2023 Interim Report on Nonquantitative Treatment Limitations and Data

SB 334/Ch. 212(3), 2020; HB 455/Ch. 211(3), 2020

(MSAR # 12745)

Kathleen A. Birrane
Commissioner

December 1, 2023

For further information concerning this document, please contact:

David Cooney
Associate Commissioner, Life & Health Division
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
410.468.2215

This document is available in alternative format upon request
from a qualified individual with a disability.
TTY 1.800.735.2258

The Administration's website address: insurance.maryland.gov

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Executive Summary

The Maryland Insurance Administration ("MIA") is issuing this Interim Report on Nonquantitative Treatment Limitations ("NQTLs") and Data to summarize the findings of the reviews of the mental health parity reports submitted by health insurance carriers on March 1, 2022 under § 15-144 of the Insurance Article, and to make preliminary recommendations regarding potential ways to improve the efficiency and effectiveness of the reports. The purpose of the mental health parity reports is to require carriers to demonstrate that any limitations applied to benefits for mental health and substance use disorders under insured health benefit plans are comparable to, and applied no more stringently than, the limitations applied to medical and surgical benefits.

Key findings:

- Analysis reports, data supplements, and data reports were submitted for 213 plans from 17 different health insurance carriers. A typical completed report for a single plan from a carrier extended over two hundred pages, including attachments and data supplements. In addition, for some plans, spreadsheets containing over a thousand pages of data were provided as well.
- The MIA engaged in extraordinary efforts to provide comprehensive, detailed, and specific regulatory guidance to carriers in advance of the reporting deadline on how to properly complete the reports and conduct a sufficient analysis to demonstrate parity in coverage of mental health and substance use disorder benefits.
- Despite those efforts, the MIA determined that the reports submitted by carriers were uniformly and significantly inadequate, impeding the ability to reach parity determinations.
- The regulatory review process to determine parity is resource intensive and time consuming, and the complexity of the reviews, combined with the extent of the filing deficiencies and persistent staffing challenges, hindered progress on the reviews.
- Upon receiving the deficient reports, the MIA sent very detailed insufficiency letters to each carrier, which contained hundreds of comments outlining the specific information and data that was needed to make a parity determination, along with examples. The initial review of the first plan consumed 300 staff hours, with a deficiency letter of 63 single-spaced pages and over 300 objections, including sub-comments.
- The MIA issued three Orders for late filing of reports, (pursuant to § 15-144(l)) with penalties ranging from $30,000 to $100,000. To date, three additional Orders have been issued for incomplete reports (pursuant to § 15-144(j)), with more Orders expected to follow. Penalties for incomplete reports ranged from $150,000 to $500,000, and carriers requested hearings on all three Orders. No final parity determinations have been reached as of the publication of this report because the information statutorily required which would allow the MIA to make such a determination has not been provided, despite direct requests and repeated instruction by the MIA to the carriers.
- The experience in Maryland reflects the considerable difficulties with obtaining sufficient analyses of NQTLs that state and federal regulators are encountering nationwide. Even though federal mental health parity laws have been in effect for more than a decade, and increasingly detailed guidance has been published by state and federal regulators, carriers

continue to struggle to provide the level of detail that regulators have uniformly concluded is necessary to make a parity determination.

- National parity review best practices are shifting to a greater focus on data outcomes, as reflected in recently published federal Proposed Rules.

The MIA offers several recommendations for options to streamline the reporting process to make the reviews more effective and efficient in order to improve the ability of regulators to reach substantive conclusions on parity compliance. Recommendations include granting the MIA greater enforcement authority and discretion on: the frequency and number of reports required to be filed; the specific NQTLs that should be subject to the reporting requirements; the structure and content of the standard reporting forms and data; and additional options for corrective actions.

Legislative History

House Bill 455, Chapter 211/Senate Bill 334, Chapter 212 of the Acts of 2020 ("House Bill 455/Senate Bill 334") established a new reporting requirement related to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act").[1] Specifically, § 15-144 of the Insurance Article requires health insurance carriers to demonstrate compliance with the Parity Act by providing information to the MIA on NQTLs and data related to health benefit plans offered in certain markets in the State.

The NQTL reports require carriers to conduct and provide the results of a comparative analysis demonstrating that the processes, strategies, evidentiary standards, or other factors used in applying each NQTL to mental health and substance use disorder ("MH/SUD") benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying each NQTL to medical and surgical ("M/S") benefits within the same Parity Act classification. There are six Parity Act classifications. § 15-144(a)(8). Section 15-144(e) outlines seven steps that carriers must complete to conduct the NQTL analysis.

In addition to requiring parity between MH/SUD benefits and M/S benefits with respect to NQTLs, the Parity Act and associated Maryland laws also require parity with respect to financial requirements (i.e., cost-sharing) and quantitative treatment limitations (i.e., any benefit limitation that can be expressed numerically). Under the federal Parity Act regulations, the test to determine parity for financial requirements and quantitative treatment limitations is different from the comparability and stringency test for NQTLs that employs the comparative analysis process described above. Determining parity for financial requirements and quantitative treatment limitations is a significantly more straightforward process than the NQTL parity analysis, and the process has been understood and effectively applied by both carriers and regulators for many years.

In contrast, in the years following the enactment of the Parity Act in 2008, state regulators and carriers have continually grappled with identifying best practices for the NQTL

[1] Pub. L. No. 110-460

parity analysis. In recognition of the need for more substantive federal guidance as to the interpretation and application of NQTLs, the 21st Century Cures Act ("Cures Act") (Pub. L. No. 114-255 [HR 34], December 13, 2016, 130 Stat 1033) (*see, e.g.,* § 13001(a)) required federal agencies to issue clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that plans and issuers may use regarding the development and application of NQTLs.

While the federal agencies responsible for enforcing the Parity Act had previously issued a set of Frequently Asked Questions ("FAQs") related specifically to NQTLs on October 27, 2016, more comprehensive NQTL guidance was published following passage of the Cures Act. This included a series of additional FAQs with solicitations for public comments, and then, on April 23, 2018, the United States Department of Labor ("DOL") published a detailed Self-Compliance Tool for the Parity Act, and committed to periodically update this tool.[2] The Self-Compliance Tool includes a section describing best practices for NQTL analyses, which closely mirrors the analysis process described in § 15-144 of the Insurance Article.

