November 15, 2021

Lisa Larson
Director of Regulations
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Submitted to: insuranceregreview.mia@maryland.gov

Dear Ms. Larson.

Thank you for the opportunity to submit comments on the revised NQTL Comparative Analysis Report and MHPAEA Compliance Reporting for NQTLs and the MHPAEA Summary Form. The following comments are submitted by the Legal Action Center and the twelve (12) undersigned members of the Maryland Parity Coalition, convened by the Center.

In brief, we request further clarification on one non-quantitative treatment limitation (NQTL) entry – the prescription drug formulary design analysis – and several revisions to the summary form to provide more guidance to consumers who will likely need additional information about the Parity Act and the plan design features to make full use of the issuer's report. Finally, we urge the Maryland Insurance Administration (MIA) to require the submission of data requested in the four supplemental data templates as part of the NQTL report; that outcome data is essential to determine in operation compliance of key NQTLs and is fully consistent with – and, in fact, required by – federal law and guidance.

Preliminarily, we appreciate the Maryland Insurance Administration's (MIA) response to the Center's September 8, 2021 recommendations to clarify several issues related to the NAIC template. We specifically commend the MIA for the following revisions:

- Clarification that carriers must report non-quantitative treatment limitations (NQTLs) separately for mental health disorder (MH) benefits and substance use disorder (SUD) benefits to the extent different NQTLs are applied or the "rules" around the application and implementation of the NQTLs are different for MH and SUD benefits.
- Clarification that the prompts identified on the NQTL Comparative Analysis Report form for each of the fourteen (14) NQTLs are not intended to limit the reporting of other plan design features that the form does not specifically identify.
- Clarification of specific definitions and inclusion of other definitions that will ensure more complete and uniform reporting, including Prescription Drug Formulary Design and reimbursement rates.
- Clarification on the NQTLs that are applied for the emergency care and pharmacy classifications.

- Explicit listing of MH, SUD and Med/Surg benefits by classification and instruction to apply the same classification for each NQTL.

We offer the following recommendations on the revised Comparative Analysis Report and Instructions, the Summary Form Instructions, and the MIA's question regarding the timeline for issuing/requiring responses to the supplemental data templates.

I. Comparative Analysis Report and Instructions

We appreciate the MIA's clarification on multiple items in the comparative analysis report and instructions. We remain confused about (1) the NQTLs that must be addressed, respectively, for pharmacy services (item 6) and prescription drug formulary design (item 7) analysis and (2) the information that must be provided for the item 7 chart. We are aware that market conduct examinations in other states have identified significant parity violations for prescription drug coverage, and we seek to ensure a full identification and review of carrier practices.

We agree that NQTLs unique to pharmacy services and not covered in other NQTL entries must be provided in item 6, yet we would appreciate further clarification on what the MIA envisions will fall into this NQTL as opposed to the formulary design NQTL. We are particularly confused because the definition of "prescription drug formulary design" will require carriers to examine (in item 7) the prescription drugs that are approved for reimbursement and the reimbursement, cost-sharing and utilization management requirements that are imposed based on the formulary tier on which a medication is placed. Those are some of the features that seem unique to the pharmacy services NQTL, and we believe further clarification will ensure that all NQTLs are identified and analyzed by all carriers.

For the item 7, we request the MIA identify the information to be entered in the chart, as it has no guiding questions/direction. At a minimum, we believe that the carrier must identify and conduct a comparative analysis of:

- the covered mental health disorder, substance use disorder and medical/surgical drugs (both brand and generic) and drugs covered on a specialty formulary;
- the tier on which each drug is placed; and
- dosage caps, quantity limitations, refill limitations and any other utilization management features.

One way to organize the disclosure and analysis of the above information is to require analysis by tier structure, so that drugs are listed by tier (including a specialty drug tier) and all relevant NQTLs are evaluated, as appropriate, by tier. This would conform to federal regulatory guidance, consistent with the carriers' request. *See* 45 C.F.R. § 146.136(c)(3)(E)(iii)(A) and (iv) Example 4.

II. MHPAEA Summary Form Instructions

The MHPAEA Summary Form is an important tool to help plan members understand their carrier's coverage of MH and SUD benefits and self-advocate for the non-discriminatory coverage they are entitled to receive. Often members know nothing about Parity Act protections or how the Act can be used to address denials of care and inability to find appropriate providers. While individuals and families may not have the ability to investigate a parity violation during a health crisis, the provision of the summary report of parity compliance will help them understand parity protections, evaluate benefit denials and other barriers to care, and recognize that a denial of benefits may not be lawful.

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To ensure that Marylanders can fully understand and use information about their carrier's coverage of MH and SUD benefits, we request the following revisions to the form. These revisions may be incorporated into the form, as appropriate, or, as Commissioner Birrane suggested at the November 1st hearing, provided in a consumer information attachment.

