F 202.331.7487
ahip.org

September 7, 2021

The Honorable Kathleen Birrane
Commissioner, Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Submitted via: MHPAEA.mia@maryland.gov

RE: Supporting Documents for Draft COMAR 31.10.51

Dear Commissioner Kathleen Birrane,

America's Health Insurance Plans (AHIP) is providing comments to the proposed Data Supplements 1-4, as part of the Supporting Documents for Draft COMAR 31.10.51. As per our comments in May (below), **AHIP continues to recommend the MIA remove the Data Supplements** for multiple reasons:

1. We anticipate further guidance from the federal government on implementing the Consolidated Appropriations Act 2020 (CAA). The Data Supplements go further than the DOL Self-Compliance Tool, usage of which the CAA FAQs indicate will put plans and issuers "in a strong position to comply with the Appropriation Act's requirement". A few examples of where the Data Supplements exceed the CAA requirements, include:

    - Data Supplement 1 (Utilization Review): The data supplement for Utilization Management and Out of Network requests, approvals, and denials requires very granular information separated by age cohorts, which is not specified in the DOL Tool.

    - Data Supplement 3 (Provider Credentialing): The data supplement requests information on the length of time to negotiate contracts, which far exceeds the information specified in the DOL Tool. To our knowledge, this data point is not typically tracked by plans and issuers, nor is there a consistent or standardized way to measure it; it is not typically used as a measure to assess benefits or network adequacy.

      In addition, if the sample size of providers or facilities in each category is small, any differences observed in this metric may not be statistically significant or may be skewed by outliers. Therefore, what is reported on this data supplement may not be indicative of whether there are "red flags" to review. The data point also fails to account for instances where delay in contract negotiation may be due to provider action (or lack thereof).

    - Data Supplement 4 (Reimbursement Rates): The DOL Tool includes Appendix II (p 38) which provides one option for demonstrating compliance by comparing reimbursement rates for Mental Health/Substance Use Disorder (MH/SUD) providers to Medical/Surgical (M/S) providers for comparable CPT codes. While the proposed data supplement includes similar elements contained in Appendix II, it goes further than the DOL Tool by appearing to limit proof of compliance to using Medicare rates as a benchmark. The DOL Tool states:

> *"This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to M/S providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits."*

Data supplement 4 constrains a payer to use Medicare as the external benchmark and removes all flexibility contained in MHPAEA for how a plan may demonstrate compliance with the NQTL. Whereas the DOL Tool acknowledges that there are additional ways to demonstrate compliance and comparability of how reimbursement rates are derived.

In addition, the data supplement breaks down provider types in a more granular fashion than what is required in the DOL Tool. It includes 4 required provider categories: Primary Care Physicians; Non-psychiatrist Medical/Surgical Specialist Physicians; Psychiatrists; and, Non-psychiatrist Behavioral Health Professionals. The DOL Tool only focuses on 2 such categories: MD specialists and non-MD specialists.

2. The information as required by MD SB 334 / HB 455 seems to be fully incorporated within the new draft MIA NQTL Analysis Report Template Form and the MHPAEA Data Report Template Form. In addition, the law requests MIA provide updates on new reporting requirements by December 2023 and 2025 which provides the MIA an opportunity to review the data they are collecting and determine whether the information received within the Template Forms are adequate with the ability to revisit reporting requirements and work with stakeholders on needed improvements, making the additional data supplement forms unnecessary at this time.

3. The MIA stated during public hearings that they utilized templates from other states, including Colorado, Texas, and Washington. Both Colorado and Washington completed reporting requirements before the passage of the CAA. NAIC will also be updating their Handbook to parallel federal guidance. If Maryland proceeds with the data supplements, it will become an outlier state, meaning health plans that operate nationally will be required to provide various templates to these different states, wasting health care dollars.

   Postponing the utilization of the MIA's supplemental data calls will allow the state to determine whether additional reporting is necessary after DOL regulations are released and the new MIA NQTL Analyses and MHPAEA Data Template Forms have been completed. As always, MIA has complete authority within a market conduct review to fully review MHPAEA parity compliance, in the short interim to 2025.

Health plans appreciate the critical importance of behavioral health to whole-person care and are committed to meeting MHPAEA parity requirements. By essentially codifying the NQTL comparative analysis requirements from the DOL Tool, the CAA provided needed clarification for both states and carriers to better understand NQTLs reporting requirements. This is an evolving issue, with anticipated DOL regulations and new mental health accreditation modules being discussed at this time.

- **Recommendation**: AHIP requests the data supplements are paused until the MIA can gauge whether the new MIA NQTL Analyses and MHPAEA Data Template Forms reporting requirements will be sufficient to find MHPAEA non-compliance, or whether additional data is needed.

Please let me know if you have any questions or concerns related to our comments at khathaway@ahip.org or (202) 870-4468. Thank you for your time and attention on this critical issue.

Sincerely,

Kris Hathaway
Vice President, State Affairs
America's Health Insurance Plans

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

May 26, 2021

The Honorable Kathleen Birrane
Commissioner, Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Submitted via: MHPAEA.mia@maryland.gov

Re: Mental Health Parity Workgroup – Provider Reimbursements

Dear Commissioner Kathleen Birrane,

America's Health Insurance Plans (AHIP) is providing comments responding to the request by the Maryland Insurance Administration (MIA) on whether rate reimbursements should become an additional NQTL reporting requirement for health plans.

