LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2090 Fax: 410-468-2020
Email: al.redmer@maryland.gov
410-468-2000 1-800-492-6116
TTY: 1-800-735-2258
www.insurance.maryland.gov

January 26, 2018

Sent Via Certified and Electronic Mail

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 the final 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.

On June 30, 2017, the MIA submitted a summary of the 2015 Survey findings to your attention. *See* Attachment A. That summary explained that investigations were ongoing for UnitedHealthcare ("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 CareFirst (including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI")). The MIA has completed those investigations, as detailed below. Information about UHC, BlueChoice, CareFirst of Maryland Inc., and GHMSI's provider networks that was received during the 2015 Survey was included in the letter the Administration sent to your attention on June 30, 2017. *See* Attachment A, Section "Provider and Facility In-Network Adequacy."

UnitedHealthcare ("UHC")

UHC's responses to the MIA's 2015 survey and resulting investigation revealed that UHC's managed behavioral health organization United Behavioral Health Inc., under the brand Optum, reviewed a five year malpractice history for all mental health/substance use disorder facilities applying to be credentialed. UHC collected but did not review a malpractice history for any medical/surgical facilities.

As a result of finding that UHC applied more stringent credentialing requirements to behavioral health facilities than to medical/surgical facilities, Consent Order # MIA-2017-08-009 was issued to UHC by the MIA to bring UHC into compliance. *See* Attachment B. The MIA directed UHC to pay a fine of $2,000.00 for the four behavioral health facilities affected by this practice, and to submit, within 30 days, a corrective action plan. UHC has paid the fine and has removed the requirement to review a five year malpractice history for mental health/substance use disorder facilities.

CareFirst

On May 1, 2017, the MIA became aware that CareFirst BlueChoice, Inc.'s ("BlueChoice") online provider directory for behavioral health listed only two of the 27 in-network mental health hospitals and two of the seven mental health non-hospital facilities that the Respondents had reported were in-network during the MIA's investigation. The MIA was informed that the 27 hospitals include acute care/general hospitals that were listed under the medical/surgical portion of the provider directory. Additionally, two of the non-hospital facilities that were reported were listed only under the medical/surgical portion of the provider directory. The remaining three non-hospital facilities that were reported were not listed anywhere in the provider directory. In response to the MIA's investigation, BlueChoice corrected the error with its online provider directory. All reported facilities are now listed in the behavioral health provider directory as well as the medical/surgical directory if the facilities provide both services.

On May 1, 2017, the MIA also became aware that CareFirst BlueCross BlueShield's Blue Preferred online behavioral health provider directory did not list any in-network inpatient mental health facilities. The MIA was informed that the inpatient mental health facilities appeared in the directory under the medical/surgical portion of the provider directory. In response to the MIA's investigation, CareFirst BlueCross BlueShield corrected the error with the Blue Preferred online behavioral health provider directory to reflect that there were seven in-network facilities.

As a result of the inaccuracies in BlueChoice and CareFirst BlueCross BlueShield's online provider directories, Consent Order # MIA- was issued to CareFirst by the MIA to bring CareFirst into compliance. *See* Attachment C. The MIA directed BlueChoice to pay an administrative penalty of $20,250.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. BlueChoice has paid the fine and corrected its directory as of December 11, 2017. The same consent order directed CareFirst BlueCross BlueShield to pay an administrative penalty of $4,725.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. CareFirst BlueCross BlueShield has paid the fine on January 5, 2018, and corrected its directory as of May 5, 2017.

Survey Three

The MIA worked with various interested parties to develop a third survey to address additional concerns regarding compliance with MHPAEA. Survey Three was sent to the health insurance carriers on October 6, 2017. (*See* Attachment C.) 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 Three analysis once it has been completed.

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

Sincerely,

[redacted]

Al Redmer
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chair, House Health and Government Operations Committee
Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

– Attachment A –

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2090 Fax: 410-468-2020
Email: al.redmer@maryland.gov
410-468-2000 1-800-492-6116
TTY: 1-800-735-2258
www.insurance.maryland.gov

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]

---

[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

---

[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

[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.

