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,

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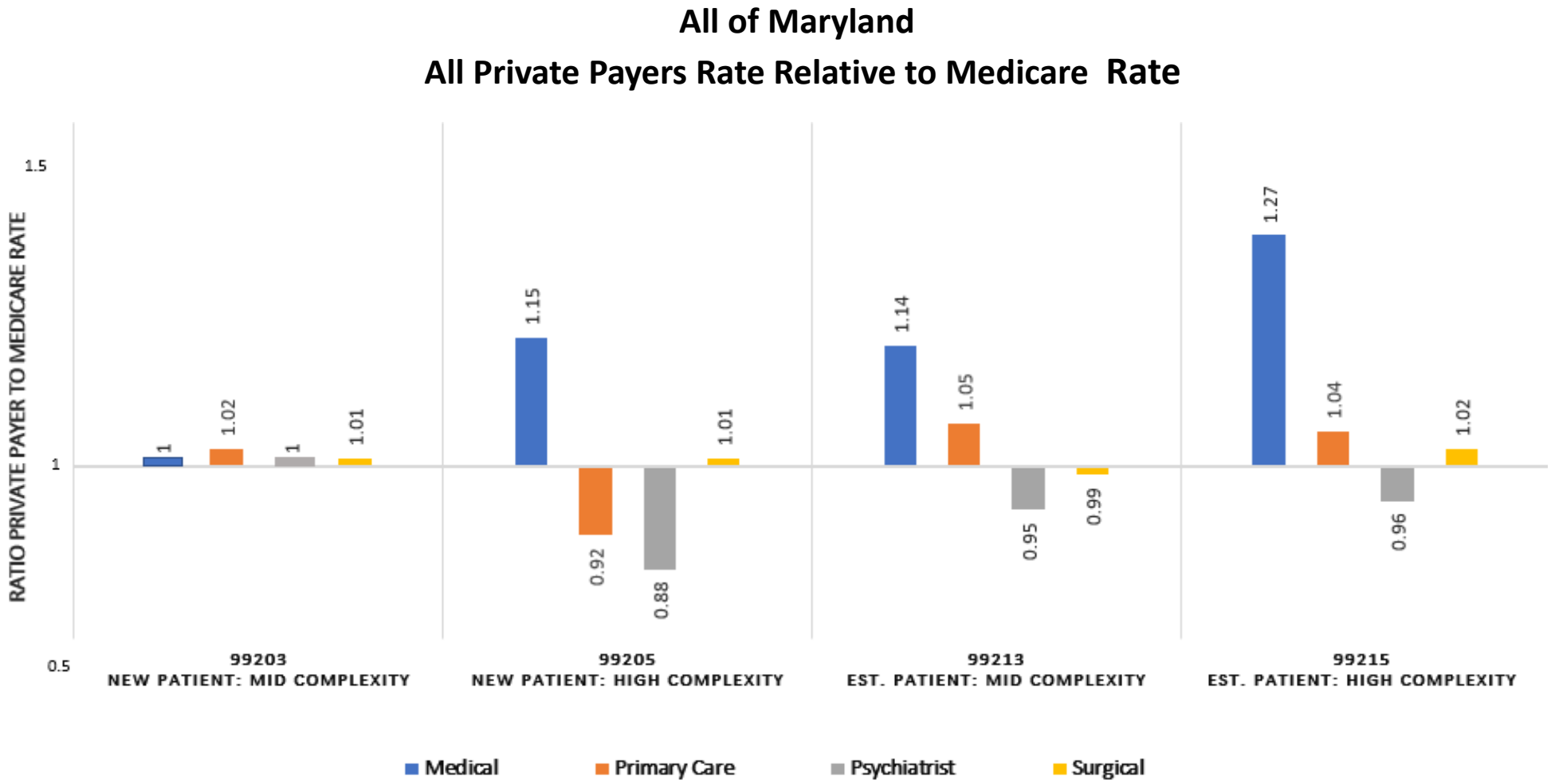
Vice President for Health Initiatives

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.