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Health Insurance – Utilization Review – Private Review Agents (SB 93)
Senate Finance Committee
February 21, 2024
FAVORABLE

Thank you for the opportunity to submit testimony in favor of SB 93, which would require private review agents to use uniform utilization review standards for mental health and substance use disorder treatment decisions and address two review practices that deny access to the appropriate level of care. This testimony is submitted by the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV and AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health and substance use disorder services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance. Utilization review (UR) standards are at the core of whether Marylanders get access to the care they need and pay for through their insurance plan, and those standards must comply with the Parity Act in their design and application.

We support SB 93 to ensure that private review agents (PRA) (1) use the **right** medical necessity standards when making authorization and payment decisions for mental health (MH) and substance use disorder (SUD) treatment and (2) apply those criteria with **fidelity**. SB 93 has three critical components to strengthen the UR process for MH and SUD care, all of which mirror or complement the standards in SB 791.

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

SB 93, like SB 791, would require private review agents to use the medical necessity and level of care standards that have been developed by the non-profit medical and clinical specialty society for mental health practitioners for all UR decisions. Since 2019, Maryland has required the use of such evidence-based standards for SUD care – the American Society of Addiction Medicine (ASAM) Criteria. Ins. § 15-802(d)(5). The **same statutory protection does not exist for mental health care**, even though well-recognized professional society standards are available. Instead, private review agents have complete discretion to select proprietary standards (e.g. InterQual or MCG) that often limit access to MH care. For example, a nationwide class action lawsuit successfully challenged United Behavioral Health's (UBH) Level of Care Guidelines for MH and SUD care, finding that the standards UBH developed were "significantly and pervasively more restrictive than generally accepted standards of care" and were developed to put its financial interests above it plan members' right to benefits. Wit v. United Behavioral Health, 2020 WL 6479273 *49 (N.D. CA), *aff'd in part, rev'd in part, remanded*, 79 F.4th 1068 (9th Cir. 2023). Nationally recognized MH professional society standards include those developed by the American Association of Community Psychiatrists (LOCUS and CALOCUS), the American Academy of Child & Adolescent Psychiatry (CASII and ESCII),the American Psychiatric Association, and World Professional Association for Transgender Health (WPATH).

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Consumers and providers will benefit tremendously from the mandatory use of a non-profit professional medical society's standards. Regardless of a consumer's insurance plan, access to care will be based on standardized professional care guidelines that address the patient's full medical condition and psychosocial needs. A patient and their practitioner will have greater control over their health care because the UR/medical necessity criteria are developed by a body that has no financial stake in the authorization of patient care. And patients will not have to choose between accepting a lower level of care that their insurer will authorize or paying out-of-pocket for the prescribed care that aligns with the professional society criteria. Receiving the right level of care at the initiation of treatment facilitates recovery and reduces the likelihood that the individual will cycle needlessly through more costly episodes of care.

Equally important, providers will spend less time challenging authorization and continuing care denials that have been based on proprietary standards that are inconsistent with professional society standards. We know that some MH providers do not participate in carrier networks because the administrative effort associated with addressing denials of patient care is far too burdensome. The proposed UR standard, if implemented with fidelity, will, over time, improve patient care and practitioner participation in networks. This standard aligns with the American Medical Association's Prior Authorization and Utilization Management Reform Principles.

2. Require Level of Care Determinations Based on a Patient's Underlying Chronic Condition Not Acute Symptoms

SB 93 would also address a very common practice that PRAs use to deny access to more intensive and expensive levels of care: **authorizing treatment based only on the patient's acute symptoms rather than the underlying chronic condition.** Like many medical conditions, an individual with a MH or SUD may present both acute symptoms (e.g. an overdose, psychotic episode, suicidal ideation) and an underlying condition (e.g. major depression, an alcohol or opioid use disorder), both of which must be treated through a range of services of varying degrees of intensity and/or medications. Health plans commonly deny authorization for medically necessary subacute care, which is delivered in a residential or partial hospitalization/day treatment level of care, by using UR standards that require on-going acute symptoms that will not be present if a patient's acute condition has been stabilized. Frequently, the health plan will deny care and determine that the patient can be treated at a lower level of care, even if the patient has failed repeatedly at that less intensive level of care and setting. Health plans across the country have been sued for denying children and adults authorization for subacute services based on restrictive UR standards that require acute symptoms and for refusing to authorize care based on the patient's underlying chronic condition as with other medical care. *See e.g., B.H. v. Anthem Health Plans of Virginia,* Inc., 2023 WL 5270658 (E.D. Va, 2023).

While the required use of the professional society's UR standards will begin to address this problem, the PRAs must also be required to implement those standards with fidelity. Even with the required use of the ASAM criteria for SUD care, PRAs continue to authorize care based only on the patient's acute drug use symptoms rather than their complete medical and psychosocial needs – such as covering treatment for their withdrawal management from the substance but denying ongoing care at the proper intensity of services to address the underlying SUD. Essentially, a PRA should not selectively apply the criteria in a way that prevents the patient from getting the care they need to recover. To prevent this misapplication or selective application of the "right" criteria, SB 93 would explicitly require the PRA to make all decisions consistent with the required criteria for chronic care treatment and not limit treatment to services for acute care.

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3. Justify Adverse Care Decision Before Issuing a Denial Based on Required Criteria

SB 93 would adopt a second safeguard against the misapplication of the required UR criteria for MH and SUD services: it would require the PRA to explain to the treating provider the specific criteria a patient does not meet ***before issuing the denial*** to allow for immediate corrective action. PRAs will commonly issue an explanation of benefits (EOB) that denies a requested level of care without identifying the specific reason(s) and UR criterion that are the basis for such denial, even though current state law requires that information. Ins. § 15-10A-02(f). For MH and SUD care, a PRA may signal simultaneously that it would authorize a lower level of care, which can lead to patients accepting the lower level of care to get "some" services and not incur unaffordable out-of-pocket costs for the prescribed care. While a practitioner may challenge the PRA's decision in a peer-to-peer conversation, the patient often cannot afford the care pending that review and leave treatment prematurely.

It is essential to prevent incorrect denials of MH and SUD care in addition to requiring PRAs to provide more detailed information in their denial notices, as proposed by SB 791. Marylanders with MH and SUD rarely challenge adverse decisions: only **one-half of one percent (0.59%)** of MH and SUD adverse decisions are challenged in a grievance process even though **one-third (37%) of challenged decisions are overturned by the carrier.** Office of Attorney General, Health Education and Advocacy Unit, Annual Report on the Health Insurance Carrier Appeals and Grievances Process for FY 2023. Marylanders challenge adverse decisions for other health services at a far higher rate: 47% for pharmacy, 24% for dental, 12% for laboratory/radiology, 6% for physician, 4% other, 2% durable medical equipment; and 1% inpatient hospital adverse decisions. With 37% of MH and SUD decisions being overturned, it is clear that many Marylanders who do not challenge their adverse decision are being denied insurance coverage to which they are entitled.

SB 93 would mitigate the burden on both patients who do not understand their appeal rights or do not have the support or capacity to challenge an adverse decision as well as practitioners who must spend significant time engaging in post-denial discussions. Addressing this administrative barrier to care will ease workforce challenges, improve access to care and lower costs associated with incorrect authorization denials.

Thank you for considering our views. We urge the Committee to issue a favorable report on SB 93.

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