SB 631

Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE
First Reader

Senate Bill 631 (Senator Augustine)
Finance

Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Requirements and Reports

This bill requires specified insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) to submit two annual reports to the Insurance Commissioner to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (Parity Act, also known as MHPAEA) and provide specified information on benefits. By December 31, 2019, the Commissioner must create two standard forms for entities to submit or post a summary of the required reports and adopt regulations to implement the reporting requirements. Carriers must provide specified information in the written notice provided to members following certain adverse, grievance, coverage, and appeal decisions. **The bill's provisions regarding notice requirements take effect January 1, 2020, and apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Maryland Insurance Administration (MIA) special fund expenditures increase by *at least* $179,100 in FY 2020 for staff, as discussed below. MIA special fund revenues increase by an indeterminate amount from the $125 rate and form filing fee and any carrier penalties. No effect on the State Employee and Retiree Health and Welfare Benefits Plan (State plan). Future years reflect annualization and ongoing costs.

(in dollars)	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
SF Revenue	-	-	-	-	-
SF Expenditure	$179,100	$219,300	$226,400	$233,900	$241,600
Net Effect	($179,100)	($219,300)	($226,400)	($233,900)	($241,600)

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

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: "ASAM criteria" means the most recent edition of the American Society of Addiction Medicine treatment criteria for addictive, substance-related, and co-occurring conditions that establishes guidelines for placement, continued stay, and transfer or discharge of patients with addiction and co-occurring conditions.

"Parity Act classifications" means in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits.

The bill repeals the limitation on a carrier charging a copayment for methadone maintenance treatment that is greater than 50% of the daily cost for methadone maintenance treatment. The bill requires a carrier to use the ASAM criteria for all medical necessity and utilization management determinations for substance use disorder benefits.

Compliance Report

By July 1 annually, each carrier must submit a report to the Commissioner to demonstrate compliance with the Parity Act. The report must:

- list all mental health, substance use disorder, and medical/surgical benefits offered by the carrier and the Parity Act classification or subclassification of each benefit;
- list all mental health and substance use disorder benefits that are excluded from coverage, including a detailed explanation for the exclusion;
- list any annual or lifetime dollar limits on benefits and provide an actuarial demonstration that any such limit complies with the Parity Act;
- list all financial requirements for benefits offered by Parity Act classification and subclassification, including an actuarial demonstration that the financial requirements satisfy the Parity Act;
- list all quantitative treatment limitations for benefits by Parity Act classification and subclassification, including an actuarial demonstration that the quantitative treatment limitations satisfy the Parity Act;
- list all nonquantitative treatment limitations that apply to benefits by Parity Act classification and identify the description of the nonquantitative treatment limitations in the carrier's plan documents;
- list the factors considered in the design of each nonquantitative treatment limitation and identify sources used to define or establish a threshold for applying such factors;

- include an analysis that demonstrates how each nonquantitative treatment limitation is comparable to and applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits;
- include a record of all claims submitted for benefits and the number of claims denied for each benefit by Parity Act classification; and
- identify the process used to comply with Parity Act disclosure requirements for mental health, substance use disorder, and medical/surgical benefits.

Benefits Report

By July 1 annually, each carrier must submit to the Commissioner a report on the carrier's data for mental health, substance use disorder, and medical/surgical benefits, including:

- the delivery of mental health and substance use disorder services, including the total number of members who received services for a specified covered benefit in the immediately preceding calendar year, reported in a specified manner;
- the total number of members receiving such services on a per capita basis;
- specified utilization management requirements and plan decisions related to prior authorization and concurrent or continuing review by Parity Act classification;
- specified denials and appeals of adverse and coverage decisions by Parity Act classification;
- network utilization reported in a specified manner, including the number and percent of claims paid for out-of-network use of specified services; and
- details on claim reimbursement.

