August 13, 2021

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

Submitted to: InsuranceRegReview.mia@maryland.gov

Director of Regulatory Affairs:

Thank you for the opportunity to submit comments on the draft proposed rule regarding Mental Health Benefits and Substance Use Disorder Benefits – Reports on Nonquantitative Treatment Limitations and Data. The following comments are submitted by the Legal Action Center and the eight undersigned members of the Maryland Parity Coalition. The Center is a law and policy organization that fights discrimination, builds health equity, and restores opportunity for individuals with substance use disorders, criminal records, and HIV or AIDS. The Center convenes the Maryland Parity Coalition – a group of advocates, consumers, and providers of mental health and substance use disorder care – which was actively involved in the enactment of HB 455/SB 334.

The draft proposed rule in conjunction with the instructions and templates offers a very good framework for ensuring that carriers file uniform parity compliance reports. We are particularly supportive of the standards outlined in Sec. 31.51.10.04 and the guidance provided in the MHPAEA Compliance Reporting instructions, which identifies carrier responses that may reflect the filing of an incomplete compliance report. This effectively builds upon the Departments of Labor and Health and Human Services FAQ 45 to enforce the 2021 Consolidated Appropriations Act provisions. Additionally, the Compliance Plan standards in Sec. 31.51.10.07 will help ensure that plan members and providers are made whole for Parity Act violations in a relatively short timeframe.

We assert, however, that the Maryland Insurance Administration (MIA) is not adhering to federal Parity Act standards, 42 U.S.C. § 300gg-26(a)(8)(A), which require carriers to conduct an analysis of *all* non-quantitative treatment limitations (NQTLs) and preempts Maryland's conflicting and non-codified requirement that allows carriers to conduct comparative analysis for a subset of NQTLs, as set out in the NAIC tool. Our analysis on this point is fully set out in the Legal Action Center's May 14, 2021 letter and is incorporated in these comments without being repeated. *See* Attachment A. We note that the MIA has tracked the DOL Self-Compliance Tool in template instructions, and we are, therefore, particularly concerned about its departure from federal law and guidance on this foundational point of NQTL reporting. **We urge the MIA to correct this lack of adherence to federal law by (1) including regulatory language that requires carriers to conduct an analysis of <u>all</u> NQTLs imposed on mental health (MH) benefits and substance use disorder (SUD) benefits and (2) revising the template form to include <u>all</u> NQTLs**

As described below, we have identified the following additional concerns:

- failure to clarify in the draft proposed rule, the instructions and all template forms that the carrier **must conduct a separate analysis and data submission for MH benefits and SUD benefits** and cannot collapse those separate analyses and data points into a single response designated as MH/SUD benefits;
- failure to provide a regulatory standard for identifying the benefit plans with the highest enrollment to ensure consistency across carriers;
- lack of clarity and completeness for specific definitions;
- lack of a regulatory standard to address the issuer's process for complying with disclosure requirements, pursuant to Ins. § 15-144(e)(7); and
- lack of inclusion in the compliance plan of a carrier's remedy for the failure to credential or contract with a provider in violation of the Parity Act.

Although our comments incorporate concerns regarding the template forms insofar as they relate to the proposed rule, we intend to submit additional comments on the instructions and forms by the September 7, 2021 deadline.

I. General Compliance Reporting Framework

A. Federal and State Law Require Separate Reporting of NQTL Compliance for Mental Health Benefits and Substance Use Disorder Benefits.

The Parity Act standards apply discretely and separately to MH benefits and SUD benefits and recognize that a carrier may apply an NQTL (as well as quantitative limitations and financial requirements) differently to MH benefits and SUD benefits. 45 C.F.R. § 146.136(c)(2) and (c)(4)(i) and (iii). **The reporting standards must, therefore, make clear that a carrier is obligated to report and analyze NQTLs discretely and separately for MH benefits and SUD benefits.** While the MHPAEA Data Report form for authorization requests, approvals and denials appropriately separates data for MH and SUD benefits, the draft proposed rule and other forms and instructions fail to make this critical distinction. The draft rule does not address this point explicitly, but the definitions include the term "MH/SUD," defined as "mental health benefits and substance use disorder benefits as a combined category." Sec. 31.51.03(B)(15). Additionally, all other draft forms and instructions collapse the reporting of MH and SUD benefits into a single category, i.e. MH/SUD, and structure the reporting of NQTLs and all other data points as a single MH/SUD element. **This reflects an incorrect application of the federal regulatory standards and is also inconsistent with the statutory standard in § 15-144.**

Numerous provisions in § 15-144 make clear that separate reporting is required for MH benefits and SUD benefits. For example, the reporting provision, § 15-144(c)(2)(i) and (ii) make clear that the selection and development of medical necessity criteria must be for "mental health benefits ***and*** substance use disorder benefits" and the identification of NQTLs must be for "mental health benefits ***and*** substance use disorder benefits." (Emphasis added). Similarly, the comparative analysis provision, § 15-144(d)(2), makes clear that an analysis is required for each NQTL applied to "mental health benefits ***and*** substance use disorder benefits." (Emphasis added). **The draft rule must be corrected to ensure that carriers identify and document NQTLs and the comparative analysis separately for MH benefits compared to medical/surgical benefits and SUD benefits compared to medical/surgical benefits.**[1] We have recommended language below to address this issue in the proposed rule.