The seven-step analysis process required by § 15-144(e) was consistent with existing federal best practices guidance in 2020, but it was not expressly required under federal law at the time. However, less than a year after the passage of House Bill 455/Senate Bill 334, the United States Congress enacted the Consolidated Appropriations Act of 2021 ("CAA"),[3] which codified a requirement for health plans and carriers to conduct and document a comparative analysis of the design and application of all NQTLs imposed by the plan. The comparative analysis described in the CAA followed the same process outlined in the DOL Self-Compliance Tool and § 15-144 of the Insurance Article. The CAA also required health plans and carriers to make their comparative analyses available to applicable federal and state agencies upon request beginning on February 10, 2021. Thus, with the passage of the CAA, the required process for performing and documenting an NQTL comparative analysis under federal law aligned with Maryland law.

Section 15-144 of the Insurance Article requires carriers to report the required information on NQTLs and data to the MIA on March 1, 2022 and March 1, 2024, and make the reports publicly available in summary form on the carrier's website. The statute also required the MIA, by December 31, 2021, to develop standard forms that carriers must use for the NQTL report, data report, and public summary form, and adopt regulations to ensure uniform definitions and methodology for the reporting requirements. The statute requires the MIA to review each report to assess each carrier's compliance with the Parity Act, and authorizes or requires the MIA to take different actions if the MIA finds that a carrier failed to comply with the Parity Act or failed to submit a complete report. The statute requires the MIA, in determining an appropriate penalty for a violation, to consider the late filing of a report and any parity violation to be a serious violation with a significantly deleterious effect on the public. This refers to a factor used by the MIA to determine a financial penalty, and would lead to a higher penalty.

House Bill 455/Senate Bill 334 also included uncodified text that stated:

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[2] See https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

[3] Pub. L. No. 116-260 [HR 133], December 27, 2020, 134 Stat 1182

SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Insurance Commissioner shall submit to the General Assembly an interim report on or before December 1, 2023, and a final report on or before December 1, 2025, in accordance with § 2–1257 of the State Government Article, that:

(1) summarize the findings of the Commissioner after reviewing the reports required under Section 1 of this Act; and

(2) make specific recommendations regarding:

(i) the information gained from the reports;

(ii) the value of and need for ongoing compliance and data reporting;

(iii) the frequency of reporting in subsequent years and whether to report on an annual or biennial basis; and

(iv) based on the carrier reports and other guidance from federal regulators and other states, any changes in the reporting and data requirements that should be implemented in subsequent years, including frequency and content and whether additional nonquantitative treatment limitations should be included in the reporting and data requirements.

Implementation of Parity Act Reporting in Maryland

Context for the MIA's Regulatory Approach

Prior to the passage of House Bill 455/Senate Bill 334, the MIA had experienced significant challenges in obtaining sufficient documentation of complete NQTL analyses from carriers. Discussions with other state regulators confirmed this was a universal problem for all regulators. When the MIA examined NQTLs in the context of market conduct surveys, complaint investigations, and policy form review, the MIA consistently had to request very specific and detailed information from a carrier over multiple rounds of correspondence. Each successive carrier response typically raised more follow-up questions that required additional explanation, information, and data before a parity determination could be made. The MIA's prior experiences with NQTL analysis demonstrated that it would be critically important to be as detailed and prescriptive as possible when developing the regulations and template forms to implement § 15-144 of the Insurance Article. Consequently, the MIA's goal was to compile and develop the most comprehensive regulatory guidance on NQTL analysis currently available.

Proponents of House Bill 455/Senate Bill 334 had expressed an expectation that requiring carriers to proactively report comprehensive information on every NQTL would reduce the labor costs and time for the MIA's Parity Act review. It was asserted that the law would have the effect of forcing the carriers to perform all of the analysis work up front using uniform methods, thereby eliminating the need for MIA to perform its own analysis of the processes and data. In

this optimistic view, the MIA would merely need to review the reports prepared and submitted by carriers to confirm or validate the carriers' conclusions about parity, and then order appropriate corrective action if needed. The MIA engaged in the efforts described below to help realize this expectation. Appendices B, C, E, and F illustrate the kind and quantum of data requested from carriers in the attempt to ensure that the carriers conducted a thorough analysis before submitting the reports.

Before finalizing the template reporting forms and regulations required under § 15-144, the MIA held four public hearings between November 23, 2020 and November 1, 2021 to consult with all interested stakeholders. The MIA also met with individual stakeholders to discuss specific concerns upon request. At the first public hearing, three panels of experts in the mental health parity field gave formal presentations on issues related to coverage of MH/SUD treatment in the commercial market, and the MIA also invited oral and written comments on the topic of which NQTLs should be subject to the new reporting requirement. For the remaining hearings, the MIA considered further stakeholder feedback on which NQTLs should be subject to the reporting requirement and also solicited public comments on various draft versions of the MIA's proposed regulations, template forms, data supplements, and associated instructions. The MIA received written comments from stakeholders, including consumer advocates and carriers, at every step of the process. Stakeholders submitted preliminary suggestions before the MIA published any draft materials, and then later submitted specific comments to support and critique the MIA's proposed regulations, instructions, and template reporting forms.

In drafting the regulations, instructions and template reporting forms, the MIA considered existing best practices guidance from a variety of sources. While the Maryland legislature was certainly a national leader in enacting Parity Act reporting requirements for comparative analyses from commercial insurance carriers, Maryland was not the first state to take significant regulatory action with respect to NQTLs. Texas, Colorado, Washington and Pennsylvania had all issued guidance or provided template reporting forms or questionnaires related to NQTL analysis by the time the MIA was developing the guidance for Maryland carriers:

Texas – *See, e.g.*, Texas Administrative Code, Title 28, Chapter 21, Subchapter P – Mental health parity;

Colorado – *See, e.g.*, https://doi.colorado.gov/insurance-products/health-insurance/consumer-resources/mental/behavioral-health-and-insurance; Colorado Insurance Regulation 4-2-64 - Concerning Mental Health Parity in Health Benefit Plans;

Washington – *See, e.g.*, https://www.insurance.wa.gov/mental-health-parity; 2020 Wash. Legis. Serv. Ch. 228 (S.H.B. 2338) (West); Wash. Rev. Code Ann., Ins. § 48.44.341 (West 2023); and

Pennsylvania – *See, e.g.*, 2020 Pa. Legis. Serv. Act 2020-89 (H.B. 1439) (Purdon's); Title 40 Pa. Cons. Stat. Ann., Ins. §§ 4301-4304 (West 2023).

