

Maryland Insurance Administration Mental Health Parity Regulations Hearing November 23, 2020

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Thank you for the opportunity to submit the Legal Action Center's recommendations on the non-quantitative treatment limitations for which the Maryland Insurance Administration (MIA) should require compliance reporting, pursuant to Ins. § 15-144(c)(d) and (e). The Legal Action Center is a law and policy organization that fights discrimination, builds health equity and restores opportunity for people with substance use disorders, criminal records, and HIV or AIDS. The Center leads the Maryland Parity Coalition, which has worked to achieve effective enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act) in Maryland's private and public insurance markets and led advocacy efforts to secure passage of HB 455/SB 334 (2020).

Effective enforcement of the Parity Act requires multiple strategies to ensure that consumers have access to mental health (MH) and substance use disorder (SUD) services at the same level as medical/surgical services. The MIA reviews health plan financial requirements through form review and, from 2014-2019, conducted market conduct surveys that identified discriminatory insurance practices in the design and application of non-quantitative treatment limitations (NQTLs) related to carrier credentialing, network admission, network adequacy, reimbursement and treatment authorization. The MIA's investigations have demonstrated that carrier compliance reporting is needed to more effectively root out system-wide practices that limit access to MH and SUD care.

The reporting requirements, under § 15-144, will improve the MIA's enforcement efforts by requiring carriers to demonstrate compliance with the NQTL provisions of the Parity Act. **The Center urges the MIA to require reporting on all NQTLs, consistent with the statutory language, federal law, federal compliance guidance issued by the Departments of Labor (DOL) and Health and Human Services (HHS), and compliance reporting practices in other states.** Any effort to limit NQTL reporting to those elements set out in the National Association of Insurance Commissioners (NAIC) Market Conduct tool would undermine the MIA's efforts to ensure equitable network adequacy, reimbursement practices, and scope of services. Moreover, it would ignore the very practices that the MIA's investigations and network adequacy reporting, under COMAR §31.10.44, have identified as most problematic for Marylanders and would forgo the most effective means to remove these barriers to care.

We, therefore, commend the MIA for launching its regulatory process with a discussion of research that has highlighted the significant disparities in out-of-network utilization of MH and SUD services in Maryland and disparate reimbursement rates for behavioral health practitioners. Additionally, gaining an understanding of the regulatory practices that other state Departments of Insurance have used to track carrier compliance with these NQTLs will provide important guidance for the implementation of § 15-144.

A. Section 15-144 Requires Reporting of all NQTLs that a Carrier Applies to MH and SUD Benefits.

As enacted, § 15-144(c)(2)(ii), requires a report that includes “for each Parity Act classification, identification of nonquantitative treatment limitations that are applied to mental health benefits and substance use disorder benefits and medical and surgical benefits.” The statute also defines “nonquantitative treatment limitations” as that term is defined in federal regulations, 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a), the HHS and DOL parity regulations, respectively. The federal regulations set out a non-exhaustive list of NQTLs, which includes:

- medical management standards based on medical necessity or appropriateness criteria, or standards for treatment that is experimental or investigative;
- formulary design for prescription drugs;
- network tier design standards;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;
- fail-first or step therapy requirements;
- exclusions based on failure to complete a course of treatment;
- restrictions based on geographic location, facility type, provider specialty; and
- 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); 29 C.F.R. § 2590.712(c)(4)(ii). Additionally, federal regulators have stated that other plan standards, while not identified in the NQTL list, must also comply with the Parity Act requirements, as they may restrict access to MH or SUD benefits:

Specifically, plan standards, such as in- and out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy...must be applied in a manner that complies with these final regulations.

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). Federal regulators also made clear that the scope of coverage for MH and SUD benefits, including the coverage of intermediate levels of care, is subject to the Parity Act standards. *Id.* at 68246-47.

Selecting a subset of NQTLs for reporting purposes, under § 15-144, would not comply with the statute, as enacted. For this reason, the Legal Action Center vigorously opposed the use of the NAIC's Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations, as it does not include all NQTLs identified in federal regulations. We believe that that MIA must revise the NAIC's tool to include all NQTLs, as provided for in Section 2 of HB 455/SB 334. **Failure to do so will inadvertently give carriers the ability to adopt discriminatory practices in critical design features, such as reimbursement rate setting, network adequacy, and the scope of benefit coverage, that will be nearly impossible to uncover through other enforcement mechanisms.**

B. The Department of Labor's Parity Act Sub-Regulatory Guidance Reinforces the Obligation of Health Plans to Comply with the Parity Act for All NQTLs.

The DOL's recently updated [Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#) references the regulation's illustrative, non-exhaustive list NQTLs (p. 19) and sets out a four-step process for assessing Parity Act compliance. (pp. 21-28). Through its examples and notes, the Self-Compliance Tool highlights a number of commonly applied NQTLs, including:

- reimbursement rate setting (p. 20 and 38-39);
- practices to address provider network shortages, including increasing reimbursement rates and accelerating enrollment of providers in networks (p. 20);
- coverage of intermediate levels of care, such as residential treatment for MH and SUD, and restrictions on reimbursement for room and board for MH and SUD services (p. 22);
- prior authorization requirements for opioid use disorder medications (p. 26);
- medical necessity review requirements imposed on a frequent basis for MH and SUD benefits (p. 27);
- training and state licensure requirements for network credentialing (p. 35); and
- exclusion of coverage for various testing procedures related to mental health conditions (p. 35).

Over the 12-year life of the Parity Act, the DOL has issued a series of sub-regulatory guidance to enhance compliance and enforcement, and the Self-Compliance Tool highlights some of the NQTLs that pose the greatest barriers to accessing MH and SUD care. Indeed, the DOL has added a new data gathering tool to assess whether a health plan's reimbursement rates for commonly billed codes for MH, SUD, and medical/surgical practitioners raise warning signs of underlying violations of rate setting practices. Self-Compliance Tool, App. II: Provider Reimbursement Rate Warning Signs (p. 38-39).