[1] We note that the MIA has used the URAC Parity Accreditation standards for certain definitions. The URAC standards and Parity Manager make clear that the NQTL analysis must be conducted separately for MH and SUD benefits and do not collapse those discrete benefits into a single comparative analysis or data point.

B. Federal Law Requires Carriers to Conduct Annual Analysis of All NQTLs.

As fully described in the Center's May 14th letter, under the Consolidated Appropriations Act of 2021, Congress amended the Parity Act to require carriers to conduct and document annually an analysis of all NQTLs applied to MH and SUD benefits and to submit those analyses upon request to the relevant state or federal regulator. While we appreciate and agree with the MIA's inclusion of reimbursement and reimbursement rate setting for purposes of NQTL reporting, the draft rule and NQTL Comparative Analysis Report Form do not require analysis and reporting on all NQTLs and omit key plan design features, including network adequacy, scope of services (apart from case management) and service coding. (*See* below for additional discussion of the scope of benefits as addressed in the definition "Restrictions that Limit Duration or Scope of Benefits or Services."). In addition, by tracking the language in the NAIC form – a 2019 form that was never intended to serve as a compliance reporting tool and has not been updated to reflect the 2021 Consolidated Appropriations Act standards – the MIA is signaling to carriers that they need not report and analyze NQTLs that go beyond the specific practices/questions identified in the Report form's descriptive language. *See e.g.* Standard for Provider Credentialing and Contracting do not identify all the limitations that can be imposed on either credentialing or contracting.

The failure to require a compliance analysis of network adequacy is particularly troublesome.[2] Network adequacy is an NQTL that is separate and distinct from credentialing practices and provider contracting. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013). **While the MIA is in the process of revising the state's network adequacy regulations, there has been no indication to date that those standards will require carriers to demonstrate that their network adequacy practices comply with the Parity Act.[3]** Therefore, without explicit coverage of network adequacy in these parity compliance reporting standards, carriers will not be required to demonstrate that this critical NQTL complies with the Parity Act.

To address the above two concerns, **we recommend the following revisions**:

1. We urge the MIA to remove the definition of "MH/SUD" from the regulations entirely and substitute "MH" and "SUD" for "MH/SUD" throughout the draft rule. *See, e.g.* Sec. 31.10.51.04(B) ("Carriers shall prepare the analysis report in coordination with any entity the carrier contracts with to provide, manage or administer MH and SUD benefits.")

2. We urge the MIA to add the following language in Sec. 31.10.51.04(A) to clarify the separate MH and SUD reporting requirements and the requirement to provide analyses of all NQTLs. (New language is underlined and deleted language in brackets.)

   For the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small and large group markets, a carrier that delivers or issues

[2] We strongly support the collection of data on requests for out-of-network services under Ins. § 15-830. *See* Supplemental Data Report Form. That data may reflect an underlying parity violation in the carrier's network adequacy practices and standards. Yet, absent a comparative analysis of the carrier's network adequacy practices, the MIA will not know if disparate out-of-network utilization constitutes a Parity Act violation that requires corrective action.

[3] The Center has consistently raised the need to conduct a Parity Act compliance review for network adequacy standards in both the Network Adequacy Workgroup and in previous discussions since implementation of the network adequacy regulations.

for delivery a health benefit plan in the State shall conduct a comparative analysis for each nonquantitative treatment limitation for mental health benefits and each nonquantitative treatment limitation for substance use disorder benefits [~~specified in~~] using the form required by the Commissioner to demonstrate the carrier's compliance with the Parity Act for mental health benefits and for substance use disorder benefits.

3. We urge the MIA to revise the template instructions and NQTL Comparative Analysis Report Form to clarify that the carrier must identify and conduct an analysis of ***all*** NQTLs imposed on mental health benefits and substance use disorder benefits. Additional comments on the instructions and forms will be provided by the September 7th deadline.

C. Standard for Identification of Five Health Plans in Each Product with the Highest Enrollment

The draft proposed rule does not identify a standard for identifying the carrier's health plans that have the highest enrollment for purposes of compliance reporting. To ensure consistency across carriers, we recommend that the rule provide a standard for such determination. We do not have the expertise to identify the proper standard, but we urge the MIA to identify a singular process for making that determination and a verification process for plan selection.

II. Definitions – Sec. 31.51.10.03

The definitions in the draft proposed rule are central to the implementation of compliance reporting as so much of the reporting function will be contained in the NQTL Comparative Analysis Report and other report forms. **We have carefully reviewed the definitions and have identified the following concerns about several definitions and, as appropriate, have proposed revised language.** Based on our familiarity with initial versions of the URAC accreditation standards, it appears that portions of some definitions have been modeled after those definitions. In some cases, additional language should be incorporated.

A. "As written." This definition is confusing, as drafted, and could be improved by reordering the words. **We recommend that the term be defined as**:

   "As written" means the written policies, procedures and related documents, including medical necessity criteria or guidelines, used in the development and description of a NQTL and the decision whether to apply an NQTL to a particular benefit by the carrier and/or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier.