[redacted] – Attachment B –

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

MARYLAND
INSURANCE
ADMINISTRATION

AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2009 Fax: 410-468-2020
Email: melaniegross@maryland.gov
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

August 10, 2017

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
REGULAR MAIL

MAMSI Life and Health Insurance Company
Attn: Joe Stangl
800 King Farm Boulevard
Rockville, MD 20850

Optimum Choice, Inc.
Attn: Joe Stangl
800 King Farm Boulevard, MD051-1000
Rockville, MD 20850

UnitedHealthcare Insurance Company
Attn: Joe Stangl
185 Asylum Avenue
Hartford, Connecticut 06103

UnitedHealthcare of the Mid-Atlantic, Inc.
Attn: Joe Stangl
800 King Farm Boulevard, MD051-1000
Rockville, MD 20850

All Savers Insurance Company
Attn: Joe Stangl
7440 Woodland Drive
Indianapolis, IN 46278

Re: MIA v. MAMSI, Optimum Choice, Inc, UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc. and All Savers Insurance Company
Case No.: MIA-2017-08-009

Dear Mr. Stangl:

This will acknowledge receipt of your check in the amount of $2,000.00 representing the administrative penalty regarding the above captioned case.

A copy of the fully executed Consent Order is enclosed for your records.

Sincerely,

[redacted]

Melanie Gross
Executive Assistant to the Deputy Commissioner

Enclosure

cc: Al Redmer, Jr., Commissioner
Nancy Grodin, Deputy Commissioner
J. Van Lear Dorsey, Principal Counsel
Lisa Hall , Deputy Counsel
Tracy Imm, Director of Public Affairs
Darci Smith, Special Assistant

MARYLAND INSURANCE COMMISSIONER *
200 ST. PAUL PLACE, SUITE 2700
BALTIMORE, MARYLAND 21401 *

*

V.

*

CASE NO: MIA-2017-08-009

MAMSI LIFE AND HEALTH INSURANCE *
COMPANY,
800 KING FARM BLVD. *
ROCKVILLE, MARYAND 20850
NAIC# 60321 *

OPTIMUM CHOICE, INC. *
800 KING FARM BLVD., MD051-1000
ROCKVILLE, MARYLAND 20850 *
NAIC # 96940

*

UNITEDHEALTHCARE INSURANCE
COMPANY, *
185 ASYLUM AVENUE
HARTFORD, CONNECTICUT 06103 *
NAIC# 79413

*

UNITEDHEALTHCARE OF THE MID-
ATLANTIC, INC., *
800 KING FARM BLVD., MD051-1000
ROCKVILLE, MARYLAND 20850 *
NAIC # 95025

*

ALL SAVERS INSURANCE COMPANY
7440 WOODLAND DRIVE *
INDIANAPOLIS, INDIANA 46278
NAIC# 82406 *

* * * * * * * * * * * *

CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc., and All Savers Insurance Company (collectively "Respondents" or "UHC") pursuant to §§ 2-108 and 2-204 of the Insurance Article,

Annotated Code of Maryland, to resolve the matter, in lieu of litigation, before the Insurance Administration ("Administration").

Facts

(1) At all times relevant to this Order, MAMSI Life and Health Insurance Company, UnitedHealthcare Insurance Company, and All Savers Insurance Company have held and currently hold Certificates of Authority from the Administration to act as an insurer in the State of Maryland.

(2) At all times relevant to this Order, UnitedHealthcare of the Mid-Atlantic States and Optimum Choice, Inc., have held and currently hold Certificates of Authority to act as health maintenance organizations in the State of Maryland.

(3) At all times relevant to this Order, United Behavioral Health, Inc., under the brand Optum, acted as the Managed Behavioral Health Organization for the Respondents.

(4) A survey was sent in October 2015 to the Respondents regarding compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA").[1] After receiving the survey response from the Respondents, the Administration opened investigation MCLH-57-2016-I to gather additional information necessary to determine compliance with the federal rule.

Findings

(5) On November 20, 2015, in response to the Administration's survey, the Respondents provided an excerpt from a document entitled "Summary of Various Non-Quantitative Treatment Limitations Mental Health Parity and Addiction Equity Act." The excerpt addressed Network Admission Criteria for providers and facilities.

[1] *See* Federal Register, Volume 78, No. 219, published November 13, 2013.

