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May 26, 2021

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

Sent via email: mhpaea.mia@maryland.gov

RE: Comments in response to public hearing held on April 26, 2021 regarding Mental Health Parity regulations.

Dear Commissioner Birrane:

CareFirst appreciates the Maryland Insurance Administration (Administration) bringing interested parties together to discuss issues surrounding reporting on compliance with nonquantitative treatment limitation (NQTL) rules as established under the federal Mental Health Parity and Addiction Equity Act (MHPAEA) regulations.

On April 26, 2021, the Administration held a public hearing soliciting feedback on two different tools that were identified as potential options for the Administration to include in regulation to aid in the assessment of carriers' compliance with MHPAEA with respect to provider reimbursement rates. The first tool was presented by consultants to the Mental Health Treatment and Research Institute LLC (MHTRI) and was identified as the Model Data Definitions and Methodology form (MDDM).¹ In its presentation, the MHTRI described the MDDM as being tested by "national experts including Milliman" and "endorsed by URAC's Parity Accreditation Standards as best practice." The MHTRI did not include any information as to any state or federal agency that has adopted the MDDM.

The second tool identified was the Appendix II – Provider Reimbursement Rate Warning Signs, included in the October 2020 U.S. Department of Labor's Self-Compliance Tool for MHPAEA (DOL Tool). The DOL Tool was issued initially in 2018, and updated in 2020, as guidance for employers and carriers to follow when determining plan compliance with MHPAEA. In December 2020, Congress passed the Consolidated Appropriations Act, 2021 (CAA),² which included requirements for all plans and issuers subject to MHPAEA to conduct a specific analysis of their plans to demonstrate MHPAEA compliance with regards to NQTLs and to provide that analysis if requested by DOL, the Department of Health and Human Services, or a state agency with regulatory jurisdiction over the issuer. This requirement went into effect on February 10,

¹ <http://www.mhtari.org/model-data-definitions-method.pdf>

² Pub. L. No. 116–260, 134 Stat. 1182.

2021. The CAA charged the Tri-Agencies³ with developing regulations to support the requirements under the law. On April 2, 2021, the Tri-Agencies issued FAQ Part 45 advising plans and issuers, among other things, that “plans and issuers that have carefully applied the guidance in the [DOL Tool] should be in a strong position to comply with the [CAA’s] requirement to submit comparative analyses upon request.”⁴ It is important to note that, as of the date of submission of these comments, no regulations have been issued by the Tri-Agencies as to the required analysis.

Support for DOL Tool

As stated previously, the General Assembly included in HB 455’s uncodified language its intent that the Administration use the NAIC tool to allow for uniformity among reporting requirements in various jurisdictions.⁵ We maintain that including additional reporting requirements and tools beyond the NAIC tool is not consistent with the legislative intent. However, in response to the Commissioner’s request for carrier feedback on which tool would be most appropriate, CareFirst provides its support for the adoption of the Appendix II of the DOL Tool.

CareFirst acknowledges that since HB 455 passed, the DOL Tool has emerged as the most likely candidate for adoption into federal regulation to demonstrate plan MHPAEA NQTL compliance, thus addressing carriers’ uniformity of reporting concerns.⁶ This national tool will provide carriers who do business in multiple jurisdictions with greater consistency and uniformity to the compliance process and will be less administratively burdensome than implementing the MDDM tool.

While CareFirst supports the uniformity benefits around adopting the Appendix II of the DOL Tool, all parties must recognize that this tool, and tools like it, is flawed. The Appendix II of the DOL Tool itself acknowledges that it may not be relied on to conclude that there is a MHPAEA violation.⁷ Additionally, the DOL Tool relies on a comparison of plan provider reimbursement rates to Medicare rates to identify “red flags.” This is inappropriate because MHPAEA does not require that plans or issuers rely on Medicare rates when developing provider reimbursement rates. Furthermore, Medicare itself is not required to comply with MHPAEA, therefore, it is unknown if Medicare’s methodology for developing provider reimbursement rates is MHPAEA compliant. However, as these same issues are true for the MDDM, and the MDDM does not have the benefit improving uniformity in reporting across multiple jurisdictions, CareFirst supports adoption of the Appendix II of the DOL Tool for this report.

Additional Issues to Be Discussed:

If the Appendix II of the DOL Tool is adopted by the Administration for inclusion in the MHPAEA reporting requirements, we request guidance on:

³ U.S. Departments of Labor, Health and Human Services, and Treasury.

⁴ <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>

⁵ Passed in the 2020 Session.

⁶ The DOL Tool has not yet been adopted into federal regulations as the tool to be used for the CAA required NQTL analysis and it is not clear whether the Appendix II of the DOL Tool will be included in any such adoption. FAQ Part 45 did not address that issue.

⁷ “The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, that can often serve as red flags or warning signs... This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance.” DOL Tool, pg. 38.

1. **Place of service:** Reimbursement rates are determined in part based on the place of service where the benefit is being provided. The Appendix II does not identify which place of service should be used when completing the tool.
2. **Column 3- Average Plan rate [insert locality]:** This column asks for “average plan rate” but does not explain how the average should be calculated (i.e., based on contracts or based on claims). CareFirst suggests using claims data because it will better define the scope of providers with the specialty providing the service. Relying on contracts would include contracts in the average rate calculation that do not actually provide the services at issue. Additionally, “locality” is not defined. CareFirst assumes Medicare localities should be used, but clarification is appreciated.
3. CareFirst is not sure which specialty is intended to be encompassed by “Internists MD”. Does this mean “Internal Medicine PCPs”? A definition is appreciated.

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

Sincerely,

A handwritten signature in black ink that reads "Deborah R. Rivkin". The signature is written in a cursive, flowing style.

Deborah R. Rivkin