B. "Emergency Services." We are confused as to how this term is used in the NQTL Comparative Analysis Report form. Under the Parity Act, "emergency care" is one of six benefit classifications. 45 C.F.R. § 146.136(c)(2)(ii)(A)(5). The form, however, lists "emergency services" as an NQTL (*see* NQTL Item 5)[4] and, requires reporting on how this "NQTL" is applied in the other five classifications as well as the emergency classification itself. Emergency services cannot be both an NQTL and a benefit classification. **We recommend that the MIA clarify its intention in identifying "emergency services" as an**

[4] We recognize that the NAIC form lists "emergency services" as an NQTL also. This is one of many limitations of the NAIC form, which was never intended to be a compliance reporting form. The Center raised these limitations repeatedly in the legislative process.

NQTL or alternatively remove "emergency services" as a separate NQTL from the report form.

C. "Evidentiary Standard." This definition fails to reflect that an evidentiary standard can operate independently of the determination of whether a specific factor is "established, present or utilized." **We recommend that the definition be modified as follows**:

"Evidentiary standard" means the carrier's defined level and type of evidence necessary to apply or not apply an NQTL or to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply an NQTL to which the factor relates.

D. "Failure to Complete a Course of Treatment." This term references the Uniform Treatment Plan Form for treatment of a MH or SUD, which is itself a "process" used in the implementation/operation of this NQTL. We have strong concerns as to whether the form complies with the Parity Act, as its requirements and mandatory use may be a more stringent procedural requirement than what is applied to med/surg benefits. **We recommend that the reference to the uniform treatment plan form be removed because it is not needed to define this term.** To the extent a carrier uses the Uniform Treatment Form for purposes of assessing completion of a course of treatment or any other utilization management or reimbursement purpose, it should be required to demonstrate that the required information and the procedural requirement itself are comparable to and applied no more restrictively than the process for med/surg benefits. A specific reference to the use of the Uniform Treatment Plan From should be included in the NQTL Comparative Analysis Report, Item 11.

E. "Medical necessity." This term is incomplete and fails to acknowledge that, for medical necessity and utilization management determinations for SUD benefit coverage, carriers are required to use the American Society of Addiction Medicine (ASAM) criteria. Ins. § 15-802(d)(5). **We recommend that the definition be modified as follows:**

"Medical Necessity" means the definitions, criteria, or guidelines used by the carrier and/or its private review agent to determine whether a service or benefit is necessary for the diagnosis and/or treatment of a medical condition consistent with generally accepted standards of medical practice.[5] The ASAM criteria must be used for medical necessity and utilization management determinations for SUD benefits.

F. "Prescription Drug Formulary Design." This definition, which is limited to the "list" of prescription drug approved for reimbursement, is incomplete because the term "design" includes far more formulary features than simply the list of covered medications. Tier placement, dosage limitations, quantity and refill limitations and a range of authorization requirements are part of "design" features and are all NQTLs that must be analyzed for compliance with the Parity Act. We noted that the NQTL Comparative Analysis Report's description of Prescription Drug Formulary Design (NQTL Item 7) includes a far more complete description of formulary design features that must be assessed for parity compliance. **We recommend that the definition be modified as follows:**

"Prescription Drug Formulary Design" means a continually updated list of prescription drugs

[5] The URAC definition of "medical necessity" references consistency with generally accepted standards of medical practice.

approved for reimbursement, including both generic and specialty drugs, and all plan features that limit the scope or duration of prescription drug benefits or treatment for mental health conditions, substance use disorder conditions or medical/surgical conditions.

G. "Plan Documents." The term is defined more narrowly than the ERISA standard for plan documents that must be disclosed to group plan members upon request. Under 29 C.F.R. § 2590.712(d)(3), plan documents include:

> Instruments under which the plan is established or operated…. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

To ensure compliance with the federal law, **we recommend that the definition be modified as follows.** We note that the URAC definition of "plan documents" incorporates the ERISA standard. *See also* Tex. Dept of Insurance, Proposed Regulations, Mental Health and Substance Use Disorder Parity, Sec. 21.2406(27) (definition of "plan documents) at p. 34. https://www.tdi.texas.gov/rules/2021/documents/mhp.pdf.

"Plan Documents" means all documents under which the plan is established or operated in which a carrier describes a requirement related to an NQTL or the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, including, but not limited to, a policy, certificate of coverage, medical policy, medical necessity criteria or guidelines, or provider manual. Plan documents also include any document reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH benefits and SUD benefits as compared to M/S benefits.

H. "Provider Credentialing and Contracting." The proposed narrow definition fails to cover the full range of credentialing and contracting limitations that carriers apply to restrict network inclusion, particularly for MH and SUD providers. We note that the NQTL Comparative Analysis Report form similarly poses a very narrow set of questions related to credentialing licensed practitioners (but not certified or otherwise authorized) and suggests that practices related to "contracting" need not be identified or analyzed. While we intend to offer additional comments on the form, **we recommend that the definition be modified as follows:**

"Provider Credentialing and Contracting" means a carrier's:
(a) Processes;
(b) Procedures; and
(c) Standards for determining which health care providers to contract with and the contract terms to be offered to providers, either directly or through a subcontracting entity, to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

I. "Reimbursement." The definition of this term is appropriately expansive to include bonuses and other incentive payments that carriers may offer to providers. We note that the definition does not reference out-of-network reasonable and customary rates (45 C.F.R. § 146.136(c)(4)(ii)(E), which FAQ 45 highlights as an important reimbursement NQTL, or

reimbursement rates for single case agreements. *See* Attachment A for a full description of reimbursement NQTLs.) **We recommend that the definition be modified to include:**

"(e) out of network reasonable and customary rates; and
(f) single case agreement payments."

