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September 7, 2021

Ms. Lisa Larson
Director of Regulatory Affairs
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Sent via email: InsuranceRegReview.mia@maryland.gov

RE: Comments on Draft Proposed Supporting Documents for COMAR 31.10.51 *Mental Health Benefits and Substance Use Disorder Benefits – Reports on Nonquantitative Treatment Limitations and Data*

Dear Ms. Larson:

On August 24, 2021, the Maryland Insurance Administration (MIA) posted its draft templates and instructions for the Mental Health Parity and Addiction Equity Act (MHPAEA) reports required to be submitted by carriers to the MIA pursuant to SB0334/HB0455 of 2020, codified at § 15-144 of the Insurance Article. (MHPAEA Report). Section 15-144 contemplates that the MHPAEA Report is made up of two parts: (1) the Non-Quantitative Treatment Limitations (NQTL) Analysis Report; and (2) the MHPAEA Data Report. We appreciate the opportunity to provide comments on the report templates and instructions.

As the MIA is aware, since the adoption of SB0334/HB0455, there has been significant federal activity concerning MHPAEA compliance. The Consolidated Appropriations Act of 2021 (CAA)[1] (discussed further below) requires health plans to provide to the Secretary of HHS or state insurance regulator, upon request, a detailed comparative analysis regarding compliance with MHPAEA's NQTL rule.

Like all carriers, CareFirst is simultaneously working to ensure our compliance with evolving federal and state reporting requirements for MHPAEA in each of our jurisdictions. While we understand that SB0334/HB0455 requires that the NAIC Tool be the basis for these reports (and advocated for this tool given it was the closest thing to a national template at the time), **CareFirst strongly urges that to the extent consistent with SB0334/HB0455, the MIA's reporting templates align with the current federal DOL tool for MHPAEA compliance.**

[1] See: https://www.congress.gov/bill/116th-congress/house-bill/133/text.

Our comments below seek to align the MIA's reporting templates with SB0334/HB0455 in such a way that they do not conflict with new and evolving federal MHPAEA reporting requirements.

(1) NQTL Analysis Report-Data Supplements 1-4

The MIA proposed four Data Supplements to accompany the NQTL Analysis Report. **These four Supplements are outside the scope of SB0334/HB0455 and are more prescriptive than federal MHPAEA compliance requirements.** The supplement instructions state that the data is being requested to "verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article." Section 15-144(e)(4) states that the NQTL Analysis Report must "include the *results* of the audits, reviews, and analyses performed on the nonquantitative treatment limitations that are identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans in operation." Emphasis added.

The MIA has the authority to create regulations as required by statute.[2] Section 15-144(e) outlines the specific elements of the NQTL analysis required by § 15-144(d)(1). Section 15-144(e)(4) expressly requires carriers to submit the "results of audits" performed on the NQTLs but does not require that carriers collect and report specific data prescribed by the MIA as required for these audits as part of the NQTL Analysis Report. Likewise, federal guidance on MHPAEA compliance does not prescribe specific data points required to be used in carrier MHPAEA compliance audits. Section 15-144(f) *does* identify specific data that must be reported (MHPAEA Data Report) to assist the MIA with its review of a carrier's MHPAEA compliance. However, § 15-144(f) limits such information to "the following data," and therefore does not require the MIA to ask for the information contained in the data supplements as part of the NQTL analysis report. Further, this limiting language indicates that the Maryland General Assembly did not intend that the MIA would request additional data that wasn't specifically outlined in the statute for either the NQTL Analysis Report or the MHPAEA Data Report.

At the August 30, 2021 hearing, the MIA indicated that it required additional information be included in the MHPAEA report in reliance on the new requirements for MHPAEA NQTL analysis established under the CAA.[3] The CAA requires that a comparative analysis be completed and available to any state regulator that regulates health plans upon request.[4] The CAA and subsequent federal guidance do not require data be reported to the state regulator.[5] The federal guidance suggests that carriers follow the U.S. Department of Labor, Self-Compliance Tool (DOL Tool)[6] as a template for conducting an adequate comparative analysis. While the DOL Tool does include in its "compliance tips" looking at certain data when conducting a comparative analysis, nothing in the DOL Tool requires that the data be collected in a specific way or disclosed to a state

[2] Md. Ins. Art. §§ 2-108 and 2-109(a)(1).
[3] See: https://www.congress.gov/bill/116th-congress/house-bill/133/text.
[4] 42 U.S.C. § 300gg-26(a)(8)(A).
[5]FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (April 2, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf
[6] 2020 MHPAEA Self-Compliance Tool, available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-andregulations/laws/mental-health-parity/self-compliance-tool.pdf

regulator in order to complete the comparative analysis. Furthermore, even where the DOL Tool does provide a specific template for analyzing data (reimbursement rates), it acknowledges that this is just one way a plan *may* assess its methodology and states "[t]his is not the only framework for analyzing provider reimbursement rates[.]"[7] **Adopting any specific template for analyzing data and requiring a carrier to use that template for its NQTL comparative analysis goes beyond what is required or even suggested by the federal government and the state law**. [8]

Furthermore, the Data Supplements are not useful for determining parity compliance or even red flags for parity issues. Data Supplement 1 (Utilization Review), for example, requests data for prior authorization, concurrent review, retrospective review broken out by age groups (0-12, 13-17, adult). Age groups are not MHPAEA classifications. The comparative analysis for parity compliance is done within the classifications as established by federal law and no subclassifications other than those specifically permitted in the regulation shall be used.[9] Nothing in the state or federal parity laws support collecting data broken down in this manner. This data will not be useful for determining if there are parity issues.