- Summary Form Instructions: We recommend the inclusion of a statement that confirms that carriers must submit a summary form for each parity analysis it conducts; i.e., one for each of the five most popular plans for each product.

- Summary Form Background and Overview: The summary will require each carrier to provide a succinct and uniform explanation of the Parity Act. We would recommend that carriers be required to include additional language on the Parity Act's non-discrimination standard and analytical approach so that consumers will have a context for the information that will be provided for each NQTL. Specifically, we recommend that:

    - In the introductory description of "treatment limitations" insert the following language: "or other limits on the scope or duration of treatment **that are not described numerically** (for example, being required to get prior authorization **for prescribed care or having a medication excluded from the list of covered drugs).**
    - The introductory statement should provide a link to federal and/or state resources that provide a layperson's description of the Parity Act. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has issued "Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits" and the Department of Labor has issued the Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits.
    - In the initial statement, add the following term: "[Carrier name] has performed an analysis of mental health **and substance use disorder** parity…
    - For the contact information on the summary, please require both an email address and a phone number, as some consumers may not have access to email.
    - Several additional statement in the Overview will help consumers understand the NQTL analysis to be presented. Specifically, we recommend:
        - Revise the second sentence as follows: "These plans contain ~~items~~ **plan requirements** called Non-Quantitative Treatment Limitations (NQTLs) that put limits on **mental health and substance use disorder services** and benefits ~~paid~~ **and will affect whether [carrier name] will pay for the treatment your provider has prescribed**.
        - Add the following statements after the second sentence: **MHPAEA requires [carrier name] to apply each NQTL to mental health and substance use disorder services in a way that is comparable (similar) to medical and surgical care. Under MHPAEA, [carrier name] must compare an NQTL for mental health disorder, substance use disorder and medical/surgical services by the following categories: in-patient, outpatient, prescription drug and emergency care. If a plan has out-of-network coverage, it will also compare NQTLs for out-of-network in-patient and outpatient services.**

          We note that the description of classifications/categories will be essential for the member to understand why a carrier is describing NQTLs via "a

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defined category" (*see* point A for each NQTL) and, for the reimbursement NQTL, the specific references to in-network and out-of-network providers and facilities.

- Fourteen NQTLs: We recommend that the carrier provide a uniform layperson definition of each NQTL. Those definitions can be taken directly, with sufficient paraphrasing, from the definitions in the instruction or, as needed, the HHS glossary of health term. *See* https://www.healthcare.gov/glossary/.

- Required Analysis: The five-step analysis for each NQTL is appropriately based on the DOL Self-Compliance Toolkit but, in our view, does not sufficiently state that the carrier must describe its comparative analysis to demonstrate that factors and sources are **comparable and no more stringently applied** in the adoption and implementation of the limitations for mental health and substance use disorder benefits. We recommend the following revisions to D and E.

  - D. **Describe** ~~Identify~~ the methods and analysis used **to determine that the development and implementation of the limitations are comparable and no more stringently applied to mental health and substance use disorder benefits**.
  - E. **Demonstrate and** provide ~~any~~ evidence and ~~any~~ documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

  We note that, in E, the term "any" should be removed because it suggests that the carrier has the discretion to submit no evidence or documentation in support of its conclusion that NQTLs are comparable and no more stringently applied. That is inconsistent with Section 15-144(e)(3) and (4) that requires carriers to "include the results of the audits, reviews, and analysis performed on non-quantitative treatment limitations" in its analysis of compliance both as written and in operation.

III. Submission of Supplemental Data

We fully support the MIA's request for submission of all four supplemental data templates as part of the parity compliance reporting process, and we urge the MIA to reject the carrier's call to either remove, suspend or delay the submission of such outcome measurement data. Throughout the nearly 10-year process[1] in which consumers and providers

[1] A bill to require parity compliance reporting was first introduced in 2013 and then reintroduced in 2015 (SB 586 of 2015). While neither bill passed, in 2015, the Senate Finance Committee requested that the MIA conduct three annual market conduct surveys to evaluate carrier compliance with the Parity Act and determine whether a statutory compliance reporting requirement was needed. The MIA's market conduct surveys revealed significant Parity Act violations, specifically with regard to provider credentialing and contracting and reimbursement rate setting, and the MIA issued numerous orders. The surveys also revealed disparate practices in utilization management and other NQTLs. **The third market conduct survey requested some of the very same data that are requested in the supplement data templates.** *See* Third Market Conduct Survey Question 10 Out-of-Network Access and Question 13 Prescription Drug Approvals, Denials and Utilization Management Data; Attachment A – Adverse Decisions and Appeals Data; and Attachment B – Facility Credentialing Data. *See* https://insurance.maryland.gov/Consumer/Pages/MHPAEA-Enforcement-Actions.aspx. The lack of