Additionally, as noted above, federal agencies, including DOL, had previously issued NQTL compliance guidance. The Maryland Department of Health began performing an annual

analysis of Maryland Medicaid and Children's Health Insurance Program's compliance with the Parity Act in 2018, and published the methodology and results of the annual analyses on the State website.[4] Comprehensive guidance was available from non-governmental entities as well, including nonprofit organizations such as the Kennedy Forum[5] and the National Alliance of Healthcare Purchaser Coalitions.[6]

The MIA considered information from all of these different sources, in addition to the feedback received from Maryland stakeholders, and attempted to draw the best elements from each one to compile the clearest and most detailed guidance possible.

The objective was to make it absolutely clear to the carriers exactly what was required to be submitted in order for a report to be considered complete.

The MIA determined that the most effective approach to providing this guidance was to establish basic standards through formal regulations, and then provide more detailed instructions and examples through sub-regulatory guidance. This approach would allow the MIA to be more nimble in revising the guidance as needed to respond to new issues as they arose. The final regulations adopted under COMAR 31.10.51 on December 7, 2021[7] established uniform definitions for the terms used in § 15-144, and also established broad regulatory standards for the NQTL analysis report, the data report, the public summary form, and the compliance plan carriers must submit under § 15-144 upon a finding by the MIA of noncompliance with the Parity Act.

The MIA elected not to include details about the required content and format of the template reporting forms and associated instructions in the regulations, and instead included language that authorized the MIA to post the forms and instructions on the MIA website. The regulations then expressly required carriers to submit all information to the MIA in the manner and format specified in the standard reporting form and instructions provided on the MIA website.

Finally, the regulations included a section outlining very specific elements that must be included in each NQTL analysis report in order for the report to be considered complete.

Template Reporting Forms

In developing the standard template forms for the NQTL analysis report, data report, and public summary form, there was one constraint on developing the final template for the NQTL analysis report. Specifically, following robust stakeholder discussion during the 2020 Legislative Session regarding the scope of information the MIA should collect to evaluate the NQTL analyses, a compromise provision was included as uncodified text in Section 2 of House Bill 455/Senate Bill 334.

[4] See https://health.maryland.gov/mmcp/Pages/Mental-Health-Parity.aspx.

[5] See https://www.thekennedyforum.org/vision/parity/

[6] See https://www.nationalalliancehealth.org/

[7] See Appendix A

The insurance carriers lobbied vigorously for greater clarity on the identification of the particular NQTLs they would be required to address in the report, and for assurances that the level of information required to be reported in Maryland would not be significantly more burdensome than existing and pending Parity Act reporting requirements in other jurisdictions. Therefore, as a concession to carriers, Section 2 of the bill specified that the standard reporting form the MIA was required to develop for the NQTL analysis report would be the National Association of Insurance Commissioners' ("NAIC") Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations, amended as necessary to incorporate all the requirements of § 15-144 of the Insurance Article. The NAIC Data Collection Tool requested high level descriptions of 13 different categories of NQTLs, but did not include specific fields to request much of the detailed information specified in § 15-144.

Unfortunately, the NAIC Data Collection Tool was rendered obsolete within a year of enactment of § 15-144 due to the Parity Act changes under the CAA and the associated federal guidance described previously. Therefore, it became necessary for the MIA to amend the NAIC Data Collection Tool significantly to fully incorporate the requirements of § 15-144 that were impacted by the CAA changes. Nonetheless, the requirement for the MIA to base the standard Maryland reporting form on the NAIC Data Collection Tool limited the extent of changes the MIA was permitted to make, and ultimately contributed to the presence of certain cumbersome aspects of the standard form. The final template forms developed by the MIA for the NQTL analysis report,[8] data report,[9] and public summary form[10] were posted to the MIA website on December 22, 2021.

The NQTL analysis report form developed by the MIA requires the carrier to list each covered service under the particular plan that is referenced on the report, with an indication of whether the covered service is considered M/S, MH, or SUD. The form then requires the carrier to identify which of the Parity Act benefit classifications and sub-classifications[11] the covered services have been assigned to, with an explanation of the methodology used to assign benefits to each classification or sub-classification. The analysis report form includes separate sections for the carrier to provide information on each of the elements specified in § 15-144(c)-(e) for 14 different categories of NQTLs. For each category of NQTL, the form requires the carrier to complete a seven-step process.

Step 1 requires the carrier to describe the applicable NQTLs it applies under each category, and identify the Parity Act benefit classifications and sub-classifications to which the NQTL applies. The remaining steps of the process follow the seven-step comparative analysis outlined in § 15-144(e), and are described in more detail in a later section of this report. The last

[8] See Appendix B

[9] See Appendix C

[10] See Appendix D

[11] There are six Parity Act benefit classifications: in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency care, and prescription drugs. The template reporting form further divides the outpatient classifications into the following four sub-classifications, which a carrier may use in place of the combined outpatient classifications: in-network outpatient-office visit, out-of-network outpatient-office visit, in-network outpatient-all other items and services, out-of-network outpatient-all other items and services.

section of the template form requires the carrier to describe its process for complying with the Parity Act disclosure requirements.