We urge the MIA to require reports on the full ranges of NQTLs, consistent with the DOL's guidance. The MIA's market conduct surveys have found violations by Maryland's carriers in these very same practices, including carrier credentialing, network admission, network adequacy, reimbursement and treatment authorization. (Attachment 1). We expect that a thorough review of the carrier's network admission practices, including the comparability of practices used to address network shortages for MH, SUD, and medical/surgical providers, will identify other disparate practices that contribute to the shortage of MH and SUD providers in carrier networks.

C. All States that Have Adopted Parity Compliance Reporting Standards Require Health Plans to Report on All NQTLs that are Applied to MH or SUD Benefits.

In addition to Maryland, eleven states – Arizona, California, Colorado, Connecticut, Delaware, Illinois, Indiana, Louisiana, New Jersey, Oklahoma, Pennsylvania – and the District of Columbia have adopted Parity Act compliance reporting requirements. (Attachment 2). All require health plans to report on compliance for all NQTLs that are applied to MH or SUD benefits. *Id.* In addition, 5 states – Colorado, Connecticut, Massachusetts, New York, Vermont – and the District of Columbia require health plans to report on specific data points annually or biennially to help test NQTL compliance “in operation.” (Attachment 3). The most common data points relate to the number of claims by parity classification, the number of paid and denied claims, and prior authorization approvals and denials. Two states – Colorado and New York – collect data on network adequacy and reimbursement rates. *Id.* **We urge the MIA to follow the standard that has been adopted by a growing number of states and require Maryland’s carriers to report on all NQTLs.**

Requiring reports on all NQTLs will not create an undue administrative burden for the MIA. With a standardized parity reporting requirement, the **burden of demonstrating compliance rests appropriately with the carriers.** They possess all the information required to demonstrate compliance and should have already conducted compliance reviews of all NQTLs to ensure that they do not offer a plan that does not comply with Parity Act standards, as required by federal law. 45 C.F.R. § 146.136(h) and 29 C.F.R. § 2590.712(h). Reporting this information through standardized tools will greatly facilitate the MIA’s review and the penalty provisions, under § 15-144(j),(k), and (l), should incentivize the carriers to submit complete and thorough reports.

Additionally, in contrast to the states identified above, the Maryland General Assembly addressed the potential administrative burden to the MIA by limiting the total number of reports that carriers will submit. *See* Ins. § 15-144(c)(1)(i) and (ii). Over the course of the legislative process, the Parity Coalition agreed to cap the number of plans for which reports would be submitted, with the explicit goal of ensuring that insurers would be required to report out on all NQTLs. **The MIA has never conducted a Parity Act review of all plan design features that may restrict access to MH and SUD benefits.** (Attachment 1) and *see* MHPAEA Enforcement Actions, <https://insurance.maryland.gov/Consumer/Pages/MHPAEA-Enforcement-Actions.aspx>. **In doing so under §15-144, we anticipate that the MIA will uncover Parity Act violations that have long limited access to care.**

D. The MIA Should Build on the Lessons Learned from Its Market Conduct Surveys and Enforcement Work in Other States to Require Compliance Reporting for All NQTLs.

State Departments of Insurance and several State Attorneys General have conducted parity- focused market conduct examinations and enforcement investigations that have uncovered a range of NQTL violations. *See* Legal Action Center and Partnership to End Addiction, *Spotlight on Mental Health and Substance Use Disorder Parity Compliance Standards: An Analysis of State Compliance Reporting Requirements*, (Nov. 3, 2020), <https://www.lac.org/assets/files/Spotlight-on-Mental-Health-and-Substance-Use-Disorder-Parity-Compliance-Standards.pdf> (7). Most recently:

- In January 2020, the New Hampshire Department of Insurance entered regulatory agreements with two carriers that found, among other violations, strong evidence of parity

violations in reimbursement rate setting and/or the development and management of provider networks.¹

- In February 2020, The Massachusetts Attorney General entered settlement agreements with three carriers over their disparate reimbursement rate setting practices for outpatient physician visits for MH and SUD services.²
- In July 2020, the Illinois Department of Insurance found violations by five carriers, two of which operated in Maryland (Cigna Health and Life and UnitedHealthcare) for a range of violations related to the use of improper medical necessity criteria, utilization management standards for MH and SUD medications, and failure to perform internal testing to confirm parity compliance. Ill. Dept. of Insurance, “Pritzker Administration Announces Over \$2 Million in Fines for Major Health Insurance Companies Violating Illinois Mental Health Parity Laws,” (July 15, 2020), https://www2.illinois.gov/IISNews/21819-IDOI_Press_Release.pdf.
- In October 2020, the California Attorney General issued a request for information from four carriers to “identify industry or individual practices that may impede access to mental healthcare.” Office of the Att. General, Xavier Becerra to Kaiser Foundation Health Plan, Inc. (Attachment 4). The Attorney General has requested information on a range of NQTLs, including prior authorization requests, claims paid and denied, in-network contracts, credentialing requirements, accuracy of provider directories, list of specialists with whom a single case agreement had been entered, utilization management criteria, including prior authorization and concurrent review requirements, internal and external appeals, and average contracted reimbursement rates and average rates actually paid for designated practitioners.

These state enforcement efforts demonstrate that the adoption of a reporting requirement for **all NQTLs** is fully aligned with Parity Act enforcement in other states and is necessary to ensure that all potential health plan barriers to MH and SUD care are examined.

Thank you for considering our views, and we look forward to working with you and all stakeholders on the Parity Act compliance reporting regulations.