(6) Under the facility credentialing section the document provided that behavioral health facilities (providing treatment for mental health and substance use disorder illnesses) are subjected to a malpractice history review. A similar requirement was not indicated for credentialing general medical/surgical facilities.

(7) On April 26, 2017, in response to the Administration's investigation, a representative of United stated, in pertinent part:

> [Mental health and substance use disorder] facilities have a malpractice history review in the same fashion as individual providers. [Medical/surgical] gathers a history where required by law or regulation (such as in [Maryland]) but does not include this history in review as it is not a requirement under NCQA credentialing standards. This does constitute a difference in the two processes but we believe the processes are sufficiently comparable to constitute parity particularly given both [medical/surgical] and [mental health/substance use disorder] facilities are subjected to review for credentialing and quality issues of which the malpractice history is just one component.

(8) Since applicable MHPAEA rules went into effect, four mental health/substance use disorder facilities have applied to Optum for credentialing and had their malpractice history reviewed.

(9) On May 9, 2017, in response to the Administration's letter advising UHC of the violations it identified, the Respondents informed the Administration that they had temporarily suspended the review of malpractice history for mental health and substance use disorder facilities since the medical/surgical process does not currently involve this review. The Respondents are undertaking a review of the process to determine the best practice moving forward.

Conclusions of Law

(10) Based on the results of the Investigation, the Administration concluded the Respondents violated § 15-802(d)(2)(ii) by failing to comply with 45 C.F.R. § 146.136(c)(4).

(11) Section 15-802 of the Maryland Insurance Article states, in pertinent part:

> (b) With the exception of small employer grandfathered health plan coverage, this section applies to each individual, group, and blanket health benefit plan that is delivered or issued for delivery in the State by an insurer, a nonprofit health service plan, or health maintenance organization.
>
> (c) A health benefit plan subject to this section shall provide at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder:
>
> (1) inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient benefits;
>
> (2) partial hospitalization benefits; and
>
> (3) outpatient benefits, including all office vists and psychological and neuropsychological testing for diagnostic purposes.
>
> * * * *
>
> (2) The benefits required under this section:
>
> * * * *
>
> (ii) shall comply with 45 C.F.R. § 146.136(a) through (d)[.]

(12) 45 C.F.R. § 146.136(c)(4) provides in pertinent part:

> (i) A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitiative treatment limitation 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.
>
> (ii) Nonquantitative treatment limitations include –
>
> (D) Standards for provider admission to participate in a network[.]

Order

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by the Respondent, that

A. Respondent shall pay an administrative penalty of two thousand dollars ($ 2,000.00) contemporaneously with Respondents' execution of this Order. Administrative

penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number MCLH-57-2016-I. Unpaid penalties will be referred to the Central Collection Unit for collections.

B. Within thirty (30) days of the date of this order, Respondents shall provide a corrective action plan to the Administration indicating that facility credentialing procedure requirements for mental health and substance use disorder facilities are developed based on the application of the same or similar factors that are applied to medical/surgical facilities credentialed by the Respondents.

Other Provisions

C. The executed Order and any administrative penalty shall be sent to the attention of: Associate Commissioner, Compliance and Enforcement, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

D. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

E. The parties acknowledge that this Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or

civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondent to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

F. Respondent has had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondent waives any and all rights to any hearing or judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

G. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties.

H. This Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

I. Failure to comply with the terms of this Order may subject Respondent to further legal and/or administrative action.

ALFRED W. REDMER, JR
Insurance Commissioner

[redacted]

By: Nancy Grodin
Deputy Commissioner

Date: 8/10/17

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: Christopher John Mullins Sr.

Signature: [redacted]

Title: CEO – Optimum Choice, Inc., MD-Individual Practice Association, Inc., MAMSI Life and Health Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.