The blank template form is 40 pages long without the information from carrier responses included. The NQTL categories included on the NQTL analysis report form are:

1) Definition of Medical Necessity;
2) Prior Authorization Review Process;
3) Concurrent Review Process;
4) Retrospective Review Process;
5) Emergency Services;
6) Pharmacy Services;
7) Prescription Drug Formulary Design;
8) Case Management;
9) Process for Assessment of New Technologies;
10) Standards for Provider Credentialing and Contracting;
11) Exclusions for Failure to Complete a Course of Treatment;
12) Restrictions that Limit Duration or Scope of Benefits for Services ;
13) Restrictions for Provider Specialty; and
14) Reimbursement Rates[12]

As stipulated by § 15-144(f), the second standard form, the data report form, requires carriers to provide, for the immediately preceding calendar year, the number of prior authorization requests received, the number and percentage of prior authorization requests approved, the number and percentage of prior authorization requests denied, the number of claims submitted, the number and percentage of claims approved, the number and percentage of claims denied, and the reasons for claim denials. The data is required to be provided separately for MH, SUD, and M/S for each of the Parity Act benefit classifications and sub-classifications.

The third standard form developed by the MIA, the public summary form, provides a plain language explanation of mental health parity, and includes sections for the carrier to insert a summary of the carrier's parity analysis submitted to the MIA for each of the 14 NQTL categories, with any confidential or proprietary information removed. The summary form also incorporates the data report in its entirety, since none of the required information on the data report is considered confidential or proprietary.

In addition to the three standard forms that were expressly identified in § 15-144, the MIA determined that certain data supplement forms would also be needed to document a sufficient comparative analysis. The comparative analysis described in § 15-144(d) and (e) requires a carrier to demonstrate that any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD benefits comply with the comparability and stringency tests of the Parity Act, both "as written" and "in operation." The MIA defined "as written" and "in operation" in COMAR 31.10.51.03.

[12] Although the NAIC Data Collection Tool only listed 13 categories of NQTLs, the MIA decided to add Reimbursement Rates as a 14th NQTL category to align with federal enforcement efforts and in response to stakeholder comments received at the public hearings.

The "as written" analysis focuses on the written policies, procedures, and related documents used in the development and description of an NQTL and the decision of whether to apply the NQTL to a particular benefit. The "in operation" analysis, on the other hand, focuses on the implementation and application of NQTLs in practice. At the time the MIA was developing the reporting regulations and template forms, current federal guidance provided that disparate results or outcomes between MH/SUD and M/S services are not regarded as dispositive of Parity Act noncompliance. Federal guidance was clear, however, in stating that such disparities constitute a warning sign or red flag of potential noncompliance, which warrants further investigation.

Consequently, while collection and analysis of outcomes data cannot prove compliance or noncompliance with the Parity Act by itself, it is an essential and fundamental component of a complete "in operation" comparative analysis. This was the basis for the data report required by § 15-144(f). However, in developing the regulations and template forms to implement the statute, the MIA determined that the particular data points identified in § 15-144(f) did not align well with the types of data that would be necessary to evaluate the in operation analysis for some of the particular NQTL categories included on the template NQTL analysis reporting form.

Therefore, the MIA supplemented the NQTL analysis report and the statutorily required data report with four additional data supplements[13] that carriers were required to complete when responding to Step 5 of the NQTL Analysis Report. Stakeholders representing consumer advocacy groups and employers expressed broad support for the inclusion of the Data Supplements, while insurance carriers were resistant, citing concerns with high administrative costs and potential nonalignment with future reporting requirements from other state and federal regulators.

Data Supplement 1 is required to support the in operation analysis for the NQTLs of prior authorization, concurrent review, retrospective review, and pharmacy services. Some of the information requested in Data Supplement 1 is similar to the information requested in the data report under § 15-144(f), but the data is broken down differently and the requests are more granular. Additionally, Data Supplement 1 requires carriers to report data related to fail-first requirements and member requests to receive services from an out-of-network provider pursuant to § 15-830 of the Insurance Article.

Data Supplement 2 requests specific data on prescription drug formulary exception requests, and is required to support the in operation analysis for the NQTL of prescription drug formulary design.

Data Supplement 3 is required to support the in operation analysis for the NQTL of provider credentialing. Data Supplement 3 requires carriers to report data related to the length of time it takes for a provider to be credentialed, in addition to the percentages of providers who complete the credentialing process, or who withdraw or are rejected at different stages of the process. The data is reported separately for facilities and practitioners.

[13] See Appendix F, which also includes the instructions for completing each Data Supplement.

Finally, Data Supplement 4 is required to support the in operation analysis for the NQTL of reimbursement. Data Supplement 4 requires carriers to report weighted average allowed amounts as a percentage of the national Medicare fee schedule amount for specific CPT codes for four groups of providers: primary care physicians; non-psychiatrist M/S specialist physicians; psychiatrists; and psychologists and clinical social workers.

All four Data Supplements allow comparisons of outcomes data between M/S and MH/SUD. Data Supplements 1-3 were internally developed based on data elements identified as relevant and important by the MIA, and incorporated elements of similar quantitative data templates being used by other states, most notably Texas. Data Supplement 4 was based on the In-Network Reimbursement Rates section of the Model Data Definitions and Methodology form ("MDDM") that was developed for regulators by the Mental Health Treatment and Research Institute ("MHTARI").

In developing the four Data Supplements, the MIA was sensitive to carrier concerns about administrative costs and national uniformity. To reduce carrier administrative costs, the final Data Supplements eliminated several data elements included in earlier drafts, and focus only on the particular data points that the MIA determined would be most useful in evaluating parity. The MDDM form was specifically chosen to evaluate the reimbursement NQTL because it was the closest thing to a national best practices Parity Act data template in existence at the time. The states of Texas[14] and Washington[15] both used the MDDM form in their Parity Act analyses; URAC's Parity Accreditation Standards recognized the form as a best practice; it was endorsed by the National Alliance of Health Care Purchaser Coalitions; and it was validated in two different Milliman studies on reimbursement disparities.[16]

Instructions and Additional Guidance

Final instructions for completing the NQTL analysis report, data report, and data supplements were also posted to the MIA website on December 22, 2021.[17] The instructions expressly state that a carrier may be subject to administrative penalties as specified in § 15-144 if the carrier fails to submit a complete report with all the data and information identified in COMAR 31.10.51 and in the instructions in the manner and format specified.

