Frequently Asked Questions Regarding the Mental Health Parity Reporting Requirements under § 15-144 of the Insurance Article

Question 1: *If NQTLs are the same across multiple plans or for multiple carriers within the same corporate group, may a carrier combine multiple plans on a single analysis report or otherwise submit a single document to report the NQTLs that are common across plans?*

Response 1: Each carrier must complete and submit a separate NQTL analysis report for each plan identified in § 15-144(c)(1)(i) of the Insurance Article using the template form(s) posted to the MIA website. However, if the description and application of factors, processes, strategies, evidentiary standards, and sources are the same for an NQTL across multiple plans, the required documentation and analysis is only required to be provided once per carrier for the set of plans that share a common NQTL analysis. The documentation and analysis must be provided in the template report form for at least one of the specific plans in the manner required by the instructions posted to the MIA website, or, in the alternate, the documentation and analysis may be provided in an "appendix" template report form that includes all the NQTL documentation that is common to multiple plans in the manner required by the instructions. A separate report form must then be completed for each plan, but any subsequent plans that have the exact same documentation as the first plan or the "appendix" are permitted to cross reference the report where the detailed information is provided, rather than providing the complete analysis and documentation. This accommodation does not apply across carriers, even if multiple carriers are affiliated under the same corporate group.

Question 2: *The instructions for the data supplement forms and for Step 7 of the NQTL analysis report indicate that any disparities in the data between medical/surgical and mental health/substance use disorders should be explained in Step 7 of the NQTL analysis report for the applicable NQTL. Since the MIA has granted carriers an additional month to submit the data supplements after the NQTL analysis reports are due, how are carriers expected to comply with this requirement?*

Response 2: If a carrier elects to submit the data supplement forms at a later date than the NQTL analysis report, then to the extent the data supplements reveal any disparities between medical/surgical and mental health/substance use disorders, the carrier must submit an addendum to Step 7 of the NQTL report to explain those disparities.

Question 3: *Are carriers required to submit analysis reports and data reports for closed blocks of business that are no longer offered to new enrollees, such as grandfathered health benefit plans?*

Response 3: With the exception of small employer grandfathered health plan coverage, grandfathered health benefit plans are required to comply with state and federal mental health parity requirements under § 15-802 of the Insurance Article and 45 CFR § 146.136. Furthermore, whether or not a plan is currently offered to new enrollees in Maryland has no specific bearing on the applicability of § 15-802 of the Insurance Article and 45 CFR §

146.136. However, for the purposes of the reporting requirements in § 15-144 of the Insurance Article, reports are only required to be submitted for plans that are currently offered in the State. See §15-144(c)(1)(i) and (f) of the Insurance Article. Therefore, carriers are not required to submit analysis reports and data reports for closed blocks of business.

Question 4: *When completing the Data Report required by § 15-144(f) of the Insurance Article, should authorizations that are partially approved be reported as "Requests Approved" or "Requests Denied"?*

Response 4: While the instructions for the Data Report do not address partial approvals/partial denials, the instructions for Data Supplement 1 (Utilization Review) define "approved" as follows: "'Approved' means that the request was approved in full or the provider agreed to accept the carrier's approval of a modification of the request. 'Approved' does not include a request for which an adverse decision or coverage decision was issued." Carriers should apply this same principle when determining whether to report an authorization as approved or denied under the Data Report.

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