ABHW
Advancing Health Care Policy
for Mental Health and Addiction

May 26, 2021

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

RE: **Comments on Inclusion of Reimbursement Rates on the Maryland Insurance Administration Parity Compliance Reporting Form and Maryland Insurance Administration Public Hearings on Parity Regulations**

Dear Commissioner Birrane:

On behalf of the Association for Behavioral Health and Wellness (ABHW), we appreciate the opportunity to comment on the important issue of inclusion of reimbursement rates on the Maryland Insurance Administration (MIA) Parity Compliance Reporting form.

ABHW is the trade association which serves as the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health, substance use disorders, and other behaviors that impact health and wellness. Many ABHW members provide behavioral health insurance coverage to individuals in the state Maryland.

Background:

For more than two decades, ABHW has supported mental health and addiction parity. We were an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a coalition developed to win equitable coverage of mental health treatment. ABHW served as the Chair of the Fairness Coalition in the four years prior to passage of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We were closely involved in the writing of the Senate legislation that became MHPAEA, and actively participated in the negotiations of the final bill that became law.

ABHW member companies have worked vigorously to understand and implement MHPAEA. We have had numerous meetings with the federal regulators to help us better understand the regulatory guidance and to discuss how plans can

operationalize the regulations. Our member companies have teams of dozens of people working diligently to implement and provide a mental health and substance use disorder (MH/SUD) parity benefit to their consumers.

General Comments:

ABHW greatly appreciates the MIA hearings and discussion on parity compliance requirements, particularly around nonquantitative treatment limitations (NQTL). Currently, our members are encumbered by a patchwork quilt of compliance requirements that have differing interpretations of what parity means. Completing and submitting a multitude of diverse documents is both burdensome and costly. We support the notion of states using uniform templates to determine parity compliance in order to have consistency across the states in the understanding of, and compliance with, MHPAEA.

The Consolidated Appropriations Act, 2021 (the "CAA") was signed into law on December 27, 2020. In relation to parity, the CAA amends the Employee Retirement Income Security Act of 1974 ("ERISA"), the Public Health Service Act and the Internal Revenue Code to include new provisions that specifically require the Secretaries of the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (the "Secretaries") to request documents that demonstrate compliance with MHPAEA NQTL requirements for group health plans and health insurance issuers. The CAA requires group health plans and health insurance issuers to make available to the applicable State authority or the Secretaries specific parity compliance information.[1]

On April 2, 2021, the Departments of HHS, DOL, and the Treasury (collectively, the "Tri-Agencies") released a set of frequently asked questions (FAQs) to provide guidance with respect to the MHPAEA requirements added by the CAA.[2] These FAQs explain that the DOL's self-compliance tool[3] outlines four steps that plans and

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[1] This new disclosure requirement requires plans and health insurance issuers to make available, upon request:

- the specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD or M/S benefits to which each such term applies in each respective benefit classification;
- the factors and evidentiary standards used to determine that the NQTLs will apply to MH/SUD benefits and M/S benefits;
- the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to M/S benefits in the benefits classification; and
- the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses.

[2] *See* FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[3] On October 23, 2020, the DOL's Employee Benefits Security Administration ("EBSA") released an updated self-compliance tool to help employers comply with MHPAEA. The self-compliance tool provides an overview of MHPAEA's requirements, including the NQTLs; summarizes guidance issued through Frequently Asked

issuers should take to assess their compliance with MHPAEA for NQTLs. For each step, the self-compliance tool also identifies certain information to support the analysis and the conclusions reached about whether the plan or coverage complies with MHPAEA. The FAQs state that this information "closely aligns" with the information that plans and issuers must include as part of their comparative analyses. The FAQs states that plans and issuers that have carefully applied the guidance in the self-compliance tool should be in a "strong position" to comply with the CAA's requirement to submit comparative analyses upon request. As such, in light of the CAA and the FAQs, we recommend that the MIA follow the DOL self-compliance tool framework/approach for guiding NQTL analyses. We believe following the federal perspective will provide all stakeholders with consistency, clarity and uniformity. At the recent April 26th MIA parity hearing, certain key stakeholders as well as Commissioner Birrane acknowledged the usefulness of the DOL Tool. In this regard, ABHW cautions against adoption of some of the other suggested tools raised at hearings and in comments, *e.g*., the Model Data Request Form (MDRF), Pennsylvania-generated grids, or the proposed reimbursement rate template on the MIA website. These tools should be rejected as they contain superfluous, confusing, and overly burdensome data elements.