The instructions begin with an introduction that includes ten specific examples of the types of carrier responses that may result in a finding that a carrier failed to submit a complete NQTL analysis report. Examples included: responses that involve production of documents without a clear explanation of how and why each document pertains to the comparative analysis; generalized and conclusory statements of compliance and mere recitations of the legal standard, without specific supporting evidence and detailed explanations of comparative analyses; and

[14] See https://www.tdi.texas.gov/rules/2021/index.html (Chapter 21, Trade Practices, Subchapter P. Mental Health and Substance Use Disorder Parity, Division 2 Data Collection link, in the middle column)

[15] See Appendix M, section C. Reimbursement Rates, page 13

[16] See https://kr.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/nqtldisparityanalysis.ashx; https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p

[17] See Appendix E for the instructions for the NQTL analysis report and data report.

statements that all standards and processes are the same for M/S and MH/SUD without evidence to substantiate such statements.

The instructions also include additional definitions of terms used in the template forms and instructions, and expressly state that the use of the definitions from COMAR 31.10.51 and the instructions is mandatory when completing the report. The instructions then provide detailed guidance for each required element of the template reporting form. The guidance states precisely what information must be provided, with an explanation of any specific methodologies that must be used to complete the various steps of the analysis. Extensive illustrative examples of expected responses for different NQTLs are also provided for each of the substantive steps of the comparative analysis.

After the regulations, template reporting forms, and instructions were finalized, the MIA provided additional guidance to insurance carriers as the initial March 1, 2022 reporting deadline approached. The MIA issued Bulletin 22-04 on February 1, 2022 to remind carriers of the due date and to specify the submission method for the first set of reports required under § 15-144. In response to carrier concerns of insufficient time to operationalize the system changes needed to gather the data requested in the four Data Supplements, the MIA granted carriers an additional month to submit the Data Supplements, and extended the filing deadline to April 1, 2022 for those items only. The MIA also compiled an FAQ for the reporting requirements based on additional questions received, and posted the document to the MIA website in early February.

Receipt and Review of 2022 Reports

Volume of Reports Received

Section 15-144 requires each carrier to submit a separate analysis report for each of the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small group, and large group markets. The MIA defined "product" in the instructions for the NQTL analysis report and data report as "a package of health insurance coverage benefits identified by a particular network type, limited to health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity." Even with this restrictive definition of product, some Maryland carriers who offered multiple products in each of the three markets would be required to submit separate reports for more than 25 different plans. Other carriers who only participated in certain markets would be required to submit reports for five or fewer plans.

The majority of carriers timely filed reports by the March 1, 2022 and April 1, 2022 deadlines. Altogether, the MIA received NQTL analysis reports, data supplements, and data reports for 213 plans from 17 different health insurance carriers representing seven distinct corporate groups. There was, however, some initial confusion from carriers about which and how many plans required separate reports to be submitted. The MIA exercised enforcement discretion and did not take action against carriers who demonstrated good faith efforts to meet the reporting deadline, but whose reports contained minor submission deficiencies and plan

identification errors.[18] The MIA worked with carriers to resolve these minor errors as quickly as possible to ensure that the correct number of reports were submitted in the required format. More than two dozen letters were sent to carriers during this initial phase of the review to obtain the necessary clarification.

There were six carriers who failed to submit the required number of reports by the statutory deadline. Two of the carriers, National Health Insurance Company ("National Health") and Freedom Life Insurance Company of America ("Freedom Life"), only sell short-term limited duration insurance in Maryland, and do not have a large market presence. While federal Parity Act laws and regulations do not apply to short-term limited duration insurance, Maryland law expressly requires these plans to comply with the Parity Act.

Freedom Life contacted the MIA the day the reports were due to request an extension, which the MIA denied. Freedom Life then submitted the required NQTL analysis reports on March 10, 2022 and submitted the required data reports on April 26, 2022. Having received no reports from National Health, the MIA contacted the carrier on April 6, 2022 to inquire about the late reports. National Health responded that they overlooked the reporting requirement and would complete and submit the reports as quickly as possible. National Health filed the required reports on June 24, 2022. The MIA issued Orders against Freedom Life[19] and National Health[20] for failing to submit the reports by the required due date, imposing penalties of $30,000 and $35,000, respectively.

Four additional UnitedHealth Group carriers (UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance Company, and Optimum Choice, Inc.) also failed to submit the required reports for certain health benefit plans by the filing deadline due to an error in identifying the top ranking plans by enrollment for each product, which the company discovered on February 28, 2022. Reports for the correct plans were not filed until April 1, 2022 and April 29, 2022. Since the late reports for UnitedHealth Group were the result of a single administrative error, the MIA issued one consolidated Order against all four UnitedHealthcare carriers, imposing a penalty of $100,000.[21]

After all the initial filings errors were resolved and the correct plans were identified for each carrier, the breakdown of the 213 plans by carrier, market, and product type was as follows: the most plans submitted by a single carrier was 26 (CareFirst BlueChoice, Inc.), and the fewest plans submitted by a single carrier was three (Freedom Life Insurance Company of America). Across all carriers, reports were submitted for 46 different plans in the individual market, 64 plans in the small group market, and 103 plans in the large group market. The distribution by product type was 63 HMO plans, 37 POS plans, 81 PPO plans, 22 EPO plans, and ten indemnity plans.

[18] Examples of minor deficiencies and errors: submitting the reports in an inaccessible electronic file format; combining multiple plans on a single reporting form when the plans used the same NQTLs; submitting reports for more than the required number of plans; or, for corporate groups with multiple carrier affiliates, failing to identify which reports were applicable to each affiliated carrier.

[19] See Appendix G

[20] See Appendix H

[21] See Appendix I

As indicated previously, the NQTL analysis template report form includes 40 pages of questions. Each question requires the carrier to provide an in-depth response with supporting documentation and data to demonstrate that the carrier is in compliance with respect to each NQTL that is applied to benefits for MH/SUD services. Unsurprisingly, the completed reports and associated supporting documentation were voluminous. A typical NQTL analysis report form submitted by a carrier for a single plan extended over a hundred pages, with additional hundreds of pages for the supporting documentation that was cross-referenced in the report form to substantiate the carrier's statements and conclusions. The data report and the four data supplements were required to use plan-level data, so these five items were also submitted for each plan. Many plans of the same product type for a particular carrier shared common NQTLs, which meant the "as written" analysis would be similar across these plans. Nonetheless, even in this situation, the analysis and materials for each plan still needed to be reviewed to confirm there were no differences. Furthermore, the "in operation" analysis of data had to be examined separately for each plan.