J. "Reimbursement Rate." The definition appears to relate to a very narrow set of payment structures: value-based or other alternative payment arrangements. While these financing models are certainly part of the reimbursement NQTL, the term "reimbursement rates" should encompass all practices and strategies that a carrier uses to establish the reimbursement for health services, including the payments identified in the definition of "Reimbursement." We also note that the Reimbursement NQTL (Item 14) in the Comparative Analysis Report form, while labeled "Reimbursement," is actually seeking a comparative analysis of the "reimbursement rate setting" process for all payments to providers, members or other person entitled to reimbursement. **While we intend to provide additional comments on the form, we recommend that this definition be modified as follows:**

"Reimbursement Rate Setting means the dollar amounts, fee schedules, [~~or~~] formulae or other processes and strategies used to calculate the dollar allowed amounts under a value-based or other alternative payment arrangement, payable for a service or set of services or any payment defined under § 31.10.51.03(B)(25).

K. "Restrictions that Limit Duration and Scope of Benefits or Services." We agree with this broad definition and specifically the inclusion of the phrase, "including exclusions of a specific or type of MH/SUD treatment." This language, which addresses the scope of services and any restrictions on the MH or SUD services covered under a plan, conforms to the federal regulatory standard. See, 78 Fed. Reg. at 68246-47. **We urge the MIA to retain this language in the proposed rule and note that "scope of services" NQTL should be added to the NQTL Comparative Analysis Report form.** We intend to provide additional comments on this form.

III. NQTL Report Filing Requirements – Sec. 31.51.10.04

We commend the MIA for identifying comprehensive standards for preparing and completing the comparative analysis report and **urge retention of all provisions in the draft proposed rule.** We are particularly supportive of the proposed requirement to report the level of discretion that carriers exercise in applying an NQTL, which is critically important to assess parity compliance.

We reiterate that a separate comparative analysis is required for MH and SUD benefits and **urge the MIA to revise all references to "MH/SUD" in Sec. 31.51.10.04 to reflect that the carrier must conduct a separate comparative analysis for MH benefits and SUD benefits (with each of those respective benefits compared to M/S benefits).**

We note that the draft proposed rule does not include a requirement to report the carrier's process for complying with the Parity Act disclosure requirements, as required in Ins. § 15-144(e)(7). Those requirements are referenced only in the NQTL Comparative Analysis Report and instructions. **We urge the MIA to include a specific regulatory standard regarding the carrier's obligation to report its process for complying with Parity Act disclosure requirements.** This is particularly important because the carrier's disclosure obligations are separate from the information that it must make available under the Summary Form requirements (*see* Sec. 31.51.10.06). Such information is

also critical for consumers who are denied MH or SUD services and need to file a complaint. We recommend the following language be added to Sec. 31.51.10.04(A) following the first complete sentence:

> A carrier shall also identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical surgical benefits. An analysis report and disclosure process shall be filed with the Commissioner using only the form developed by the Commissioner and posted on the Administration's website.

We intend to review this section of the form and submit any additional comments.

IV. Summary Form – Sec. 31.51.10.06

We note that, as of August 12th, the MIA has not made its Summary Form available for public review and comment. We request an update on the timing for release of that form.

V. Compliance Plan – Sec. 31.51.10.07

We strongly support standards set out in the draft proposed rule as they create an expectation that members and providers will be compensated promptly for Parity Act violations. We request the inclusion of additional information that carriers must provide for parity violations related to provider credentialing and contracting practices. The failure to credential or contract with a MH or SUD provider in a manner comparable to credentialing and contracting practices for M/S providers, or a delay in that process, is one NQTL violation that cannot be remedied with a payment to either the member or provider. The carrier's exclusion or delay means the provider cannot bill ***at all*** for services. **We request that the following provision, (C)(5), be added.**

> (5) A summary of amounts owed and paid to providers for failure to credential or enter a contract during the period of non-compliance.

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Thank you for considering our views. We are happy to answer any questions.

Sincerely,

Ellen M. Weber, JD
Vice President for Health Initiatives
Legal Action Center
202-607-1047 (cell)

Addiction Resources Connection
Institutes for Behavior Resources, Inc.
Maryland Addiction Directors Council
Maryland Association for the Treatment of Opioid Dependence
Maryland Psychological Association
Maryland Psychiatric Society, Inc.
National Council on Alcoholism and Drug Dependence-Maryland
Voices of Hope, Inc.

Attachment A

LEGAL ACTION CENTER

EQUAL INSURANCE COVERAGE OF SUBSTANCE USE AND MENTAL HEALTH DISORDERS
PARITY AT 10
IT'S THE LAW.