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¹ State of New Hampshire Insurance Dept. In re: Parity Examination of Harvard Pilgrim Health Care of New England, Inc., Docket No.: INS NO. 17-047-MC, Regulatory Settlement Agreement and Order (Jan. 24, 2020); and State of New Hampshire Insurance Dept. In re: Parity Examination of Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc., Docket No.: INS No. 17-046-MC, Regulatory Settlement Agreement and Order (Jan. 21, 2020).

² Comm. of Massachusetts v. Harvard Pilgrim Health Care, Inc., HPHC Ins. Co., Inc. and United Behavioral Health, Assurance of Discontinuation Pursuant to G.L. Ch. 93A, § 5 (Suffolk Superior Court, Feb. 27, 2020); Comm. of Massachusetts v. Allways Health Partners Inc. and Allways Health Partners Ins. Co., Assurance of Discontinuation Pursuant to G.L. Ch. 93A, § 5 (Suffolk Superior Court, Feb. 27, 2020); and Comm. of Massachusetts v. Fallon Community Health Plan, Inc., Fallon Health & Life Assurance Co., Inc. and Beacon Health Strategies, LLC, Assurance of Discontinuation Pursuant to G.L. Ch. 93A, § 5 (Suffolk Superior Court, Feb. 27, 2020).

ATTACHMENT 1

MIA Orders and Market Conduct Survey Findings: Parity Act Compliance

Carrier	Order/ Date	Violations	Penalty
Aetna/Coventry ⁱ	MIA-2015-12-035	- No in-network psychologists in all of Western Maryland 2 counties with no in-network psychiatrists and 1 county had 1 1 county no in-network licensed professional counselors or licensed social workers - Statewide - 1 or no in-network methadone treatment programs	No Financial Penalty
CareFirst Blue Choice	MIA-2015-10-036	- Statewide - no in-network methadone treatment programs - Different reimbursement rates for MH/SUD network because used a separate vendor to manage MH/SUD benefits - Geofactors applied to somatic illnesses not applied to MH/SUD providers	Initial Financial Penalty of \$30,000; Retracted Based on Consent Order
CareFirst GHMSI	MIA-2015-10-034	Failure to meet network adequacy goals for neuropsychological doctors and geriatric psychiatrists	No Financial Penalty
Cigna ⁱⁱ	MIA-2015-10-007	- Additional screening requirement for MH/SUD credentialing - Requirement that MH/SUD applicants who had received treatment for SUD must be sober for 2 years - Imposed shorter response time for MH/SUD providers to submit requested credentialing information	\$9,000 Financial Penalty

Evergreen	MIA- 2015-10-033	- Used 2 different vendors for MH/SUD services and somatic services and no coordination to ensure no more stringent credentialing requirements - Used different factors to set reimbursement rates for MH/SUD 1 county - no in-network psychiatrists, psychologists, licensed social workers or professional counselors	No Financial Penalty
United Healthcare ⁱⁱⁱ	MIA-2017-08-009	Reviewed 5-year malpractice history for all MH/SUD facilities applying for credentialing but no malpractice review for med/surg facilities	\$2,000 Financial Penalty
CareFirst BlueChoice, Inc. GHMSI (CareFirst BlueCrossBlueShield)	MIA-2018-01-023	- BlueChoice – on-line behavioral health directory failed to list 25 of 27 in-network MH hospitals and 5 of 7 MH non-hospital facilities - BC/BS Blue Preferred – online behavioral health directory failed to list any in-network inpatient MH facilities	\$20,250 Financial Penalty against BlueChoice \$4,725 Financial Penalty Against CareFirst BC/BS
Second Market Conduct Survey Other Findings	June 2017 MIA indicated carriers corrected issues during investigations. Carriers not identified	- Carrier limited disclosure of med/surg medical necessity criteria to 3 guidelines at a time to member/provider - Large group plan – financial testing did not account for all OP benefits - Carrier – on-line directory indicated no in-network inpatient MH facilities - Carrier’s credentialing documents for MH/SUD	

		providers required site visit but not for med/surg providers Carrier reported different authorization practices in notices for inpatient MH/SUD treatment and med/surg treatment.	
Second Market Conduct Survey Other Findings	June 2017 Carriers with inadequate networks not identified	6 counties – no in-network non-hospital facilities for opioid use disorders^{iv} 11 counties – no in-network non-hospital facilities for treatment of bi-polar disorders^v 4 counties – no in-network opioid providers^{vi} 7 counties – no in-network providers of bi-polar disorders^{vii}	No Financial Penalties or Other Actions Taken
Aetna	MIA-2018-10-037	Required MH/SUD outpatient and inpatient facilities to complete detailed Personnel Review for credentialing; medical facilities not required to complete Personnel Review	\$1,500 Financial Penalty
Cigna	MIA-2019-06-012	Denied credentialing for 5 of 13 SUD treatment facilities based on “no network need identified.” Admitted all 122 medical facilities even though “no network need identified.”	\$25,000 Financial Penalty
Optum Choice, Inc. UnitedHealthcare Ins. Co. UnitedHealthcare of the Mid-Atlantic	MIA-2020-04-039 MIA-2020-04-040 MIA-2020-04-41	Violated State law reimbursement standard for HMO non-participating MH and SUD providers; applied a greater percent reduction for reimbursement of MH and SUD providers than medical providers.	UHIC - \$62,500 Financial Penalty UHCMA - \$30,000 Financial Penalty