Under the CAA, it is likely that the Tri-agencies will issue additional NQTL guidance within the next year or so, including examples of reimbursement rate NQTL analyses. ABHW has requested that the Tri-agencies provide stakeholders with best practice NQTL examples to bring uniformity to the compliance process. ABHW is urging the Tri-agencies to issue clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health issuers may use regarding the development and application of NQTLs to ensure compliance with MHPAEA. This guidance may include:

- Methods of determining appropriate types of NQTLs;
- Sources of information that may be used as evidentiary standards for making determinations of and developing NQTLs;
- Specific factors and evidentiary standards used to evaluate the factors;
- How specific evidentiary standards may be applied to each service category;
- Methods of reaching appropriate coverage determinations for new MH/SUD treatments; and
- Methods of reaching coverage determinations for which there is an indirect relationship.

As noted earlier, we recommend against the MIA implementing new or separate interpretations of the CAA requirements, including the adoption of a reimbursement rate template that goes beyond the DOL self-compliance tool approach (see Appendix II of self-compliance tool). In enacting the MHPAEA provisions of the CAA,

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Questions; includes examples of how a group health plan can come into compliance if it identifies certain MHPAEA violations; includes compliance examples and warning signs; and provides some best practices for establishing an internal MHPAEA compliance plan.

Congress underscored its intention to strengthen MHPAEA. Now that the federal requirements have been "upped," states no longer need to have different standards to supplement any perceived federal deficiencies. Maryland's adoption of a different compliance regime from the federal standard (as the CAA is on the cusp of implementation) may create consumer confusion and increases costs (thereby lessening consumers' ability to access MH/SUD services).

ABHW has specific concerns with the proposed reimbursement rate template on the MIA website. Disparate results alone do not mean that the NQTLs in use fail to comply with MHPAEA or state law. All too often, the fact that disparate results exist for a data point creates a more prejudicial than probative framework that subsumes any comparable methodology analyses. The MHPAEA final rule states, "Disparate results alone do not mean that the NQTLs in use do not comply with these requirements" and as such, it is crucial that the focus of the MIA NQTL analysis should be on methodologies as opposed to outcomes. Given such a focus, we recommend that only essential data elements be collected as part of the parity requirements and the scope should be refocused on process instead of results to reflect the intent of MHPAEA.

Moreover, the use of any particular base rate for a code (as set forth in the proposed tool) is only one factor in the overall processes, strategies, etc. that lead to provider reimbursement rates. Indeed, these base rates serve only as a floor for contract negotiations for newly contracted providers. Both MH/SUD and medical/surgical providers are subject to a similar process for setting in-network, contracted rates. The parties begin at the base rate, and via arms-length negotiations reach the final rate, meaning that market forces, and not the chosen base rate, determine whether providers receive higher rates. In addition, we do not support the approach of solely comparing plan reimbursement rates to a singular Medicare benchmark which itself represents only one version of a method of determining reimbursement. The proposed tools apparent focus on a single factor in the provider-reimbursement process, without taking into consideration the other factors in this process (as well as the interaction between factors and how they may bare on provider reimbursement), appears to be entirely results driven which, as noted above, is inappropriate for NQTL analyses.

ABHW thanks the MIA for this opportunity to provide our comments on parity compliance. Please feel free to contact Deepti Loharikar, Director of Regulatory Affairs, at loharikar@abhw.org or 202-505-1834 with any questions.

Sincerely,

Pamela Greenberg

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President and CEO