May 14, 2021

Kathleen A. Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Emailed to: MHPAEA.mia@maryland.gov

Dear Commissioner Birrane:

Thank you for the opportunity to submit testimony on the reporting requirements for reimbursement rate setting practices in connection with the Maryland Insurance Administration's parity compliance regulatory process. The following comments are submitted by the Legal Action Center and the eighteen undersigned members of the Maryland Parity Coalition. The Center is a law and policy organization that fights discrimination, builds health equity, and restores opportunity for individuals with substance use disorders, criminal records, and HIV or AIDS. The Center convenes the Maryland Parity Coalition – a group of advocates, consumers, and providers of mental health (MH) and substance use disorder (SUD) care – which was actively involved in the enactment of HB 455/SB 334.

We commend the MIA for determining that the NAIC Market Conduct MHPAEA Collection Tool must be amended to include reimbursement rate setting information as a non-quantitative treatment limitation (NQTL). As described below, recently enacted federal legislation, Section 203 of Title II of Division BB of the Consolidated Appropriations Act of 2021, clearly requires Maryland's issuers to prepare Parity Act compliance reports on **all NQTLs** and submit reports to the MIA upon request. 42 U.S.C. § 300gg-26(a)(8)(A). Federal law preempts Maryland's conflicting requirement that allows issuers to conduct comparative analyses for a subset of NQTLs, as set out in the NAIC Tool and amended by the MIA. As described below, a number of key NQTLs covered by federal law are absent from the NAIC tool, including reimbursement rate setting.

In addition to requiring reporting for all NQTLs, we recommend that the MIA address the following reimbursement rate issues in regulation:

- Identify common reimbursement rate setting design features to ensure that issuers identify and conduct a parity analysis for all reimbursement practices for mental health (MH) and substance use disorder (SUD) benefits.
- Identify the level of detail and documentation that is required to comply with sufficiency standards for the comparative analysis of factors, processes and evidentiary standards used to design and implement a reimbursement NQTL, as set out in federal guidance.

- Require issuers to submit an "outcome" analysis that includes **all MH and SUD providers** that deliver services in Maryland and compares reimbursement rates and other quantifiable measures to medical/surgical benefits using an appropriate benchmark.

I. Mandatory Compliance Reports for all Non-Quantitative Treatment Limitations.

Under Section 203 of the Appropriations Act, state-regulated issuers are now required to conduct Parity Act compliance reviews and document their comparative analyses annually and, as of February 10, 2021, submit their analyses and supporting documentation to the MIA upon request. 42 U.S.C. § 300gg-26(a)(8)(A). Federal law and guidance issued on April 2, 2021 by the Departments of Labor, Health and Human Services, and Treasury make crystal clear that issuers must "perform and document comparative analyses for ***all*** NQTLs imposed." FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021, Part 45, Q8 (emphasis added), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf. Federal regulators emphasized that issuers are required to perform and document comparative analyses for all NQTLs, even though DOL intends to focus its near-term enforcement efforts on discrete NQTLs such as standards for network admission – including reimbursement rates – and out-of-network reimbursement rates. *Id*.

The April agency guidance is grounded in the 2013 Parity Act regulations that provide a non-exhaustive list of NQTLs, which includes reimbursement rate setting and "any other criteria that limit the scope or duration of benefits for services provided under the plan or coverage." 45 C.F.R. § 146.136(c)(4)(ii)(A)-(H). DOL had previously advised that reimbursement rate setting is an NQTL in both its 2018 and 2020 tools. Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) at 19-20, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.

State law reporting requirements under Ins. §15-144, were, in fact, inconsistent with federal law when enacted in 2020, absent expansion by the MIA, as the NAIC tool contains a subset of NQTLs and excludes many of the most consequential plan design features for ensuring access to MH and SUD treatment. These include: reimbursement rate setting, network adequacy and several network admission features, step therapy, restrictions on facility type, scope of services, service coding, in and out-of-network geographical limitations, limitations based on threat to self, and exclusions for court-ordered treatment.

The enactment of federal compliance reporting standards preempts state law exclusive reliance on the NAIC tool (as amended by the MIA) as the basis for the scope of NQTL reporting. While § 15-144 is an insurance law that falls within the ERISA "savings clause," 29 U.S.C. § 1144(b)(2)(A), (*see Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), a state insurance law is preempted "to the extent it actually conflicts with federal law." *Epps v. JP Morgan Chase Bank*, 675 F.3d 315, 322 (4th Cir. 2012), *citing Pacific Gas & Elect. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 204 (1983); *see also Conn. Gen'l Life Ins. Co. v. Insurance Comm. State of MD*, 371 Md. 425, 432 (Ct. App. 2002) (Maryland's internal grievance procedures are not preempted as they do not "directly conflict with the provisions of ERISA or the associated federal regulations.").

