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Executive Nominations Committee

Education, Energy and the Environment Committee

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Senate Bill 93 - Health Insurance - Utilization Review - Private Review Agents

Dear Colleagues,

I am pleased to present **Senate Bill 93 - Health Insurance - Utilization Review - Private Review Agents**, which requires private review agents to adopt best practices in the criteria and standards they use for health insurance utilization reviews relating to mental health and substance use disorder (MH/SUD) benefits, provide clear rationale linked to established criteria before issuing an adverse decision, and specifies the procedure private review agents must follow when making decisions about MH/SUD benefits.

In 2020, HB455 and SB334 established a new requirement for insurance carriers to submit reports to the Maryland Insurance Administration (MIA) demonstrating that they were in compliance with state and federal parity law. Following a 2 ½ year review of parity compliance reports with clear guidance and examples, followed by detailed insufficiency letters and penalties for late and incomplete reports, the **MIA has still not received the information** it needs to verify that carriers are in compliance. In a report of their findings, the MIA stated that **reports were "uniformly and significantly inadequate**," comparative analyses were either **missing or had "extensive [deficiencies] at each step**," and conclusions regarding compliance were described as "problematic and hollow" because **none of the carriers submitted complete comparative analyses** that could support their conclusions.[1]

Yet there continues to be evidence from providers and patients of inconsistent practices, lack of transparency, and a lack of clear rationale justifying adverse decisions. The Mental Health Association of Maryland outlines common examples of non-quantitative treatment limitations (NQTLs) that patients and providers should investigate if they seem more burdensome for behavioral health care than for medical/surgical care:

- **Frequent and time-consuming authorization requirements** like repeated resubmission of treatment plans, lengthy phone calls to request the full outpatient treatment or inpatient stay recommended by a physician (beyond simply acute crisis stabilization), or burdensome treatment contracts that impact a patient's willingness or ability to engage in treatment.

[1] Maryland Insurance Administration. 2023 Interim Report on Nonquantitative Treatment Limitations and Data. 1 Dec 2023. Accessed 22 Jan 2024. https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data-MSAR-12745.pdf

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- **"Fail-first" policies** that require a documented history of failure with lower level treatments, regardless of a provider's clinical judgment, patient's demonstrated need, or local capacity and available resources.
- Requiring evidence that the patient is **"likely to demonstrate improvement"** and making determinations that **contradict a provider's clinical judgment** and assessment of the patient**.**
- Inconsistent reimbursement rates, unclear criteria for closing panels and not accepting more in-network providers, and overly restrictive requirements for providers to join these networks.[2]

In the absence of clear criteria and evidentiary standards for insurance utilization review, and the MIA's inability to verify the conclusions due to incomplete comparative analyses of NQTLs, **the burden of detecting parity violations remains on overworked providers and Marylanders in crisis.**

<u>What SB93 would do:</u>

- Requires private review agents to adopt **best practices in the criteria and standards they use for health insurance utilization reviews** relating to mental health and substance use disorder (MH/SUD) benefits.
- Specifies the **procedure private review agents must follow when making decisions** about MH/SUD benefits.
- Require private review agents to **provide clear rationale linked to established criteria** before issuing an adverse decision.

<u>How SB93 improves statutory language:</u>

Strengthens and clarifies standards for the utilization review process:

- Adds language around **timely access, communication, transparency, and clear criteria** for utilization review.
- Specifies that MH/SUD criteria will be **evaluated at least annually** (which is consistent with federal requirements).
- Provides specific standards for criteria used in utilization review of MH/SUD benefits. Existing standards for utilization review criteria make no distinction between behavioral health care and somatic care. Currently, criteria must be:
  - Objective
  - Clinically Valid
  - Compatible with established principles of care
  - Flexible enough to allow for deviation and case-by-case decisions

  In theory, this should result in no difference in the way MH/SUD benefits are evaluated (and applied) when compared to medical/surgical benefits. But this is not what we are seeing in practice. New language for MH/SUD criteria **aligns with existing criteria for**

[2] Mental Health Association of Maryland. Navigating Parity Toolkit. Oct 2019. Accessed 22 Jan 2024. https://www.mhamd.org/wp-content/uploads/2019/10/Parity-Toolkit-2018-final.pdf

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somatic care (sometimes word-for-word), but **provides elaboration where elaboration is needed**.

Requires greater transparency surrounding adverse decisions:

- requires private review agents to first **give the individual provider a voice in the process** (the opportunity to speak to the medical necessity of that treatment), and for MH/SUD benefits **demonstrate how they came to their decision** (how criteria and standards were applied).
- Specifies that the same criteria used for utilization review must be clearly **applied to any decision related to service intensity, level of care placement, continued stay, transfer, and discharge**.

Decisions should be consistent with the **required criteria for chronic care treatment,** and private review agents **may not limit treatment to acute care only.**

The amendment submitted to Senate Bill 93 emphasizes that private review agents must certify that the criteria and standards for utilization review are generally recognized by health care providers practicing in the relevant clinical specialties. It provides detailed criteria for physical health conditions and mental health disorders, including reliance on peer-reviewed scientific studies, development by nonprofit health care provider professional societies or organizations working directly with health care providers, recommendations by federal agencies, and compliance with various quality and updating standards. The amendment also includes considerations for atypical patient populations and diagnoses and mandates compliance with other criteria and standards required for coverage under the specified title, including treatment of substance use disorders.

Furthermore, Senate Bill 93 strengthens statutory language by delineating clear standards for utilization review criteria, emphasizing timely access, communication, and transparency. It establishes annual evaluation of MH/SUD criteria and ensures consistency in decision-making regarding service intensity, level of care, and treatment duration.

In essence, Senate Bill 93 seeks to rectify the disparities between behavioral health care and somatic care in utilization review processes. By promoting transparency, accountability, and adherence to established criteria, SB93 aims to safeguard the rights of Marylanders in need of MH/SUD treatment and improve access to quality care.

Thank you for your attention to this critical matter. I urge the committee to give a **favorable** report for **Senate Bill 93 - Health Insurance - Utilization Review - Private Review Agents as amended.**

Sincerely,

Malcolm Augustine

Senator Malcolm Augustine