- AHIP recommends the MIA not introduce a new NQTL reporting template, and instead to utilize the existing requirements included in the Self Compliance Toolkit for the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the NAIC Market Conduct Annual Statement Handbook.

Within the last few years there have been several new and updated reporting requirements for health plans as related to MHPAEA.

NAIC: In 2019, health plans started reporting on a new mental health and substance use disorder component of the NAIC Market Conduct Annual Statement (MCAS) Handbook. This reporting commenced after a year-long deliberative process with stakeholders on which data elements to include in the Handbook. To ensure uniformity and consistency among states, Maryland should work within this group to minimize the potential for overall health care cost increases due to administrative expenses that could result should states create a new, inconsistent NQTL template.

Federal Government: In December 2020, Congress passed the Consolidated Appropriations Act of 2021 (CAA) which provided additional MHPAEA guidance and codified the Self Compliance Toolkit - requiring an NQTL comparative analysis be made available to both federal and state regulators upon their request. Federal regulators have indicated in subsequent guidance that they expect to focus their enforcement efforts in the near term on specific NQTLs, **including reimbursement rates**. New regulations are required by 2022, which will be informed by public comment and the Toolkit itself must be updated every two years with input from stakeholders. Maryland can utilize both of these tools.

Maryland passed SB 334 / HB 455 in 2020 requesting a development of standard compliance reporting forms. Given that the CAA now requires issuers conduct and document an NQTL comparative analysis and make that analysis available to regulators upon request, we urge the MIA to avoid imposing reporting requirements that are duplicative or contradictory to the federal requirements.

Reimbursement Rates: MHPAEA requires the underlying processes and strategies used to apply an NQTL to mental health and substance use disorder benefits, such as reimbursement rates, must be comparable to those used to apply the NQTL to medical/surgical benefits in the same benefit classification. MHPAEA does not, however, require provider reimbursement rates be equal between behavioral health and medical/surgical providers and acknowledges that reimbursement levels for providers are determined based on multiple factors, including: market dynamics, supply and demand,

education and training, geographic location, etc. Different rates are not by themselves determinative of non-compliance to MHPAEA.

Moreover, we are concerned that a focus on reimbursement rates disregards the root cause of behavioral health access challenges – a significant and well documented national shortage of behavioral health providers that has only been exacerbated by the growing demand for their services arising from the ongoing pandemic. Health plans have made significant investments and efforts designed to expand their members' access to behavioral health, including recruitment of behavioral health providers and expansion of tele-behavioral health.

Health plans are also working hard to address access, by supporting:

- more effective use of the full range of providers qualified to provide behavioral health care, including by integrating behavioral health with primary care;
- loan re-payment programs to encourage providers to enter the behavioral health field;
- integrate medical training to ensure general practitioners are getting training in behavioral health and team-based care; and
- programs such as National Health Service Corps and Teaching Health Centers to encourage persons from diverse backgrounds to become behavioral health providers and to serve in high-need areas.

Additionally, in Maryland, as with all states, carriers have processes in place, for both medical/surgical and behavioral care, where the plan will authorize care provided by an out-of-network provider as in-network care if an appropriate in-network provider is unavailable.

Federal Transparency: In addition to pending regulations and guidance related to MHPAEA, implementation of federal transparency requirements, which would include provider rate information, is also underway. Executive Order 13877 signed in June 2019 required price and quality transparency within the health care system. The final regulations mandated health plans to make detailed pricing information available to the public on negotiated rates for all covered services for in-network providers, historical payments to out-of-network providers, as well as drug costs by January 1, 2022. The endeavor is estimated to cost $3 billion per Centers for Medicare and Medicaid Services. The CAA also requires reporting on plan medical costs. AHIP is working with member plans and the Departments of Labor, Treasury, and Health & Human Services, to work through the multiple complexities of these requirements.

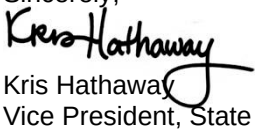
- If the MIA determines they want to move ahead on a NQTL provider contracted rate template, we ask Maryland to postpone consideration until outstanding questions related to implementation of the federal transparency requirements are clarified to avoid duplicative reporting requirements that would create unnecessary burden for health plans, adding costs to the overall health care system.

Access to behavioral health specialists is a priority for health insurance providers and our members are pioneering innovative programs designed to raise patient awareness of the importance and availability of behavioral health care, reduce stigma, integrate behavioral and medical and surgical care, encourage discussions with providers, and focus on proactive identification of behavioral health needs. Health plans rely on evidence-based criteria to guide coverage policy and use proven quality metrics where available to track and improve patient outcomes across both behavioral and medical/surgical benefits.

We greatly appreciate the opportunity to provide insight related to MIA's consideration of additional NQTL templates and stand ready to work with the MIA to improve access to behavioral health care. We urge the MIA to leverage the significant resources already available with respect to MHPAEA implementation and enforcement and join other stakeholders in providing input and expertise as additional federal regulations and guidance are developed.

Please let me know if you have any questions or concerns related to our comments at and khathaway@ahip.org or (202) 870-4468. Thank you for your time and attention on this critical issue.

Sincerely,



Kris Hathaway
Vice President, State Affairs
America's Health Insurance Plans

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.