In this case, state law directly conflicts with federal Parity Act standards that apply to both individual and group health plans. Federal law requires carriers to conduct a comparative analysis for all NQTLs, thereby requiring a more extensive review of plan features than authorized under §15-144. Although uncodified language in § 15-144 permits the MIA to extend reporting

requirements to other NQTLs, it is under no obligation to do so. As a result, Marylanders will have fewer protections against insurance discrimination than exist under federal law if the MIA fails to amend the NAIC tool to include all NQTLs. **Accordingly, Maryland's regulations must require issuers to report comparative analyses for all NQTLs,[1] including reimbursement rate setting practices.**

II. Identification of Reimbursement Rate Setting NQTLs

Issuers implement a number of reimbursement rate setting practices for which comparative analyses are now required. Federal regulations, the DOL Self-Compliance Tool and federal Parity Act litigation have identified the following reimbursement NQTLs:

- Reimbursement rate setting practices for network providers (DOL Self-Compliance Tool at 19), which, by extension, would include reimbursement practices for single case agreements.
- Methods for determining usual, customary and reasonable charges for out-of-network reimbursement, (45 C.F.R. § 146.136(c)(4)(ii)(E)), including, as courts have found, reducing reimbursement for MH and SUD providers by a set percentage based on the practitioner's education/licensure level. *Smith v. United Healthcare Ins. Co*., 2019 WL 3238918, *7 (N.D. Cal. July 18, 2019) (court denied motion to dismiss plaintiff's cause of action challenging carrier's percentage reduction for psychologists and masters' level counselors); *Doe v. United Health Group*, 2018 WL 3998022 (E.D.N.Y. Aug 20, 2018) (same). *See also Maryland Insurance Comm. v. Optimum Choice, Inc., UnitedHealthcare Ins. Co. and UnitedHealthcare of the Mid-Atlantic, Inc.*, MIA-2020-04-039, MIA-2020-04-040, MIA-2020-04-041 (April 1, 2020).
- Restrictions on applicable provider billing codes. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013) (preamble to Parity Act regulations identifies "service coding" as an NQTL).
- Reimbursement rate adjustment practices to address network gaps. (DOL Self-Compliance Tool at 20).
- Failure to honor reimbursement obligations. *Out of Network Substance Use Disorder Claims against United Health Care*, 8:19-cv-02075 (C.D. Cal. Oct. 31, 2019) (complaint filed raising Parity Act, ERISA and state claims).

We urge the MIA to identify these and other reimbursement rate setting practices in regulations to ensure complete NQTL identification and comparative analyses.

III. Identification of Factors, Evidentiary Standards, and Processes with Sufficient Detail to Demonstrate Compliance.

A Parity Act analysis must examine reimbursement rate standards both as written and in operation and must identify and compare a number of elements across MH, SUD and medical/surgical benefits. Federal regulators have made clear that issuers must provide an analysis that is sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying an NQTL are comparable to and applied

[1] Section 15-144 contains additional reporting standards, including frequency of reporting, that are inconsistent with the federal compliance reporting framework. LAC will submit a separate analysis of preemption principles for those state standards.

no more stringently to MH/SUD benefits than to medical/surgical benefits….: FAQs Part 45, Q2 at 3. According to federal regulators, "general statements of compliance" and "conclusory references to [the] broadly stated" elements set out above are "insufficient to meet" the statutory requirement. *Id*. **To ensure submission of sufficient analyses, we urge the MIA to include the federal guidance standards in state regulations and embed prompts in the report template to ensure that a report cannot be submitted without the inclusion of all required information, including definitions of each factor, the quantitative measures that have been used as the evidentiary standard for applying the factor, and supporting documents.**

The preamble to the federal parity regulations identifies a number of factors that apply in the reimbursement context including: "service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers." 78 Fed. Reg. at 68246. Several additional factors have been identified in market conduct examinations conducted by the New Hampshire Department of Insurance:[2] statewide average reimbursement rate and reimbursement rates that issuers must pay to be competitive with others in the state. *See* Harvard Pilgrim Report at 36 and 37. Finally, the DOL Self-Compliance Tool states that:

> Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits.

DOL Self-Compliance Tool at 20; see also FAQs Part 45, Q.

Every factor that is used in the design or implementation of reimbursement rates must be defined, and the evidentiary standard that is applied as the threshold for the application of such factor must be identified. For example, if the carrier uses "demand for services" as a factor for increasing or reducing rates, the quantitative or other measure for identifying "demand" must be identified for purposes of the comparability analysis. Similarly, if the carrier uses the "supply of providers" as a factor, it must identify the quantitative measure used to identify an adequate or insufficient supply for purposes of adjusting rates. Because reimbursement rates are "quantitative" in nature, many evidentiary standards that are used to set a threshold are likely to be expressed numerically; e.g. a designated percentage increase or reduction compared to the Medicare rate. Finally, if the issuer establishes its rates by using an average statewide payment calculation or by comparing the rates set by other issuers, it must submit that information to document comparability and no more stringent application. The absence of this level of documentation means that the issuer has not complied with the Parity Act's NQTL analytical requirement. *See* NH Dept. of Insurance Market Conduct Examinations of Harvard-Pilgrim Report at 38 and Anthem Report at 38.

[2] New Hampshire Insurance Dept., Market Conduct Targeted Examination of Harvard Pilgrim Health Care of New England, Inc. for the Period of January 1, 2016 Through July 31, 2017 Regarding Mental Health Parity and Substance Use Disorder Benefit Treatments, Docket No. Ins 17-047-MC (Jan. 17, 2020), https://www.nh.gov/insurance/consumers/documents/harvard-pilgrim-parity-exam-final-report.pdf; New Hampshire Insurance Dept., Market Conduct Targeted Examination of Anthem Health Plans of New Hampshire for the Period of January 1, 2016 Through July 31, 2017 Regarding Mental Health Parity and Substance Use Disorder Benefit Treatments, Docket No. Ins 17-046-MC, https://www.nh.gov/insurance/consumers/documents/anthem-parity-exam-final-report.pdf.