Additionally, Data Supplement 1 (Utilization Review) requests data concerning carrier compliance with § 15-830(d) of the Insurance Article, a law which is not even referenced in SB0334/HB0455. Although we acknowledge that the Commissioner has the authority under § 15-830 of the Insurance Article to request specific data that is required to be tracked by carriers in compliance with this statute, we question the appropriateness of asking for this data as part of a report that arises from § 15-144 and did not, until the templates were posted, contemplate § 15-830(d)'s network adequacy requirements and data. If the MIA wishes to assess carrier compliance with § 15-830(d), it would be more appropriate to issue a survey that is separate from the MHPAEA Report to ask for this information. Furthermore, the data requested pursuant to § 15-830(d) is also broken out into different age brackets (0-12, 13-17, adult). Section 15-830(d) does not require carriers to track, record or report the § 15-830(d) exception requests based on the age of the member. We question the usefulness of this data broken out into age groups for determining compliance with either § 15-830(d) or MHPAEA. It seems instead that the MIA is interested in collecting specific data about network access for specific age groups to identify network gaps or gaps in available providers within Maryland. While that is a noble pursuit, we suggest that such work be done via a survey or workgroup rather than through this MHPAEA Report.

Finally, we are awaiting federal regulations, due June 2022, that may include additional templates for data reporting.[10] Moving forward with these MIA Data Supplements at this time could create conflicting tools at the state and federal level and inconsistency across states. **While the MIA is required to implement the requirements of § 15-144 and cannot wait for federal regulations, the required MHPAEA Report can be fully implemented and satisfy the statutory requirement without creating additional templates that may not be consistent with the eventual federal regulations.**

[7] See Appendix II of the DOL Tool.
[8] See Supplemental Data Report Four- Reimbursement Rates.
[9] 45 C.F.R. § 146.136(c)(2)(ii).
[10] 42 U.S.C. § 300gg-26(a)(8)(C)(ii).

Because Data Supplements 1-4 contain information not included in the Maryland statute, and not required by the federal MHPAEA compliance requirements, Data Supplements 1-4 should be deleted in their entirety.

(2) <u>Instructions for NQTL Analysis Report and Data Report</u>

CareFirst offers the following clarifying questions and suggestions on the Instructions for the NQTL Analysis Report and Data Report:

- Step 4 and Step 5 (pages 6-8) request "the methodology" and results of any audits and reviews performed to assess NQTLs as written and in operation, in reliance on §§ 15-144(e)(3) and (4). As noted above, these sections of the statute require carriers to report the ***results*** of such audits and reviews but not the methodology. We ask that this language be revised to be consistent with the statute.

- It appears that Step 6 should only be responded to if a carrier has a delegate administer its MH/SUD benefits. Please confirm this by adding clarifying language to the instructions. We suggest, "If the carrier delegates to an entity the management of its MH benefits, SUD benefits or M/S benefits, identify the measures used to ensure comparable design, development, and application of each NQTL that is implemented by the delegate(s)."

(3) <u>NQTL Analysis Report Template</u>

CareFirst offers the following clarifying questions and suggestions for improving the NQTL Comparative Analysis template:

- Step 1(b) (page 2) asks the carrier to identify whether the NQTL applies to MH/SUD or M/S benefits in each parity classification listed in the chart. Step 1(c) (page 2) asks the carrier to explain the methodology used to assign M/S and MH/SUD benefits to each classification or subclassification. Can you please clarify whether carriers are supposed to provide a list of benefits that the NQTL applies to in each classification in response to Step1(b) or just state yes/no the NQTL applies to some M/S and MH/SUD benefits in each classification?

- Step 1(c) (page 2) for each NQTL ask that the carrier "explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification." This methodology is required to be the same for all NQTLs within a plan and will be redundant if provided in response to each NQTL.[11] We recommend asking for that information once in the template, prior to NQTL 1 (Definition of Medical Necessity).

- It is not clear how some of the NQTL prompts in the template should be responded to within the seven steps included in the template. We request that the MIA include an example response for NQTL 14 – Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities as an appendix to the "MHPAEA Compliance Reporting for

[11] 45 C.F.R. § 146.136(c)(2)(ii).

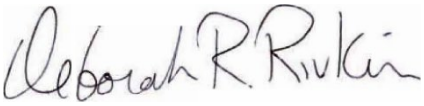
NQTLs" instructions. This would be extremely helpful to ensure carriers are providing complete responses and that all carriers are responding in a consistent manner.

(4) <u>Data Report Template</u>

The Data Report Template requires carriers to identify specific codes that correspond to claim denials for MH/SUD benefits and M/S benefits for each classification. CareFirst has over 2,000 denial codes in our systems. We do not believe that receiving data for 2,000 plus denial codes in one cell will be useful to the MIA. We suggest that the form be expanded to identify specific denial types (i.e., denied for not a covered benefit, denied for no prior authorization, etc.) and carriers can sort the codes into the different denial type categories.

We want to thank you for this opportunity to provide our comments, and we look forward to continuing this important conversation.

Sincerely,



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