America's Health Insurance Plans
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May 26, 2021

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

Re: Mental Health Parity Workgroup – Provider Reimbursements

Dear Commissioner Kathleen Birrane,

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

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

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

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

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

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

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

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

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

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

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

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

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

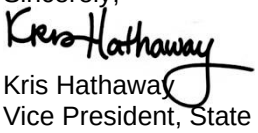
- If the MIA determines they want to move ahead on a NQTL provider contracted rate template, we ask Maryland to postpone consideration until outstanding questions related to implementation of the federal transparency requirements are clarified to avoid duplicative reporting requirements that would create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

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

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

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

Sincerely,



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

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