Additionally, several rate-setting ***processes*** were highlighted in the New Hampshire market conduct examinations, including:

- the frequency of updating the reimbursement rate schedule (Harvard Pilgrim Report at 36);
- whether the carrier allows for rate negotiation (Anthem Report at 37, 38);
- whether the carrier has discretion in applying its reimbursement framework (Anthem Report at 38).

As examiners noted, an issuer must demonstrate that it uses a "consistent, non-arbitrary, and non-discriminatory methodology" for rate negotiations and any exercise of discretion in applying its reimbursement framework for Parity Act compliance. Anthem Report at 3; Harvard Pilgrim Report at 38-39.

In conducting the comparative analysis, federal regulators have given explicit guidance on the level of detail and documentation that the issuer must provide to meet sufficiency standards. *See* FAQs Part 45, Q3. **To enforce state law requirements to submit a complete parity report (Ins. § 15-144(j), we urge the MIA to include in regulation the standards articulated in the federal guidelines.** Specifically, issuers must provide:

- "a clear explanation of how and why each document [provided] is relevant to the comparative analysis;"
- "specific supporting evidence and detailed explanations" rather than "conclusory or generalized statements;"
- a "clear and detailed comparative analysis" for processes, strategies, sources and factors that are identified;
- a "clear explanation of how [factors, evidentiary standards, and strategies] were defined and applied in practice;"
- "precise definitions, data, and information necessary to assess [the] development or application" of any factor or evidentiary standard that is defined or applied in a quantitative manner; and
- Current analyses that are up-to-date for plan structure.

FAQs Part 45, Q3. These guidelines are intended to address deficiencies that federal regulators have identified from extensive investigations. **The MIA has noted similar deficiencies in its parity market conduct surveys, and regulations should include standards that will ensure that issuers waste no more time in submitting insufficient and meaningless parity reports.** *See* Maryland Insurance Comm. v. Optimum Choice, Inc. et al. at 4 (noting that the "Administration investigated Respondents for a year and seven months before it obtained all the information it needed to understand how Respondents were developing reimbursement rates for OON providers.").

IV. Outcome Analysis of Reimbursement Rates for Substance Use Disorder and Mental Health Providers Compared to Medical/Surgical Providers.

As the DOL Self-Compliance Tool recognizes, an outcome analysis of issuer reimbursement rates for MH, SUD and medical providers measured against a standardized benchmark is essential to "flag" underlying parity violations. DOL Self-Compliance Tool at App. II at 38-39. An outcome analysis is particularly important to satisfy the Parity Act's "in operation" analyses of reimbursement rates because issuers strongly resist the disclosure of data on reimbursement rate setting practices and their rate negotiation practices are highly subjective. The New Hampshire Dept. of Insurance identified significant outcome disparities in reimbursement rates for MH and SUD services using the Medicare benchmark and concluded that the plans did not provide sufficient documentation of parity compliance. *See* Anthem Report at 35-36; 38; and Harvard Pilgrim Report at 35-36, 38.[3] **We urge the MIA to require issuers to submit an outcome analysis for reimbursement rates as part of the NQTL analysis.**

In establishing a uniform benchmark for comparison purposes, we agree that the Medicare benchmark is an appropriate starting point for providers that are eligible for reimbursement under Medicare; i.e. psychiatrists, psychologists, and licensed clinical social workers. We note however, that Medicare is not subject to the Parity Act, and it contains reimbursement rate reductions for psychologists and licensed social workers that likely "bake in" discriminatory rates setting standards. Thus, regardless of the findings in the benchmark analysis, the issuer must provide a detailed comparative analysis of factors, evidentiary standards, strategies and processes used to set and implement the issuer's rates.

Additionally, a significant portion of MH and SUD providers in Maryland are community-based facilities, which are not covered under Medicare. Many do not join private carrier networks because of low reimbursement rates. **To fully assess issuer reimbursement practices for this large provider pool, we urge the MIA to identify an appropriate benchmark for an outcome analysis for the full range of SUD and MH practitioners, including licensed professional counselors, certified alcohol and drug counselors, and the full range of community-based programs.** Reimbursement rate data for a full range of MH and SUD practitioners has been requested by the California Attorney General. *See* Legal Action Center's Testimony, MIA Mental health Parity Regulations Hearing (Nov. 23, 2020) Att. 4.

[3] The Maryland Health Care Commission conducted a similar analysis in August 2019, at the request of the MIA, and identified reimbursement disparities by private payers for psychiatrists compared to primary care, medical and surgical practitioners using the Medicare benchmark. *See* Commissioner Al Redmer to Del. Shane E. Pendergrass, Re: June 5, 2019 HGO Letter – House Bill 837 – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists (Oct. 1, 2019), Q. 5 and Exh. 6. *See* Attachment A, Legal Action Center Analysis of MHCC Data.

Thank you for considering our views. We look forward to working with the MIA throughout this regulatory process.