			OCI – \$30,000 Financial Penalty Pay restitution to members for behavioral health claims
Third Market Conduct Survey Other Findings	Sept. 18, 2019 MIA indicated that carriers corrected issues during investigations but investigation was not complete. Carriers not identified	• 1 carrier imposed prior authorization requirements on all MH/SUD services but not all medical services • 1 carrier’s standards for submitting malpractice history during credentialing differs for MH/SUD facilities and med/surg facilities • 1 carrier imposed 7-day cap on the number of days for inpatient MH/SUD authorization, but no cap on inpatient medical services	No Financial Penalties or Other Actions Taken
Third Market Conduct Survey Other Findings	Sept. 18, 2019 Carriers not identified.	• All carriers reported that non-network MH/SUD services are accessed more frequently than non-network med/surg services • Some carriers took longer to credential MH/SUD facilities than med/surg facilities • Carriers have not assessed “in operation” compliance; some carriers have no team to conduct compliance audits • Some carriers have no policies for conducting review of plan compliance and some have no documentation of reviews • Contracts with entities that manage MH/SUD	

		benefits do not address Parity requirements.	
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ⁱ Includes Aetna Health Inc., Aetna Life Insurance Co., Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Co.

ⁱⁱ Includes Cigna Health and Life, Insurance Co. and Connecticut General Life Insurance Company.

ⁱⁱⁱ Includes MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company and UnitedHealthcare of the Mid-Atlantic, Inc.

^{iv} Calvert, Charles, St. Mary's, Allegany, Garrett and Washington Counties had no in-network opioid treatment facilities.

^v Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worcester and Talbot Counties had no in-network non-hospital facilities for bi-polar disorder treatment.

^{vi} Garrett, Queen Anne's and Worcester Counties had no in-network opioid treatment providers.

^{vii} Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worcester Counties had no in-network providers for bipolar-disorders.

ATTACHMENT 2

Legal Action Center (11.18.20)

Carrier Compliance Reporting Requirements for Non-Quantitative Treatment Limitations

	MD ⁱ	DE ⁱⁱ	IL ⁱⁱⁱ	CO ^{iv}	NJ ^v	CT ^{vi}	D.C. ^{vii}	AZ ^{viii}	IN ^{ix}	OK ^x	PA ^{xi}	LA ^{xii}	CA ^{xiii}
Report Frequency	Every two years for two cycles	Once and subsequent for significant changes	Annual	Annual	Annual	Annual	Annual	Every 3 years; annual attestations of compliance and summary of changes	Annual	Annual	Annual attestation of documented analysis; baseline and annual changes	Annual, as required by the La. Dep't. of Ins.	Annual, as required by the Cal. Dep't. of Ins.
Plans Included	Each carrier's 5 plans with the highest enrollment for each product	All	All	All	All	All	All	All	All	All	All	All	All
List all benefits and parity classification		18 Del. Admin. Code § 1410 App. A, A-1											Part III
Process for developing or selecting medical necessity criteria	Md. Ins. Code § 15-144(C)(2)(I)	Del. Code §§ 3343(g)(1), 3571U(1)	215 ILCS § 5/ 370c.1(k) (4)	C.R.S.A. § 10-16-147(2)(b) (I)	N.J. Rev. Stat. § 26:25-10.8(c)(1)	P.A. 19-159 § 1(b)(1)	D.C. Code § 31-3175.03(a) (2)	Ariz. Rev. Stat. § 20-3502(B)(1)	Ind. Code 27-8-5-15.8(d)(1)	36 Okla. Stat. § 6060.11(E)(1)		Dir. 216 § 1	
Identify all NQTLs	Md. Ins. Code § 15-144(C)(2) (II) ^{xiv}	Del. Code §§ 3343(g)(2), 3571U(2)	215 ILCS § 5/ 370c.1(k) (5)	C.R.S.A. § 10-16-147(2)(c)	N.J. Rev. Stat. § 26:25-10.8(c)(2)	P.A. 19-159 § 1(b)(2)	D.C. Code § 31-3175.03(a) (3)	Ariz. Rev. Stat. § 20-3502(B)(2)	Ind. Code 27-8-5-15.8(d)(2)	36 Okla. Stat. § 6060.11(E)(2)	40 Penn. Stat. § 604.2-B(B)(1)	Dir. 216 § 2	Part I
Identify factors considered in designing NQTLs	Md. Ins. Code § 15-144(E)(1)	Del. Code §§ 3343(g)(3) (a), 3571U(3)(a)	215 ILCS § 5/ 370c.1(k) (6)(A)	C.R.S.A. § 10-16-147(2)(d)(II)(A)	N.J. Rev. Stat. § 26:25-10.8(c)(3)(a)	P.A. 19-159 § 1(b)(3)(A)	D.C. Code § 31-3175.03(a)(4)(A)		Ind. Code 27-8-5-15.8(f)(1)	36 Okla. Stat. § 6060.11(E)(3) (a)	40 Penn. Stat. § 604.2-B(B)(3)	Dir. 216 § 3(a)	
Identify sources/	Md. Ins. Code § 15-144(E)(2)	Del. Code §§ 3343(g)(3)	215 ILCS § 5/ 370c.1(k)	C.R.S.A. § 10-16-147(2)(d)(II)(B)	N.J. Rev. Stat. §	P.A. 19-159	D.C. Code § 31-3175.03(a)(4)(B)		Ind. Code 27-8-5-15.8(f)(2)	36 Okla. Stat. § 6060.11(E)(3)	40 Penn. Stat.	Dir. 216 § 3(b)	

Legal Action Center (11.18.20)

Carrier Compliance Reporting Requirements for Non-Quantitative Treatment Limitations