Date: 8/2/17

ALFRED W. REDMER, JR
Insurance Commissioner

[redacted]

By: Nancy Grodin
Deputy Commissioner

Date: 8/10/17

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: Jeffrey Donald Alter

Signature: [redacted]

Title: CEO – UnitedHealthcare Insurance Company

Date: 8/1/17

ALFRED W. REDMER, JR
Insurance Commissioner

[redacted]

By: Nancy Grodin
Deputy Commissioner

Date: 8/10/17

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: Patrick Francis Carr

Signature: [redacted]

Title: CEO – All Savers Insurance Company

Date: 8/2/17

- Attachment C -

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

MARYLAND
INSURANCE
ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2009 Fax: 410-468-2020
Email: melaniegross@maryland.gov
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

January 11, 2018

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
REGULAR MAIL

Ms. Jenene Lyn Williams, Director, External Audit
CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

CareFirst of Maryland, Inc.
1501 S. Clinton Street
Baltimore,MD 21224

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

Re: MIA v. CareFirst BlueChoice, Inc.; CareFirst of Maryland, Inc.;
Group Hospitalization and Medical Services, Inc.
Case No.: MIA-2018-01-023

Dear Ms. Williams:

This will acknowledge receipt of your check in the amount of $24,975.00 representing the administrative penalty regarding the above captioned case.

A copy of the fully executed Consent Order is enclosed for your records.

Sincerely,

[redacted]

Melanie Gross
Executive Assistant to the Deputy Commissioner

Enclosure

cc: Al Redmer, Jr., Commissioner
Erica J. Bailey, Associate Commissioner
J. Van Lear Dorsey, Principal Counsel
Lisa Hall , Assistant Attorney General
Tracy Imm, Director of Public Affairs
Darci Smith, Special Assistant

MARYLAND INSURANCE ADMINISTRATION 200 ST. PAUL PLACE, SUITE 2700 BALTIMORE, MARYLAND 21202	*	BEFORE THE INSURANCE COMMISSIONER
vs.	*	
CAREFIRST BLUECHOICE, INC. 840 FIRST STREET, NE (NAIC #96202) WASHINGTON, DC 20065	*	ORDER NO.: MIA-2018-01-02-3
CAREFIRST OF MARYLAND, INC. (NAIC #47058) 1501 S. CLINTON STREET BALTIMORE, MD 21224	*	INVESTIGATION NO.: MCLH-141-2015-I
GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. (NAIC #53007) 840 FIRST STREET, NE WASHINGTON, DC 20065	*	

CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and CareFirst BlueChoice, Inc. ("BlueChoice"), CareFirst of Maryland, Inc., and Group Hospitalization and Medical Services, Inc., (collectively "CareFirst BlueCross BlueShield" and, together with BlueChoice, "Respondents") pursuant to §§ 2-108 and 2-204 of the Insurance Article, Annotated Code of Maryland, to resolve the matter, in lieu of litigation, before the Insurance Administration ("Administration")

Facts

(1) At all times relevant to this Order, CareFirst BlueCross BlueShield held and currently holds a Certificate of Authority from the State of Maryland to act as non-profit health service plans.

(2) At all times relevant to this Order, BlueChoice held and currently holds a Certificate of Authority from the State of Maryland to act as a health maintenance organization ("HMO").

(3) At all times relevant to this Order, Magellan Healthcare, Inc., ("Magellan") managed and currently manages the Respondents' behavioral health benefits as a managed behavioral healthcare organization ("MBHO").

(4) The Respondents offer individual and group health plans in Maryland on and off the Maryland Health Benefit Exchange.

(5) A survey ("Second Parity Survey") was sent in October 2015 to the Respondents regarding compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA").[1] After receiving the Second Parity Survey response from the Respondents, the Administration opened investigation MCLH-141-2015-I to gather additional information necessary to determine compliance with MHPAEA.

Findings

1. BlueChoice Online Provider Directory

(6) On May 1, 2017, the Administration became aware that BlueChoice's online provider directory for behavioral health listed only two of the 27 in-network mental health hospital and two of the seven non-hospital facilities that the Respondents had reported were in-network during the Administration's investigation.

(7) On October 19, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part regarding the BlueChoice directory for in-network inpatient mental health hospital facilities:

> ...Magellan reported the 27 inpatient [mental health] hospital facilities and 7 inpatient non-hospital [mental health] facilities [for BlueChoice]. The 27 include Acute Care/General Hospitals that treat Inpatient Psychiatric/Mental Health patients. Since they are general/acute care, they are included in the directory under the medical facility search — not Mental Health. Recognizing this may not be apparent to a member or provider searching the directory, I have shared this observation with the CareFirst team that maintains the directory.