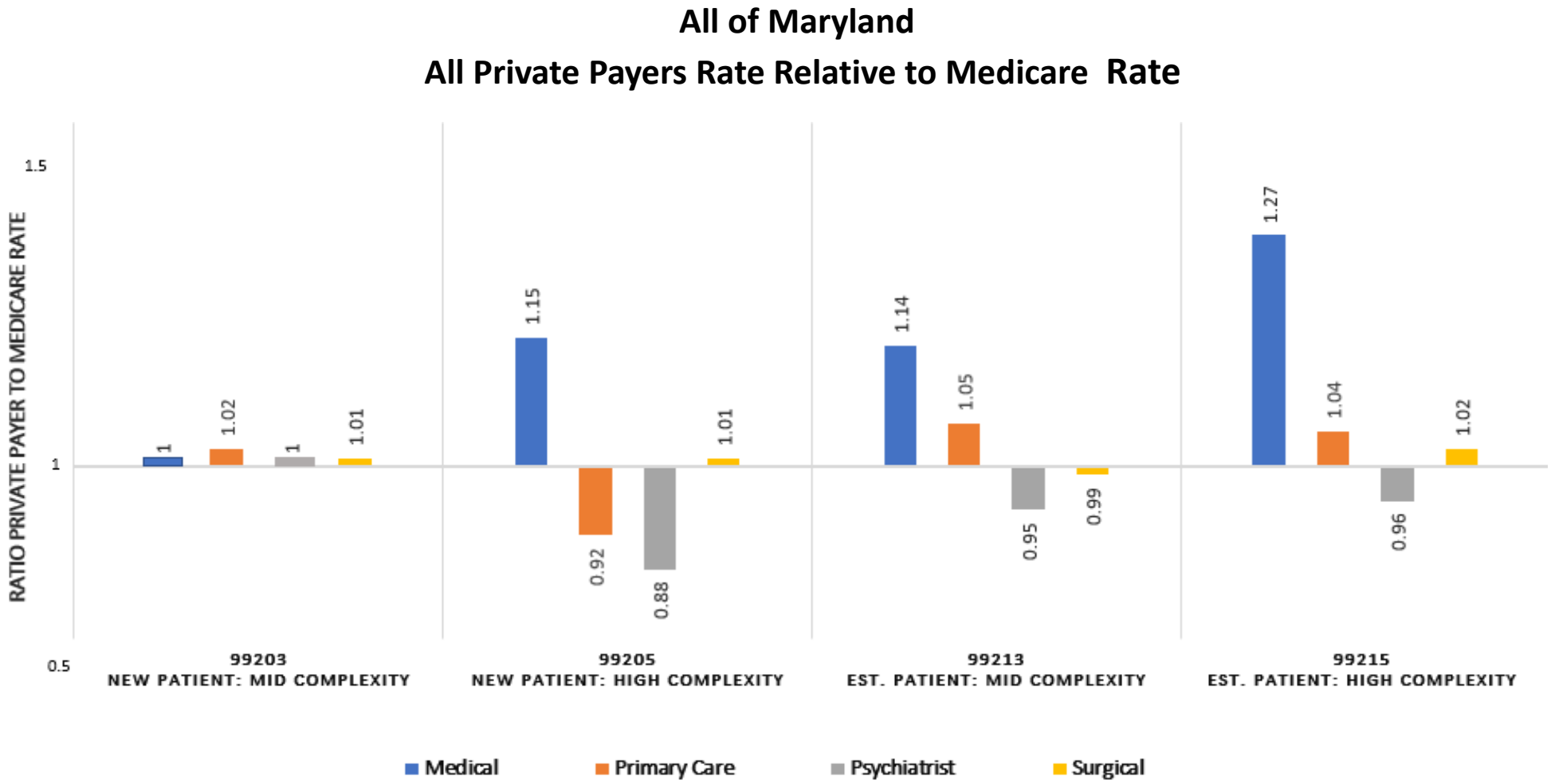
Sincerely,

Ellen M. Weber, J.D.
Vice President for Health Initiatives

Addiction Connections Resource
Black Mental Health Alliance
Community Behavioral Health Association of Maryland
Daniel Carl Torsch Foundation
Health Care for the Homeless
Institutes for Behavior Resources, Inc.
James' Place Inc.
Maryland Addiction Directors' Council
Maryland Association for the Treatment of Opioid Dependence
Maryland Coalition of Families
Maryland Clinical Social Work Coalition
Maryland-DC Society of Addiction Medicine
Maryland Psychiatric Society, Inc.
Mental Health Association of Maryland
Patricia Miedusiewski R.N., BSN Family Advocate with Lived Experience
NAMI Maryland
National Council on Alcoholism and Drug Dependence Maryland
Voices of Hope, Inc.

Attachment A

Evaluation & Management (E&M) Services: 2017 All Maryland Reimbursement Rates Relative to Medicare Benchmarks by Private Payer and Four Physician Specialties



Kenneth Yeates-Trotman, Maryland Healthcare Commission, Maryland All-Payer Claims Database. Prepared in response to June 5, 2019 HGO Letter – House Bill 837 – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists (Oct. 1, 2019). All Private Payers includes CareFirst, United Healthcare, Aetna, and Cigna.