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June 29, 2016

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

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

Dear Senator Middleton:

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

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

Responses were requested and provided from the following carriers:

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

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

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

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

Aetna/Coventry:

Coventry’s responses revealed the following:

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

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

CareFirst:

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

BlueChoice’s responses revealed the following:

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

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

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

CareFirst/GHMSI responses revealed the following:

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

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

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

Cigna:

Cigna's responses revealed the following:

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

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

Evergreen:

Evergreen's responses revealed the following:

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

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

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

Kaiser:

Kaiser's initial responses indicated the following:

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

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

United Healthcare:

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

Freedom:

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

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

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

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

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

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

Other states are initiating other action, including:

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

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

We hope this information is helpful.

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

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

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

Sincerely,

Al Redmer  
Insurance Commissioner

Cc: Delegate Peter A. Hammen, Chairman, House Health and Government Operations  
Committee

Cc: Patrick Carlson, Senate Finance Committee Staff

Cc: Linda Stahr, HGO Committee Staff

Cc: Nancy J. Egan, Esq., Director of Government Relations, MIA

Attachments: (5)