	MD ⁱ	DE ⁱⁱ	IL ⁱⁱⁱ	CO ^{iv}	NJ ^v	CT ^{vi}	D.C. ^{vii}	AZ ^{viii}	IN ^{ix}	OK ^x	PA ^{xi}	LA ^{xii}	CA ^{xiii}
evidentiary standards used to define/ establish NQTLs		(b), 3571U(3)(b)	(6)(B)		26:2S-10.8 (c)(3)(b)	§ 1(b)(3)(B)				(b)	§ 604.2-B(B)(3)		
Comparative Analysis of parity “as written”	Md. Ins. Code § 15-144(D)(1)(I)	Del. Code §§ 3343(g)(3) (c), (e), 3571U(3)(c), (e)	215 ILCS § 5/ 370c.1(k) (6)(C), (E)	C.R.S.A. § 10-16-147 (2)(d)(II)(C) and (E)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(c), (e)	P.A. 19-159 § 1(b)(3) (C), (E)	D.C. Code § 31-3175.03 (a)(4)(C), (E)	Ariz. Rev. Stat. § 20-3502(B)(3)	Ind. Code 27-8-5-15.8(f)(3)(A)	36 Okla. Stat. § 6060.11(E)(3) (c)	40 Penn. Stat. § 604.2-B(B)(4)	Dir. 216 § 3(c)	
Comparative Analysis of parity “in operation”	Md. Ins. Code § 15-144(D)(1)(II)	Del. Code §§ 3343(g)(3) (d) - (e), 3571U(3)(d) - (e)	215 ILCS § 5/ 370c.1(k) (6)(D), (E)	C.R.S.A. § 10-16-147 (2)(d)(II)(D) and (E)	N.J. Rev. Stat. § 26:2S-10.8 (c)(3)(d), (e)	P.A. 19-159 § 1(b)(3) (D), (E)	D.C. Code § 31-3175.03 (a)(4)(D), (E)	Ariz. Rev. Stat. § 20-3502(B)(3)	Ind. Code 27-8-5-15.8(f)(3)(B)	36 Okla. Stat. § 6060.11(E)(3) (d)	40 Penn. Stat. § 604.2-B(C)	Dir. 216 § 3(d)	
Process to comply with disclosure	Md. Ins. Code § 15-144(E)(7)			C.R.S.A. § 10-16-113(3)(c) ^{xv}							40 Penn. Stat. § 604.2-B(D)		
Forms/ Templates		Yes ^{xvi}		Yes ^{xvii}			Yes ^{xviii}						Yes ^{xix}

ⁱ Md. Ins. Code § 15-144 (2020), <https://legiscan.com/MD/text/HB455/id/2170865/Maryland-2020-HB455-Engrossed.pdf>.

ⁱⁱ Del. Code § 3343; 3571U; 18 Del. Admin. Code § 1410 and App. 1; DDI Guidance Concerning Providing the Information Required on the NQTL Portion of the Data Collection Tool for Mental Health Parity Analysis, <https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/06/NQTL-Guidance-and-Worksheet-FINAL.pdf>; SB 230 (2018).

ⁱⁱⁱ 215 ILCS § 5/370c.1; SB 1707 (2018).

^{iv} Colo. Rev. Stat. Ann. § 10-16-147; HB 19-1269 (2019); 3 Code Colo. Reg. 702-4-2-64 (2020).

^v N.J. Rev. Stat. § 26:2S-10.8; AB 2031 (2019).

^{vi} Conn. Gen. Stat. Ann. Pub. Act 19-159 (2019); H.B. No. 7125; Conn. Gen. Stat. § 38a-514c. (2020).

^{vii} D.C. Code § 31-3175.03; B22-0597 (2019).

^{viii} Ariz. Rev. Stat. 20-3502 (2020), <https://www.azleg.gov/legtext/54leg/2R/laws/0004.htm>. While this statute does not explicitly require all of the same elements as most of the other states, the enacted legislation does direct the department of insurance to “[r]eview the United States department of labor’s self-compliance tool for the mental health parity and addiction equity act and other reasonable and applicable resources” when “developing the forms, worksheets or other means that health care insurers must use to prepare the reports required by section 20-3502, Arizona Revised Statutes, as added by this act.” SB 1523, Sec. 8(C)(2) (2020). Although a full report is only required every three years, carriers are required to attest annually that their plans comply with the Parity Act and to submit a summary of any changes. Ariz. Rev. Stat. 20-3502(E).

^{ix} Ind. Code 27-8-5-15.8 (2020).

^x 36 Okla. Stat. § 6060.11 (2020), http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENR/SB/SB1718%20ENR.PDF.

^{xi} H.B. 1696. To be codified at 40 Penn. Stat. § 604.2-B (2020), <https://www.legis.state.pa.us/CFOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2019&sessInd=0&billBody=H&billTyp=B&billNbr=1696&pn=3630>.

^{xii} Louisiana Dep’t. of Ins., Directive 216 (Sept. 9, 2020), <https://www.lidi.la.gov/docs/default-source/documents/legaldocs/directives/dir216-cur-mentalhealthparityre>.

^{xiii} Cal. Dep’t. of Ins., Mental Health Parity Supporting Documentation Instructions (2019), <https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/upload/Instructions-for-Mental-Health-Parity-Supporting-Documentation-Template.pdf>.

^{xiv} The law requires identification of NQTLs, as defined by federal law, that are applied to mental health, substance use disorder and medical/surgical benefits. Md. Ins. Code § 15-144(A)(6). The NAIC template, which the MIA is required to use as a starting point for the reporting requirements, does not include all of the NQTLs. S.B. 344/H.B. 455, Section 2 (2020).

^{xv} The statute mandates how plans comply with disclosure requirements, rather than asking plans to describe how they comply.

^{xvi} Del. Dep’t. of Ins., Reporting Form for Medical Management Protocols for Insurance Coverage for Serious Mental Illness and Drug and Alcohol Dependency Pursuant to 18 DE Admin. Code 1410 (2020), <https://delawaregov-search.clients.us.funnelback.com/s/redirect?collection=delaware-meta&url=https%3A%2F%2Finsurance.delaware.gov%2Fwp-content%2Fuploads%2Fsites%2F15%2F2020%2F06%2FReg-1410-Mental-Health-Parity-Reporting-Form.docx&auth=tYDC6fUGK0GGBS%2BZnxhRSQ>.

