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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

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[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,

[redacted]

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.

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August 13, 2014

Sent Via E-Mail and Via Certified Mail

[Address of Carrier]

RE: Mental Health Parity Survey – Maryland Business Only

Dear [Carrier]:

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be sitused in the state of Maryland with one or more Maryland employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).

    a. Do you have the same or different requirements for MHPAEA compliance within each market?
    b. If the requirements are different between markets, describe the differences.

2. The MHPAEA final rule[1] differentiates between six different classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.[2] MHPAEA

[1] *See* "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule." 78 F.R. 219 at 68240 (Wednesday, November 13, 2013).
[2] *See* 45 C.F.R. 146.136(c)(2)(ii).

[redacted] - Attachment A

requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be treated for medical and surgical conditions.

a. How do you determine into which classification a particular benefit belongs?
b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.

3. To comply with MHPAEA's general parity requirement,[3] a plan may not apply any "financial requirement"[4] or "treatment limitation"[5] to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant" [6] financial requirement or treatment limitation of that type applied to "substantially all"[7] medical/surgical benefits in the same classification.

a. Please describe the process that you use to determine whether the "substantially all" test is met.
b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.
c. Provide a detailed example of your process using your plan with the most enrollees in Maryland (please specify market).

4. Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with

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[3] *See* 45 C.F.R. 146.136(c)(2)(i).

[4] *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. *See* 45 C.F.R. 146.136(a).

[5] *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. *See* 45 C.F.R. 146.136(a).

[6] A financial requirement or treatment limitation is "predominant" if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. *See* 45 C.F.R. 146.136(c)(3)(i)(B).

[7] A financial requirement or treatment limitation applies to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. *See* 45 C.F.R. 146.136(c)(3)(i)(A).

respect to medical/surgical benefits in the classification.[8] Under MHPAEA, NQTLs include:

> (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
> (B) Formulary design for prescription drugs;
> (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
> (D) Standards for provider admission to participate in a network, including reimbursement rates;
> (E) Plan methods for determining usual, customary, and reasonable charges;
> (F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
> (G) Exclusions based on failure to complete a course of treatment; and
> (H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. [9]

a. Provide a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
b. How do you provide the policyholder with information pertaining to NQTLs?

5. Medical Necessity Criteria

a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what company do you use?
b. Is that company different than the PRA you use for medical/surgical benefits? If so, what steps does your company take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

6. Formulary Design for Prescription Drugs

a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.

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[8] *See* 45 C.F.R. 146.136(c)(4)(i).
[9] *See* 45 C.F.R. 146.136(c)(4)(ii).

b. Explain how you determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.

7. Provider Networks

   a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
   b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification was undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to Salama Karim-Camara, Market Data Analyst, no later than close of business on September 30, 2014. If you have any questions or concerns, please contact Nour Benchaaboun, Chief, Market Analysis at (410) 468-2222 or by e-mail at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis

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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"),

[redacted] - Attachment B

- 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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INSURANCE
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(Date)

Sent Via E-Mail and Via Certified Mail

(Insert Address)

RE: (Insert Company)
2015 Mental Health Parity Survey – Maryland Business Only

Dear (Insert Name):

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration ("Administration") is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Administration will be conducting these surveys on a yearly basis for the next three years. Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be sitused in the state of Maryland with one or more Maryland employees.

Financial Testing

1) To comply with MHPAEA's general parity requirement,[1] a plan may not apply any "financial requirement"[2] or "treatment limitation"[3] to mental health or substance use disorder benefits in

[1] *See* 45 C.F.R. 146.136(c)(2)(i).
[2] *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. *See* 45 C.F.R. 146.136(a).
[3] *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of

[redacted] – Attachment C

any classification that is more restrictive than the "predominant"[4] financial requirement or treatment limitation of that type applied to "substantially all"[5] medical/surgical benefits in the same classification.

a) Do you currently write business subject to MHPAEA in the large group market?
b) If so, provide the financial testing explained above for the large group plan with the most enrollees in Maryland.

Nonquantitative Treatment Limitations

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.[6]

2) Do you have a fail first requirement for any prescription medications on any formulary the Company employs? If so, provide the following for each formulary:
   a) A description of the terms of the fail first requirement.
   b) A list identifying all mental health/substance use drugs vs. somatic drugs that have this requirement and which drug an individual is required to try first.
   c) A detailed description of how you determine a particular drug should be given a fail first requirement.
   d) Specifically identify if Vivitrol and Suboxone are included in the formulary and if they have a fail first requirement.

3) When creating your provider panel, how do you determine the level of need for a type of provider? Are there parameters or formulas used for mental health/substance use providers and for medical providers? If so, what are they? How do you determine if you have sufficient number of providers in a geographic area to meet the level of need for the type of provider?

4) Provide a detailed description of the processes that are used to determine the length of stay for inpatient/residential treatment for mental health/substance use conditions and for medical/surgical conditions. For example, do you approve only one day at a time for all types of inpatient or residential care, or do different processes for approving inpatient or residential care apply to different conditions?

5) Identify the percentage of total requests for inpatient admissions (including residential treatment services) for which you denied a requested level of care, but authorized a lower level of care for:
   i) mental health diagnoses

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benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. *See* 45 C.F.R. 146.136(a).

[4] A financial requirement or treatment limitation is "predominant" if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. *See* 45 C.F.R. 146.136(c)(3)(i)(B).

[5] A financial requirement or treatment limitation applies to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. *See* 45 C.F.R. 146.136(c)(3)(i)(A).

[6] *See* 45 C.F.R. 146.136(c)(4)(i) and for a description of what is included in NQTL's *see* 45 C.F.R. 146.136(c)(4)(ii).

ii) substance use disorder diagnoses, and
iii) somatic diagnoses.

Specify the numbers by market segment (individual/small group/large group) for admission authorizations requested between January 1, 2014 and March 31, 2015. Include prior and concurrent authorization requests. Describe the processes, strategies, and evidentiary standards used to determine when lower levels of care are authorized in place of inpatient admissions for MH/SA vs. medical/surgical conditions.

6) a) Please specify if the following levels of care are available in your network for the following conditions and services:
   i) in regard to the treatment of heroin and opioid abuse disorders:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services.
   ii) In regard to the treatment of diabetes:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services, e.g. outpatient self-management training and educational services.
   ii) In regard to the treatment of stroke:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services.
   iii) In regard to treatment of bipolar disorder:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services.

   b) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.
   c) 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).
   d) 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.
   e) 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.
   f) List which drugs are covered at each level of care for each condition listed in 6(a), and how are they tiered. Include limitations on dosage. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in placing drugs in tiers and determining limitations on dosage.
   g) Provide the requirements for utilization review for each level of treatment for the conditions listed in 6(a) above. Include limitations on length of treatment for each such condition.

Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the requirements for utilization review and the limitations on length of treatment.

h) Provide the medical necessity criteria used for utilization review for each level of treatment for the conditions listed in 6(a) above. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the medical necessity criteria.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification has undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to me no later than close of business on November 30, 2015. If you have any questions or concerns, please call or e-mail me at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis