. ch. 26, § 8K; Div. of Insurance Bulletin 2013-06, available at https://www.mass.gov/files/documents/2017/11/22/Bulletin%202013-06%20%28Mental%20Health%20Parity%29.pdf. **(Overlap: BC/BS and United).**

[iii] 18 V.S.A. § 414a; Regulation 2000-3-H, available at https://dfr.vermont.gov/sites/finreg/files/regbul/dfr-regulation-health-h-2000-03-mental-health-substance-abuse.pdf. **(Overlap: BC/BS).**

[iv] N.Y. Ins. Law § 343 (2019), available at https://www.nysenate.gov/legislation/laws/ISC/343. (Overlap: Aetna, BCBS [Empire], and United)

[v] D.C. Code §§ 31-3175.03, 7-3202. **(Overlap: Aetna, CareFirst, Kaiser, and United).**

[vi] 18 DE Admin. Code § 1410 (2019), available at https://regulations.delaware.gov/register/june2019/final/22%20DE%20Reg%201025%2006-01-19.pdf; DE Div. of Insurance, Regulation 1410 – Appendix A and Guidance Concerning Providing the Information Required on the NQTL Portion of the Data Collection Tool for Mental Health Parity Analysis (2019), available at https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/06/NQTL-Guidance-and-Worksheet-FINAL.pdf. **(Overlap: Aetna, BC/BS [Highmark], and United).**

[vii] COLO. REV. STAT. § 10-16.147(2)(A). **(Overlap: Aetna, BC/BS [Anthem], Kaiser, and United)**