^{xvii} 3 Code Colo. Reg. 702-4:4-2-64, App. A-K (2020)..

^{xviii} Available upon request from D.C. Dep’t of Insurance, Securities & Banking (DSIB).

^{xix} Cal. Dep’t. of Ins., Mental Health Parity Analysis Workbook (Apr. 5, 2019); Cal. Dep’t of Ins., Mental Health Parity Supporting Documentation Template (Apr. 5, 2019), <https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/index.cfm>.

ATTACHMENT 3

Carrier Quantitative Data Reporting Requirements

Data Requests ⁱ	MD ⁱⁱ	CO ⁱⁱⁱ	CT ^{iv}	DC ^v	MA ^{vi}	NY ^{vii}	OR ^{viii}	TX ^{ix}	VT ^x
Frequency	Every two years for two cycles	Annual	Annual	Annual	Annual	Biennial	1-time report	1-time report	Annual
Plans Included	Each carrier's 5 plans with the highest enrollment for each product	All	All	All	All	All	All		All
Beneficiaries Receiving Care	Number of claims by parity category	Number of claims paid by benefit classification	Number, percent of patients by level of care	Number of patients treated for OUD	Number, amount of services requested; number of claims				Number, percent of patients receiving inpatient and outpatient care
Claim Denials	Number and rate of denial by parity category and reason	Number of claims denied by benefit classification and reason	Number, percent of denials and reason	Rates of and reasons for denials and timeframe for denial	Number of denials and reasons	Number of denials		Number of denials based on medical necessity or experimental	
Medical Management Standards/ Medical Necessity Criteria			Specify if UR/denial/appeal is based on medical necessity	Specify if denial is based on medical necessity			UM procedures for office-based visits		
Prior Auth. or Ongoing Auth. Requirements	Frequency and rate of received, approved, and denied	Number approved and denied by benefit classification and reason	Total number	Number requested, approved, denied by benefit classification		Rate of requests and outcome		Number of benefits subject to prior auth. or utilization review.	Number and percent denied

Carrier Quantitative Data Reporting Requirements

Data Requestsⁱ	MDⁱⁱ	COⁱⁱⁱ	CT^{iv}	DC^v	MA^{vi}	NY^{vii}	OR^{viii}	TX^{ix}	VT^x
Concurrent Review Standards		Number approved and denied by benefit classification and reason	Total Number			Rate of review and outcome			Number and percent of denied
Appeal Rates and Reversals			Number, rate and reason		Number, rate and outcomes	Rate and outcomes		Number of internal appeals and outcomes; number of external review and outcomes	Number of appeals
Standards for Provider Network Admission, including Reimbursement Rates		Number of providers required to furnish covered benefits; reimbursement data by provider type, service type and code, including minimum, median, maximum and percent of Medicare.	Claims expenses per member per month for inpatient and outpatient services	Describe efforts to ensure in-network capacity to treat OUD meets the need		Percentage of in-network and out-of-network claims Number and type of in-network provider; any other data to evaluate network adequacy and reimbursement rates	Reimbursement rates for time-based procedural codes for in-network mental health and medical providers		
Restrictions that Limit the Scope or Duration of Benefits			Number of providers located in each county by type						Average length of stay and number of sessions

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Carrier Quantitative Data Reporting Requirements

ⁱ See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii) (list of non-quantitative treatment limitations).

ⁱⁱ HB 455/SB 334 codified at Md. Ins. Code § 15-144 (2020), <https://legiscan.com/MD/text/HB455/id/2170865/Maryland-2020-HB455-Engrossed.pdf>.

ⁱⁱⁱ COLO. REV. STAT. § 10-16.147(2)(A); 3 Code Colo. Regs. 702-4:4-2-64 and Appendices A-K (2020).

^{iv} CONN. GEN. STAT. §§ 38a-478c, 38a-478l; Conn. Dept. of Insurance, “Consumer Report Card On Health Insurance Carriers in Connecticut,” 52-63 (Oct. 2019), https://portal.ct.gov/-/media/CID/1_Reports/2019-ConsumerReportCard.pdf?la=en.

^v D.C. Code §§ 31-3175.03, 7-3202.

^{vi} M.G.L. ch. 26, § 8K, and ch. 176O, §7(b)(5); 958 Mass. Code. Regs. 3.600; Div. of Insurance Bulletin 2013-06, <https://www.mass.gov/files/documents/2017/11/22/Bulletin%202013-06%20%28Mental%20Health%20Parity%29.pdf>.

^{vii} N.Y. Ins. Law § 343 (2019).

^{viii} SB 860 (2017), <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB860> (to be repealed Jan. 2, 2021).

^{ix} HB 10 § 3 (2017), <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/HB00010F.pdf#navpanes=0>. Pre-publication proposed rules to enforce HB 10 would require data reporting for MH/SUD and medical/surgical benefits related to: (1) number of enrollee complaints on covered benefits, accessibility and availability of covered benefits, quality of care, dollar amount of insurer payments or balance billing, claims processing, utilization review; (2) number of appeals of adverse determinations, resolution of external review, and adverse determinations subject to peer-to-peer review and resolution of reviews; (3) reimbursement rates for physicians compared to psychiatrists for common CPT codes and reimbursement rates for other providers. <https://www.tdi.texas.gov/rules/documents/mhpcvrltr2.pdf>.

^x 18 V.S.A. § 414a; Regulation 2000-3-H.