[1] *See* Federal Register, Volume 78, No. 219, published November 13, 2013.

(8) On October 24 and 26, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part regarding the seven reported BlueChoice in-network inpatient non-hospital mental health facilities:

> For the providers being displayed, we have the same issue that they are listed under "hospitals"; [two] under medical, [two] under mental health. Recognizing that this may not be apparent to a member or a provider searching the directory, I asked my colleagues to add this to the list of follow up. .. .
>
> ...Three providers [] are in-network but are not being displayed in the directory. [The Provider Relations Department] has linked with the information technology team that supports them to identify why the facilities are not displaying and the appropriate remediation.

II. CareFirst BlueCross BlueShield's Online Provider Directory

(9) On May 1, 2017, the Administration became aware that CareFirst BlueCross BlueShield's BluePreferred online provider directory did not list any in-network inpatient behavioral health facilities,

(10) On May 5, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part:

> Thank you for bringing this to our attention. [CareFirst BlueCross BlueShield] has reviewed its online provider directory and has corrected the technological errors that incorrectly made it appear that there were no in-network behavioral health facilities.

(11) On May 5, 2017, the BluePreferred online provider directory displayed seven in-network inpatient behavioral health facilities.

(12) On November 7, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part:

> My colleague has confirmed that the BluePreferred inpatient mental health facilities appeared in the directory under the "medical" hospital search [prior to correction on May 5, 2017].

Conclusions of Law

(13) Section 15-1 12 of the Insurance Article states, in pertinent part:

(n)(l) A carrier shall make the carrier's network directory available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form.

* * * *

(p)(2)(ii) 1. Information provided on the Internet under subsection (n) of this section shall be accurate on the date of initial positing and any update.

2. In addition to the requirement to update its provider information under subsection (t)(l) of this section, a carrier shall update the information provided on the Internet at least once every 15 days.

(14) Based on the results of the Investigation, the Administration concluded the BlueChoice and CareFirst BlueCross BlueShield violated §15-112 by failing to have an accurate online provider directory.

(15) Based on the information provided in response to the Second Parity Survey, the Administration did not identify any violation of MHPAEA.

Order

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by Respondents:

A. That pursuant to §4-113 of the Insurance Article, Respondents, prior to execution of this Order, correct their online provider directories for mental health providers to include the in-network mental health hospital and non-hospital facilities that the Respondents had reported were in-network during the Administration's investigation.

B. That, pursuant to §19-730 of the Health-General Article, based on consideration of COMAR 31.02.04.02, BlueChoice pay an administrative penalty of Twenty Thousand Two Hundred and Fifty Dollars ($20,250.00) for violation of §15-112 of the Insurance Article, simultaneously with the execution of this Order.

C. That, pursuant to §4-113 of the Insurance Article, based on consideration of COMAR 31,02.04.02, CareFirst BlueCross BlueShield pay an administrative penalty of Four Thousand Seven Hundred and Twenty-Five Dollars ($4,725.00) for violation of §15-112 of the Insurance Article, simultaneously with the execution of this Order.

Other Provisions

D. The executed Order and any administrative penalty shall be sent to the attention of: Erica J. Bailey, Associate Commissioner, Compliance and Enforcement, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

E. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondents, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondents made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

F. The parties acknowledge that this Order resolves the Second Parity Survey, Investigation MCLH-141-2015-I and all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondents to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondents including the conduct that is the subject of this Order.

G. Respondents have had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondents waive any and all rights to any hearing or

judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

H. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties,

I. This Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under §2-204 of the Insurance Article.

J. Failure to comply with the terms of this Order may subject Respondents to further legal and/or administrative action.

ALFRED W. REDMER, JR.
Insurance Commissioner

[redacted]

By: Erica J. Bailey
Associate Commissioner
Compliance & Enforcement
Date: 1/11/2018

RESPONDENTS' CONSENT

RESPONDENTS hereby CONSENT to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondents, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondents to the obligations stated herein and does, in fact, have the authority to bind Respondents to the obligations stated herein.

Name: Jonathan D. Blum

Signature: [redacted]

Title: Executive Vice President, Medical Affairs

Date: December 21, 2017