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have called for parity compliance reporting, the carriers have repeatedly asserted that statutory compliance reporting requirements are not needed **because the MIA can request and require carriers to submit outcome data at any time.** The MIA has taken that step as part of the compliance reporting process, because the in operation analysis is not complete without quantitative outcome data showing, along with an analysis of the "in operation rules," that NQTLs are no more stringently applied to mental health and substance use disorder benefits than medical/surgical benefits. The MIA cannot confirm a carrier's in operation compliance without such data. **The carriers should not be permitted to further delay and obstruct a full parity review under the guise that the MIA does not have the authority to request such information or that the data request goes beyond federal law or guidance.**

Contrary to the carriers' assertion, the supplemental data requests are fully consistent with the DOL Toolkit (and previously issued FAQs) and, indeed, are identified as a compliance practice. For example, in referencing health plan strategies to address provider shortages in networks, the DOL highlighted the importance of an examination of the number of network mental health, substance use disorder and medical/surgical providers to identify underlying Parity Act violations.

> The Departments note that substantially disparate results – fore example, a network that includes far fewer MH/SUD providers than medical/surgical providers – are a red flag that a plan or issuer may be imposing an impermissible NQTL.

DOL Toolkit at 20, citing FAQs Part 39, Q6 and Q7 (Sept. 5, 2019). **The credentialing data supplement seeks to access one element of the well-documented inadequate networks of mental health and substance use disorder providers.** Additionally, the DOL Toolkit sets out warning signs that are "indicative of noncompliance and warrant further review" including "inequitable reimbursement rates established via a comparison to Medicare" and "lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes." DOL Toolkit at 21. **This is the precise information that the MIA has requested in the reimbursement template.** Finally, the DOL Toolkit states, as a compliance tip, "[d]eterimine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits." DOL Toolkit at 27. **This is the precise information that the MIA has requested in Supplemental Data Form 1.**[2]

Finally, the DOL has stated that "[w]hile results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance." DOL Toolkit at 28. **As the regulatory authority responsible for ensuring the Maryland's carriers comply with the Parity Act, the MIA would be remiss if it**

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carrier compliance with the Parity Act demonstrated the need for formal compliance reporting, and the General Assembly enacted SB 334/HB 455 in 2020. Violations would not have been identified without outcome data.

[2] CareFirst has suggested that the MIA's request for service delivery denial broken down by age is impermissible because age is not a classification. The MIA is not creating an impermissible classification or subclassification but is simply examining potential in operation violations that exist based on a member/beneficiary's age. The dearth of mental health and substance use disorder services in Maryland for youth and adolescents may be based on the application of different plan practices. A disparity between mental health disorder, substance use disorder and medical services will help uncover any noncompliance practices.

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did not request quantitative outcome data to identify areas of potential noncompliance.[3] We have learned in conversations with DOL officials regarding the implementation of the Consolidated Appropriation Act parity provisions that, while states have latitude in assessing parity compliance, federal regulators will scrutinize practices that do not meet federal guidance.

The carriers assert that the MIA must rely exclusively on the audits, analysis and reviews that they perform to determine in operation compliance. **That poses the proverbial "fox guarding the hen house" enforcement model**; it would mean that the MIA and plan members must trust the carriers to conduct a thorough in operation compliance analysis without the ability to **independently confirm** either the **thoroughness or accuracy** of that analysis. The MIA's market conduct survey results and subsequent orders demonstrate the limitations of that approach. The Parity Act requires more, and the MIA's enforcement obligations and authority are not limited to what the carriers wish to audit and, subsequently, disclose. The carriers should not resist "showing their work" on key data points if they maintain that they are offering parity compliant plans.[4]

Finally, it is particularly important to include the supplemental data in the Parity Act compliance analysis, as opposed to a separate data call, as the Parity Act imposes unique disclosure standards. Under ERISA, "plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value." DOL Toolkit at 30. We are concerned that carriers will assert a claim of proprietary information for any data not requested as part of the parity compliance reporting process.

Thank you for considering our views.

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Addiction Connections Resource
Daniel Carl Torsch Foundation
Institutes for Behavior Resources, Inc./REACH Health Services
Maryland Addiction Directors Council (MADC)
Maryland Association for the Treatment of Opioid Disorders (MATOD)
Maryland and District of Columbia Society of Addiction Medicine (MDDCSAM)
Maryland Psychiatric Society
Maryland Psychological Association
National Council on Alcoholism and Drug Dependence-Maryland (NCADD-Maryland)
Western Maryland Area Health Education Center West (AHEC West)
Voices of Hope
Laura Mitchell, Individual Advocate

[3] CareFirst seems to suggest that the purpose of requesting the supplemental data templates is to facilitate a comparison of parity compliance across all carriers. That is not the goal; assessing plan compliance is the singular goal. At the same time, the supplemental data templates will assess basic plan practices that apply to all carriers, and their data submissions will reveal critical information. And, to the extent one carrier offers plans that satisfy the Parity Act to a greater extent than other carriers, consumers can consider such information in future plan selection.

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