Staffing and Resource Challenges

Despite the large volume of documents and lengthy explanations provided by carriers in the reports, it was immediately apparent from cursory reviews that the reports filed on March 1, 2022 were uniformly inadequate to allow the MIA to make a determination of compliance. Thus, the hope that establishing comprehensive NQTL reporting requirements would reduce the labor costs and time for the regulatory review of Parity Act compliance was, unfortunately, not realized.

The nature of the widespread deficiencies of the reports reflected that additional detailed review and guidance would be needed if the MIA was to obtain the information needed to make a substantive parity determination, rather than simple rejection of the reports for incompletion. Notwithstanding the federal requirement under the CAA for carriers to have conducted and documented their comparative analysis of all NQTLs and to make the analyses available to regulators beginning on February 10, 2021, the reality was that carriers across the nation were still unprepared to do this by the time the reports required under § 15-144 were submitted. Consequently, as the MIA had anticipated, in order to reach a parity determination, significant regulator time and effort was going to be necessary to examine and evaluate the information provided by the carriers and to then provide very detailed, directed, and specific requests for additional follow-up information.

The comparability analysis for each NQTL is multi-faceted, involving complex quantitative and qualitative analysis that requires a highly specialized skill set for the personnel conducting the reviews. A critical, but data intensive, aspect of the compliance analysis includes a focus on a carrier's operations and application of NQTLs, in addition to consideration of written information, policies, and procedures relating to the NQTL's adoption and proposed use/application. The review process is time-consuming and resource-intensive, with repeated exchanges between regulators and carriers necessary in attempting to obtain the information required to reach conclusions on Parity Act compliance.

In addition to the underlying analytical skills that are needed for this work, in-depth technical understanding of mental health parity laws is critical.

There were not many current MIA staff members with the necessary combination of analytical skills, experience, and expert knowledge of Parity Act compliance to review the reports, and those MIA employees who were capable lacked the capacity to take on the onerous task of reviewing these reports in addition to their existing duties. Previous experiences reviewing just one NQTL at a time in the context of complaint investigations and policy form review demonstrated the length of time the analysis process would likely consume. Based on the volume of NQTL reports that were expected to be filed in March of 2022 and the presumed amount of resources that would be needed, the MIA determined that it would be necessary to have full-time staff dedicated solely to reviewing the reports in order to complete the task in a timely manner. The MIA began recruitment efforts for additional full-time staff in 2021, and initially was seeking to fill three full-time permanent positions to perform this work: two high-level compliance analyst positions, and one supervisory director-level position. Unfortunately, the MIA's recruitment efforts for these positions soon confirmed concerns about the dearth of qualified candidates interested in working in the public sector.

After the initial round of recruitments for full-time permanent staff failed to yield any qualified applicants, filling these positions became a priority of the MIA's human resources department. The positions were advertised on numerous free and paid job posting websites, as well as on websites for different insurance regulatory compliance and industry associations. Various paid print and digital advertising options were pursued. MIA staff also proactively searched job recruitment databases for individuals with Parity Act experience who could be contacted directly about the opportunity, and reached out to industry contacts, other regulators in the public and private health care sectors, and MH/SUD consumer advocacy groups to publicize the job opening and solicit referrals to qualified candidates. Internal candidates who were identified as possessing the fundamental required analytical skills and who had familiarity with the Parity Act were encouraged to apply. Recruitment periods were repeatedly extended or changed to "open and continuous" when no qualified applications were received by the initial recruitment closing dates. The job descriptions and minimum qualifications were re-evaluated and modified multiple times in an attempt to broaden the pool of potentially qualified candidates without eliminating the essential knowledge, skills, and abilities. There were four separate recruitments for the Director position alone.

Meanwhile, the MIA also pursued alternative avenues for acquiring assistance in reviewing the reports. Recognizing the urgent need to be prepared to review the NQTL reports immediately upon receipt on March 1, 2022, the MIA was initially hesitant to pursue a contract with an outside consulting firm because of concerns about potential delays due to the lengthy state procurement process. Prior MIA experience suggested that the entire process could take between 12 and 18 months for a new procurement of the size anticipated for this project. The MIA instead evaluated whether it would be possible to amend any existing MIA contracts with vendors and Requests for Proposals ("RFPs") that were already in progress to include assistance with the Parity Act reporting requirements. The MIA also attempted to leverage the expertise of other executive branch agencies and educational institutions in the State, by exploring the possibility of entering into memorandums of understanding ("MOUs") or other arrangements.

Finally, the MIA attempted to recruit part-time temporary employees on a contractual basis. After several months of unsuccessful efforts on all these fronts, the MIA began working on a new separate RFP to obtain a contractor with subject matter expertise in Parity Act compliance and NQTL analysis.

These hiring and recruitment challenges were reflective of the national market in the government sector for individuals possessing the necessary expert knowledge of and experience with the Parity Act to perform and evaluate NQTL comparative analyses. There are not many true subject matter experts in NQTL analysis, and those there are remain in high demand with insurance carriers and regulatory agencies across the country. A significant number of the individuals who do possess the required skills and experience and who are not already employed by insurance carriers are under contract with specialized private consulting firms that offer their services to various state and federal regulatory agencies on a contractual basis.

The MIA had been very fortunate to develop a professional relationship with two of the premiere Parity Act experts in the country when the initial implementation work for House Bill 455/Senate Bill 334 was just getting underway. After giving a presentation at the MIA's first public hearing on § 15-144 and learning more about the MIA's efforts to enforce the Parity Act, these individuals soon agreed to enter into an MOU with the MIA for consulting services to assist in the development of the regulations and template reporting forms. Because the consultants' services were in such high demand, they unfortunately had very limited time to devote to the MIA's work in Maryland. However, the insight they provided for the MIA's regulations, template forms, and instructions was invaluable, and they had offered to continue to assist the MIA once staff was hired to review the NQTL reports by training the new employees and performing limited first-level reviews for a selection of plans.

