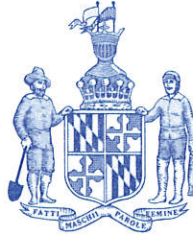


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August 16, 2017

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
ATTN: Darci Smith, Special Assistant - MHPAEA, Compliance and Enforcement

Re: Third Mental Health Parity and Addiction Equity Act (MHPAEA) market conduct survey

Dear Ms. Smith:

The Health Education and Advocacy Unit of the Office of the Attorney General's Consumer Protection Division appreciates the opportunity to provide suggestions for specific survey questions and documents and data that should be collected from insurance carriers for review during MIA's third market conduct survey.

The HEAU concurs with the MIA's intended goal of the next survey – evaluating whether carriers' policies and procedures are actually applied uniformly and consistently to mental health and substance use disorder benefits and medical/surgical benefits. Once a consumer has access to a provider, the only effective way to review limitations and denials of treatment is to obtain and review all claims data over a discrete period of time. Unfortunately, other states that have reviewed claims data have discovered higher denial rates and more frequent and stringent reviews leading to limitations and denials of mental health and substance use disorder benefits, despite carrier compliance attestations.

As it has in the past, the HEAU recommends that the MIA seek at least two years' worth of closed claims data to compare limitations and denials of treatment for mental health/substance use disorder claims against medical/surgical claims and to evaluate application of utilization review and appeal processes of limited/denied claims. The actual claims data should be requested, not just a summary.

Suggested requests:

1. Documents sufficient to show, for each plan, every request or claim for coverage of treatment services, including, for each request or claim: (i) diagnosis; (ii) type of service; (iii) whether claims were for medical/surgical or mental health/substance use disorder treatment; (iv) whether services were to be rendered to such members by in-



network or out-of-network providers; (v) if utilization or coverage review decisions were made; (vi) the extent to which such decisions were prospective, concurrent, or retrospective; (vii) the extent to which such decisions were made on an expedited basis; (viii) with respect to each request or claim, whether a coverage or an adverse decision was made; (ix) the names and qualifications of those persons who rendered any such adverse or coverage decision; (x) provider submitting the claim; (xi) rate claimed; (xii) allowed amount; (xiii) amount paid; (xiv) amount applied to deductible; (xv) co-payment amount; and (xvi) co-insurance amount.

- "Treatment" should be defined to be all inclusive.
- It must be made clear that a denial of a claim, in whole or in part, must be reported as an adverse or coverage decision. (e.g. approval of a lower level of care or fewer in-patient days than requested is an adverse decision).

2. For those requests or claims where an adverse or coverage decision was made, all correspondence or other documents sent to members and/or providers regarding the adverse or coverage decision and all standards of care, criteria, guidelines, protocols, and directives used to support the adverse or coverage decision.

a. For those mental health/substance use disorder claims where an adverse or coverage decision was made, provide all documents sufficient to show how standards of care, criteria, guidelines, protocols, and directives used to support the adverse or coverage decision were applied in a no more restrictive manner to behavioral benefits than to medical/surgical benefits provided under the plan.

b. If the adverse or coverage decision was based on concurrent review of an in-patient admission, provide all documents and criteria for the concurrent review process for the in-patient admission and document how that is comparable to and applied no more stringently than the development and application of pre-authorization and concurrent review requirements under the medical/surgical benefit.

c. If the adverse or coverage decision was for residential treatment, provide all documents sufficient to show that any exclusion of coverage for residential treatment for mental health/substance use disorders is comparable to exclusions of coverage for medical/surgical treatment and no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the plan.

d. If the adverse or coverage decision was appealed internally, provide all documents sufficient to show: (i) the subject matter of each such appeal; (ii) the outcome of each appeal, including the rationale for upholding or reversing the original determination; (iii) the name of the private review agent used; and (iv) names and qualifications of those persons who rendered the internal appeal decision.

e. If the adverse or coverage decision was appealed externally, provide all documents sufficient to show: (i) the subject matter of each such appeal; (ii) the outcome of each appeal, including the rationale for upholding or reversing the original determination; (iii) the name of the private review agent used; and (iv) the names and qualifications of those persons who rendered the external appeal decision.

As noted in the MIA's June 30, 2017 Update Summary of Survey Two Analysis, California's Department of Managed Health Care's recent audits revealed that self-reported carrier compliance was inaccurate and that inaccuracies existed between what plans reported to use for utilization management standards and what standards are actually used in practice. It is imperative for Maryland consumers that the Administration review actual claims processing practices and not just rely on carrier attestations.

Thank you for your consideration of HEAU's comments and requests.

Sincerely,



Kimberly S. Cammarata
Assistant Attorney General
Director, Health Education and Advocacy Unit