ATTACHMENT 4



State of California
Office of the Attorney General

XAVIER BECERRA
ATTORNEY GENERAL

October 15, 2020

Kaiser Foundation Health Plan, Inc.
1 Kaiser Plaza
Oakland, CA 94612

RE: Californians' Access to Mental Healthcare

Dear Partner:

As the Attorney General, it is my job to protect the health and welfare of all Californians, including those suffering from mental illness. One out of every six Californians experience some type of mental illness.¹ In 2014, the Patient Protection and Affordable Care Act (“ACA”) greatly expanded access to mental health treatment across the country. It did so by classifying certain mental health and substance use disorder services as “essential health benefits” for small group and individual plans and by prohibiting pre-existing condition bans. California’s laws, such as the recently signed SB 855, complement the ACA and further expand coverage of mental health and substance use disorder conditions, not only for individual and small group plans but large group plans as well.

Despite such efforts, recent polling reflects that many Californians still have limited access to appropriate mental healthcare with two thirds of those surveyed reporting that they or a family member sought mental health services but were unable to get them.² This is likely why, as of December of 2019, the top health issue Californians want the state to address is ensuring access to mental health treatment.³

¹ Wiener, *Breakdown: California’s mental health system, explained* (April 30, 2019) Cal Matters. Available at <https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/>

² Hamel, et al., *The Health Care Priorities and Experiences of California Residents: Findings from the Kaiser Family Foundation/California Health Care Foundation California Health Policy Survey* (January 2019) Kaiser Family Foundation. Available at <https://www.chcf.org/wp-content/uploads/2019/02/HealthCarePrioritiesExperiencesCaliforniaResidents.pdf>

³ Ben-Porath, et al, *Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey* (February 2020) California Health Care

The current COVID-19 pandemic only further amplifies the importance of access to and coverage of mental health treatment. The virus and measures taken to address it have exacerbated mental health conditions while also causing a reduction in access to services.⁴ It is thus more important than ever that we continue to remove whatever impediments exist to necessary mental health care.

Both California and the federal government have recognized the importance of mental healthcare and sought to address potential barriers through parity laws. Mental health parity laws, including the California Mental Health Parity Act, the federal Mental Health Parity and Addiction Equity Act of 2008, and the ACA, which greatly expanded the 2008 law, generally require insurers to provide coverage for medically necessary treatment of mental disorders without limitations or conditions more restrictive than those for medical illnesses. Despite such parity laws, many Californians with insurance are exponentially more likely to go out of network for mental health treatment than they are for medical services.⁵ My office and I are committed to investigating and ensuring compliance with these laws to protect the mental health and wellbeing of all California residents.

To further this goal, we are collecting information and documents to identify industry or individual practices that may impede access to mental healthcare. This includes, for example, reimbursement rates for mental health providers, clinical guidelines used to determine medical necessity, provider network information, claim and preauthorization data, and provider contracts and credentialing requirements. Please provide the information and documents listed in “Attachment A” to the Attorney General’s office by November 16, 2020.

Foundation p. 4. Available at <https://www.chcf.org/publication/mental-health-tops-californians-health-care-priorities-in-statewide-survey/>

⁴ Malapani, *COVID-19 and the Need for Action of Mental Health* (May 25, 2020) Columbia University Department of Psychiatry. Available at <https://www.columbiapsychiatry.org/news/covid-19-and-need-action-mental-health>

⁵ Melek, Davenport, and Gray, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (November 19, 2019) Milliman Research Report, p. 38. Available at http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

Kaiser Foundation Health Plan, Inc.

October 15, 2020

Page 3

Please contact Deputy Attorney General Martine D'Agostino at Martine.DAgostino@doj.ca.gov to coordinate. Thank you in advance for your cooperation.

Sincerely,

A handwritten signature in blue ink, appearing to read "Martine D'Agostino", is written above a dashed horizontal line.

Attorney General

Attachment A

1. Provide aggregate data regarding the number of approvals and denials (partial or full) for all preauthorization requests made at any time between January 1, 2018 to the present. This request is limited to fully insured commercial business. Separate the information by the service, medication or equipment for which coverage is requested, procedure code(s) associated with the service, medication or item, and into groupings for either behavioral health or medical diagnosis. Also delineate the number of administrative denials versus those for lack of medical necessity. Please use the following charts as an example:

Preauthorization Requests for Behavioral Health Diagnoses

Service/Item for which Coverage Requested	Procedure Code(s)	No. Approved	No. Denied	Denial Basis	
				Admin.	Lack of Med. Nec.

Preauthorization Requests for Medical Diagnoses

Service/Item for which Coverage Requested	Procedure Code(s)	No. Approved	No. Denied	Denial Basis	
				Admin.	Lack of Med. Nec.

2. Provide aggregate data regarding the number of claims paid or denied for all made at any time between January 1, 2018 to the present. This request is limited to fully insured commercial business. Separate the information by the service, medication or equipment for which payment was requested, procedure code(s) associated with the service, medication or item, and into groupings for either behavioral health or medical diagnosis. Also delineate the number of administrative denials versus those for lack of medical necessity. Please use the following charts as an example:

Claims for Behavioral Health Diagnoses

Service/Item for which Payment Requested	Procedure Code(s)	No. Paid	No. Denied	Denial Basis	
				Admin.	Lack of Med. Nec.

Claims for Medical Diagnoses

Service/Item for which Payment Requested	Procedure Code(s)	No. Paid	No. Denied	Denial Basis	
				Admin.	Lack of Med. Nec.