In early March of 2022, these consultants provided a reference to a colleague who had worked on Parity Act projects with them in the past and who expressed an interest in assisting the MIA in reviewing the NQTL reports. While this individual was only able to commit to the MIA on a part time basis, she was soon hired as a contractual employee assigned to the review of NQTL reports. Two MIA Associate Commissioners collaborated with this employee and the two consultants to implement a process to begin reviewing the reports. Several months later, a second part-time contractual employee with Parity Act experience was hired, and by October of 2022, the MIA had two consultants and two part-time contractual employees actively reviewing the reports with oversight by the two MIA Associate Commissioners. Unfortunately, the combined man hours for the contractual and consulting staff amounted to an average of only 20 hours per week, so additional help was still needed to accelerate completion of the reviews. On December 2, 2022, the MIA issued an RFP to obtain assistance from a consulting firm experienced with NQTL analysis under the Parity Act. While the RFP process progressed over the next year, the MIA's recruitment efforts for full-time positions finally yielded results. On July 12, 2023 the MIA hired a Life and Health Data and Compliance Analyst to review the NQTL reports on a full-time basis, and a few weeks later, on August 9, 2023, the MIA hired a Director of Mental Health Parity and Network Adequacy. Then, in October of 2023, Examination Resources, LLC was awarded the contract for Parity Act consulting services under the December 2, 2022 RFP.

Review Process Strategy

While actively working toward hiring additional staff for the first year and a half following receipt of the reports, the MIA employed strategies to triage and prioritize the reviews. In an effort to achieve the greatest potential positive impact on Maryland consumers, the MIA focused on the reports for the plans with the highest enrollment, starting with the carrier with the largest overall market presence in Maryland. As noted previously, cursory reviews of all the carriers' reports revealed common and widespread deficiencies in the analyses and documentation included with the reports. Additionally, many of the reports submitted by the same carrier contained similar analyses because the carriers' plans within the same product type often shared common NQTLs. Consequently, to ensure the MIA reviews were as efficient as possible, the MIA decided to select one sample plan for each group of affiliated carriers, and then perform an in-depth review of all the NQTLs reported for that sample plan. The MIA would provide specific and detailed feedback to the carrier, and direct the carrier to revise and resubmit all the reports for every plan based on the MIA's guidance regarding the additional analysis and information that was required for the sample plan.

Under § 15-144(j), the MIA possesses authority to impose penalties for failure to submit a complete report based on the initial deficient filings from all the carriers. The MIA also chose to afford each carrier an additional opportunity to submit revised reports in response to the MIA's initial deficiency letter in an attempt to obtain sufficient comparative analyses that would allow the MIA to make a substantive determination on compliance with the Parity Act.

The CareFirst of Maryland, Inc. PPO plan with the highest enrollment was selected as the first sample plan to review. An estimated combined 300 staff hours were required to complete the review of all 14 NQTLs for this single plan, including the associated data report and data supplements. This included the time spent drafting and editing the deficiency letter, as well as meetings between MIA staff and the Parity Act consultants to discuss the analysis of the reports and the draft letter. The final deficiency letter was 63 single-spaced pages with 113 objections, or, if sub-comments are counted separately, over 300 objections. The letter meticulously identified the specific deficiencies for each of the 7 Steps of the required analysis for all 14 NQTLs, and provided statutory support for each conclusion. The comments also provided detailed guidance on the precise additional information that would be needed for the reports to be considered complete, and the letter cited the particular sections of the instructions on the MIA's website that required this information to be submitted. The letter also advised the carrier that the filing may be subject to penalties described in § 15-144(j), and that by requesting additional information and giving a deadline for the response, the MIA was not extending the deadline under the statute for submission of a complete report.

Upon completing the deficiency letter for the CareFirst sample plan, the MIA moved on to the reports for the other four largest carrier groups in Maryland by market share: UnitedHealthcare, Kaiser, Aetna, and Cigna. The MIA selected the largest plan by enrollment for each carrier group, and reviewed the reports for the sample plan following the same process described above for the CareFirst plan. The MIA's experience reviewing the NQTL reports for these other four large carrier groups was disappointingly consistent with the situation of CareFirst. The review of each sample plan consumed an inordinate amount of staff hours, and

with the sustained limits in personnel, progress in the reviews was very slow. The deficiency letters for these four carriers ranged from 70 to 100 single-spaced pages each, with between 98 and 104 objections per letter, or more than 400 objections if sub-comments were counted separately.

For the reports from smaller carriers not associated with these five largest carrier groups, the letters were generally shorter with fewer comments. The shorter length, however, was not a result of the reports being less deficient, but was due to these reports being more likely to completely omit responses or assert that certain NQTLs were not applicable. A detailed description of the common deficiencies exhibited in the carriers' reports is provided in the next section of this report.

Each initial deficiency letter included staggered deadlines for the carrier to submit revised reports for the 14 NQTLs for all plans filed by the carrier. Generally, the MIA required resubmission of reports within 30 days for specific NQTLs the MIA identified as having the greatest impact on member access to care for MH/SUD services (such as prior authorization, reimbursement, and provider credentialing and contracting), with reports for the remaining NQTLs due at various later intervals. While the resubmissions reviewed by MIA staff were slightly improved over the initial filings, they were still uniformly deficient and did not contain sufficient information to allow the MIA to make a parity determination. Additionally, the resubmissions consistently failed to even address a large percentage of the specific issues identified by the MIA in the deficiency letters.

The MIA's next step was to issue an administrative Order finding the carrier in violation of the reporting requirements under § 15-144(c)(1) through 15-144(e) for failing to submit complete reports and impose penalties pursuant to § 15-144(j).

As of the publication of this report, the MIA has issued three Orders against carriers for failure to submit complete NQTL analysis reports:

- On March 13, 2023, the MIA issued MIA-2023-03-020 against CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc., imposing a penalty of $250,000.[22]

- On June 8, 2023, the MIA issued MIA-2023-06-023 against MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc., imposing a penalty of $500,000.[23]

- On September 13, 2023, the MIA issued MIA-2023-09-010 against Kaiser Foundation of the Mid-Atlantic States, Inc., imposing a penalty of $150,000.[24]

All three carrier groups requested a hearing on the MIA's determination, which stays the penalty until the hearing is decided. Although hearings for all three cases have been scheduled

[22] See Appendix J
[23] See Appendix K
[24] See Appendix L

and various motions have been filed, the hearings have not yet been held, and the MIA continues to engage in settlement negotiations with the carriers.