Submission of Reports

Both reports must (1) be submitted on a standard form developed by the Commissioner; (2) be submitted by the carrier that issues or delivers the health benefit plan; (3) be prepared in coordination with any entity the carrier contracts with to provide mental health and substance disorder benefits; (4) contain a signed statement attesting to the accuracy of the report; (5) be made available to all plan members and beneficiaries on the carrier's website and on request; (6) be available to plan members and the public on the carrier's website in a summary form developed by the Commissioner; and (7) exclude any identifying information of any plan members.

Insurance Commissioner Review of Reports and Penalties

The Commissioner must (1) review each report to assess each carrier's compliance with the Parity Act; (2) notify a carrier of any noncompliance; (3) require the carrier to address any noncompliance within 90 days after the carrier is notified; (4) require the carrier to

send notification to members and beneficiaries of the carrier's noncompliance; (5) require reimbursement to members and beneficiaries for costs incurred as a result of any noncompliance; and (6) as appropriate, impose a penalty for each violation.

The Commissioner must impose a penalty of $5,000 per day for which a carrier fails to submit a required report. Penalty revenues must be used only for enforcement of a carrier's compliance with the Parity Act.

Required Notice to Members

Each carrier must include specified information in the required written notice that must be provided to a member following a (1) nonemergency case when a carrier renders an adverse decision; (2) nonemergency case when a carrier renders a grievance decision; (3) written notice of a coverage decision; and (4) written notice of an appeal decision. More specifically, for any such decision regarding mental health or, for the first three types of decisions above, substance use disorder benefits, the carrier must provide notice regarding Maryland's mental health parity law, MHPAEA, and that the member may contact the Commissioner for further information about benefits.

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

MHPAEA (referred to in the bill as the Parity Act) requires group health plans of large employers, as well as qualified health plans sold in health insurance exchanges and in the small group and individual markets as of January 1, 2014, to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways. MHPAEA prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those imposed on other general medical benefits. MHPAEA also imposes nondiscrimination standards on medical necessity determinations.

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

State Fiscal Effect: Under the bill, the Commissioner must develop standard and summary forms for carriers to submit their compliance and benefits reports to MIA (standard forms) and make the reports available on the carrier's website (summary forms), as well as regulations to implement the reporting requirements. Carriers must submit both reports (on the standard form) to the Commissioner by July 1 annually. The Commissioner must review each report to assess compliance, notify a carrier of noncompliance, require the carrier to address noncompliance and notify members and beneficiaries of noncompliance, require reimbursement to members and beneficiaries for costs incurred as a result of noncompliance, and impose a penalty of $5,000 per day for which a carrier fails to submit a required report.

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

As the bill represents a substantial additional workload for MIA, special fund expenditures increase by *at least* $179,078 in fiscal 2020, which accounts for the bill's October 1, 2019 effective date. This estimate reflects the cost to hire at least three analysts to assist in developing forms, regulations, and report submission procedures; review carrier reports for compliance; notify carriers of noncompliance; and assess penalties as necessary. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	3.0
Salaries and Fringe Benefits	$157,377
One-time Start-up Costs	14,670
Ongoing Operating Expenses	7,031
Total FY 2020 State Expenditures	**$179,078**

Future year expenditures reflect full salaries with annual increases and employee turnover and ongoing operating expenses.

The Department of Budget and Management advises that all carriers participating in the State plan comply with the Parity Act and are able to demonstrate such as required.

Additional Comments: MIA advises that, per federal guidance, it is inappropriate to do mental health parity testing at a *carrier* level as, to demonstrate compliance, a carrier must report all information at the *plan* level. MIA further notes that similar review will have already taken place to approve forms and rates *before* the compliance report required under the bill is submitted and reviewed. Finally, MIA has no authority over self-insured groups; thus, a carrier report showing the testing details of all the carrier's plans (both fully insured and self insured) would not help support any of MIA's oversight responsibilities.

Additional Information

Prior Introductions: None.

Cross File: HB 599 (Delegate Kelly) - Health and Government Operations.

Information Source(s): American Psychiatric Association; Department of Budget and Management; Maryland Insurance Administration; Maryland Health Benefit Exchange; Department of Legislative Services

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