3. List the average contracted reimbursement rates and the average rates actually paid for (1) office visits and (2) evaluations, under fully insured commercial plans or policies, with the following specialists between January 1, 2018 to the present:
 - Child and adolescent psychiatrists
 - Geriatric psychiatrists
 - Addiction psychiatrists
 - Forensic psychiatrists
 - General psychiatrists
 - Psychologists (Ph.d, PsyD, Ed.D)
 - Social workers
 - Substance abuse counselor (CADC)
 - Marriage and family therapists
 - Psychiatric nurse practitioners
 - Psychiatric nurses (PMHN)
 - Applied behavioral analysis provider
 - Primary care physicians
 - Occupational therapists
 - Physical therapists
 - Speech therapists
 - Respiratory therapists
 - Physician's assistants
 - Nurse practitioners
 - Geriatricians
 - Neurologists
 - Pain management physicians
4. Provide exemplars of each contract into which any healthcare practitioner has entered to become an in-network provider for fully insured commercial plans or policies that was created or in effect any time between January 1, 2018 and the present. This request does not include contracts with facilities but does include contracts with medical groups.
5. Provide templates used for contracts through which all different types of healthcare facilities have become an in-network provider for fully insured commercial plans or policies that was created or in effect any time between January 1, 2018 and the present.
6. Provide all contracts with any entities to which utilization management of mental health and substance abuse services and/or medication was delegated, such as to any mental

health service administrators, for fully insured commercial plans or policies and which were created or in effect at any time between January 1, 2018 and the present.

7. Provide a description of the credential requirements which each specialty type of mental health and/or substance abuse treatment practitioner must meet before they can contract to be an in-network provider for fully insured commercial plans or policies and which were created or in effect at any time between January 1, 2018 to the present.
8. Provide a description of the credential requirements which each specialty type of medical treatment practitioner must meet before they can contract to be an in-network provider for fully insured commercial plans or policies and which were created or in effect at any time between January 1, 2018 to the present.
9. Provide a description of all processes in place to assure accuracy of network provider information available to insureds or health plan members of fully insured commercial plans or policies, including accuracy of in-network status, provider contact information, and provider availability for new patients.
10. Provide all documents created at any time between January 1, 2018 and the present which reflect the results of any audit or investigation into the accuracy of network provider directory information.
11. Provide all policies governing what actions are taken when consumers in fully insured commercial plans or policies complain of inaccurate provider network information. This includes training materials, written procedures, and workflows.
12. Provide a description of all oversight and audit measures of any entity to which utilization management of mental health and substance abuse services and/or medication has been delegated for fully insured commercial plans or policies, such as any mental health service administrators.
13. Provide all policies relating to all oversight and audit measures of any entity to which utilization management of mental health and substance abuse services and/or medication has been delegated, such as any mental health service administrators.
14. Provide a description of all efforts currently taken to assure compliance with non-quantitative treatment limitation parity requirements.
15. Provide a description of all efforts currently taken to assure compliance with quantitative treatment limitation parity requirements.
16. Provide a list of all of the specialists or facilities with whom a letter of agreement or single case use agreement was entered for the provision of a mental healthcare or substance abuse service to a fully insured commercial plan or policy member at any time

between January 1, 2018 and the present, with corresponding description of the services each contracted to provide and the city in which they practice or operate.

17. Provide all utilization management clinical criteria for fully insured commercial plans and policies, including those used internally or by any entity to which any utilization management has been delegated, separated by those for medical versus those for mental health and substance abuse treatment. Provide both, current versions of these documents and any substantively different versions that will be in effect in 2021.
18. Provide a list of all medical services for which preauthorization is currently required by name and associated procedure code(s). This request is limited to fully insured commercial plans and policies. Please see the following example:

Name of Medical Service for which Preauthorization is required	Associated Procedure Code(s)

19. Provide a list of all mental health and substantive abuse services for which preauthorization is currently required by name and associated procedure code(s). This request is limited to fully insured commercial plans and policies. Please see the following example:

Name of Mental Health Service for which Preauthorization is required	Associated Procedure Code(s)

20. Provide a list of all medical services for which concurrent reviews are currently required by name and associated procedure code(s). This request is limited to fully insured commercial plans and policies. Please see the following example:

Name of Medical Service for which concurrent review is required	Associated Procedure Code(s)

21. Provide a list of all mental health and substantive abuse services for which concurrent reviews are currently required by name and associated procedure code(s). This request is limited to fully insured commercial plans and policies. Please see the following example:

Name of Mental Health Service for which Preauthorization is required	Associated Procedure Code(s)

22. Provide the number of denials of in-patient mental health treatment coverage through a concurrent review which occurred at any time between January 1, 2018 to the present, where the denied member or insured was subsequently admitted for in-patient mental health treatment within 30 days of the denial, 60 days of the denial, and 90 days of the denial. This request is limited to fully insured commercial health plans or policies.
23. Describe the practices or data trends that can result in a deviation from standard utilization review policies and practices applied in a fully insured commercial health plan or policy utilization review, regardless of whether the deviation from a standard policy is done by a health plan directly or by a delegate entity.
24. Provide the number of internal appeals made at any time between January 1, 2018 to the present, regarding a denial of coverage for a mental health or substance abuse treatment. This information should be separated by treatment for which coverage was denied, whether the initial denial was administrative or for lack of medical necessity, and reflect the amount that resulted in a full overturn versus a fully or partially upheld denial. This request is limited to fully insured commercial plans or policies. Please use the following charts as an example:

Denied Treatment	No. of Appeals Upheld	No. of Appeals Overturned

25. Provide the number of grievances made at any time between January 1, 2018 to the present, regarding an inability to access any mental health or substance abuse treatment. This information should be separated by the treatment which the member or policy holder is having trouble accessing and is limited to fully insured commercial plans or policies. Please use the following charts as an example:

Treatment at Issue	No. of Grievances

26. List the types of providers (including generalists, specialists, and facilities) with whom you contract for inclusion as an in-network provider for fully insured commercial plans and policies and provide the number for each type currently contracted as an in-network provider.