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Senate Bill 791 Health Insurance - Utilization Review - Revisions
Finance Committee
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Position: SUPPORT

Mental Health Association of Maryland (MHAMD) is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of Senate Bill 791.

SB 791 reforms utilization review[1] standards to improve patient access to needed health care. Among its many positive revisions, the bill specifies that private review agents (PRAs) must use utilization review criteria developed by a non-profit health care provider professional medical or clinical specialty society. If no specialty society exists, the bill requires that the utilization review criteria be consistent with standards generally recognized by health care providers practicing in the relevant specialty.

SB 791 also outlines a number of patient-centered requirements related to an insurance carrier's treatment determination processes that should help to limit carrier denials of needed health care (i.e. adverse decisions). The bill ensures that expedited reviews are based on the determination of the health care provider and not the carrier, sets a timeframe for authorizing additional visits/days for an existing course of treatment, requires that carrier denials explain why the request was not medically necessary and did not meet utilization review criteria, and provides that a request for care is deemed approved if a carrier fails to make a determination within a required timeframe.

The reforms in SB 791 are particularly important for those seeking mental health or substance use care. Too often, private health plans rely on medical necessity criteria that are not consistent with evidence-based care for mental health conditions. According to a recent national patient-experience survey conducted by NORC, nearly 70% of Marylanders reported that they had problems with their health insurance plan denying coverage for mental health or substance use care based on either the care not being medically necessary or the care being not covered or excluded.

And although carrier adverse decisions continue to increase (95,327 in 2022 compared to 81,143 in 2021),[2] and although upwards of 70% of challenged care denials are ultimately modified or reversed,[3] appealing adverse decisions is not a reasonable option for individuals experiencing a behavioral health crisis. Appealing decisions takes significant time and support, and currently less than one-half of one percent of adverse mental health or substance use disorder decisions are challenged.

SB 791 will limit inappropriate denials of care and help Marylanders get more timely treatment. For these reasons, MHAMD supports this bill and urges a favorable report.

[1] "Utilization review" is a process where a health insurance company, in advance of a health care service being rendered, reviews a health care provider's request for care to determine whether the service is medically necessary.
[2] https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2022-Report-on-the-Health-Care-Appeals-and-Grievance-Law-MSAR-6.pdf
[3] Id.

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