One Consent Order has been executed as of the writing of this report, in which a lowered penalty of $175,000 is agreed upon with CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc., and in which it is agreed that additional information will be provided in accordance with requests from the MIA which would allow it to make a substantive parity determination in connection with the 2024 filing date.

In reviewing the resubmissions from all carriers, the MIA found that it was evident that some carriers put forth more effort in responding to the MIA's information requests than others. Certain carriers proactively worked on additional resubmissions of the reports in an attempt to provide the outstanding information needed by the MIA. While these efforts were appreciated, each iteration of the resubmitted reports still failed to include the level of detail needed to draw conclusions about parity. The MIA met virtually and in person with some carriers to provide a detailed walk-through of a carrier's response to a particular NQTL, in order to provide practical examples of why the carrier's response was deficient and what additional information the MIA would need in order to make a parity determination. While it was not necessary or practical to hold these meetings for every NQTL for each carrier, the meetings were very helpful in certain situations.

Summary of Common Deficiencies in Carrier NQTL Analysis Reports

As stated above, the initial filings by carriers did not include sufficient information from which the MIA could make a finding of substantive compliance with the Parity Act. Unfortunately, the deficiencies were so pervasive and substantial that this was true of every carrier and every NQTL that was audited. Carriers uniformly did not follow the MIA's detailed instructions for the completion of the template forms and data supplements. Some failures to follow instructions were relatively minor, but others were major.

However, it was also noteworthy that the reports did not reveal any glaring disparities between M/S and MH/SUD benefits, or any flagrant violations that could preliminarily be deemed parity violations, such as limitations, restrictions, or exclusions that only applied to MH/SUD benefits.

Rather, the persistent issue was the insufficiency of the comparative analyses to demonstrate that the processes used to design and implement the NQTLs were comparable and no more stringently applied to MH/SUD benefits. Under current Maryland law, failure to provide a sufficient analysis is not grounds for a determination of substantive noncompliance with the Parity Act. Therefore, while § 15-144 authorizes the MIA to impose substantial penalties for failure to submit a complete report, the MIA must ultimately obtain all the necessary data and information related to the comparative analyses in order to have a basis for a final determination regarding compliance with the Parity Act.

This is why it was critical for the MIA to provide detailed guidance to carriers about both large and small areas of deficiency, and make specific requests for corrections. As summarized

below, the deficiencies were extensive at each step of the analysis, and this necessitated comprehensive feedback from the MIA for each item.

Factors, Sources, and Evidentiary Standards

Section 15-144(e) requires that a carrier's analysis include the factors used to determine that an NQTL will apply to a benefit, the sources for the factors, and the evidentiary standards used to define the factors. Factors that were considered, but rejected, and the weighting of factors are also required to be listed. These three terms (factor, source, and evidentiary standards) are defined in COMAR 31.10.51.03B (4), (5) and (16). Examples of the terms are included in the instructions. For example, a factor would be high cost of treatment; a source would be internal claims analysis; and the evidentiary threshold would be the dollar amount at which the NQTL would be applied. Carriers must provide this information in Steps 2 and 3 of the NQTL analysis report.

The MIA's review of carriers' analysis reports found that there was confusion around the terms, but also a failure to include sufficient information. In determining that carriers failed to file complete reports, the MIA did not focus on situations where a carrier provided all the required information, but conflated the terms and, for example, provided a source as a factor or an evidentiary standard as the definition of a factor. Most of the reports, however, lacked sufficient detail in the information, rather than confusing the meaning of the terms; carriers did not include the factor or evidentiary standard, rather than misidentifying it. Still, the MIA did provide an explanation of how to provide correct information in its letters to carriers, for each NQTL and factors identified in the report.

For example, the first NQTL in the report is Medical Necessity. If the carrier included a definition with the criterion "in accordance with generally accepted standards of medical practice", the MIA would view this as a factor. The MIA would then expect that the carrier would list the sources to determine if a service were in accordance with generally accepted standards of medical practice, such as peer reviewed studies, and the evidentiary standard, such as a specific number of peer reviewed studies.

In some reports, the factors were vague and subjective, such as "Promote use of most cost-effective products (generics and/or lower cost brands)." This factor would require a more precise definition, the sources used to determine the cost-effectiveness, and the evidentiary standards to determine if one drug were more cost-effective than another.

The factors, sources, and evidentiary standards are the basic building blocks for an analysis of whether the NQTL is applied no more stringently to MH/SUD than to M/S. Without this information, it is difficult, if not impossible, to determine the comparability. These three elements should lead into the carriers' analysis of compliance. The instructions and definitions were provided to give clarity as to the expectations for these elements.

Comparative Analyses

In general, the reports had disappointing responses for Steps 4 and 5. Step 4 of the NQTL analysis report requires the carrier to provide the comparative analyses performed to determine whether each NQTL is comparable and no more stringently applied as written. Step 5 requires the comparative analyses performed to determine whether each NQTL is comparable and no more stringently applied in operation. There was little substantive analysis provided. If carriers conducted these analyses, the results were not conveyed adequately in their filings to the MIA. In many cases, the responses were conclusory statements that the carrier found that the processes were comparable and no more stringently applied, with little explanation of the analysis leading to that conclusion.

The instructions for Step 4 begin by asking the carrier to indicate how the factors are applied comparably to establish the written policy as to which services are subject to the NQTL. The lack of clarity regarding factors and their definitions made it difficult for carriers to even begin to explain how the factors were applied comparably.

To illustrate the insufficiency of the reports, the MIA's instructions gave examples of responses for Step 4 that included:

- Internal review of published treatment guidelines by appropriate clinical teams (with comparable compositions and qualifications for both MH/SUD and medical/surgical benefits) to identify (using comparable standards and thresholds for both MH/SUD and medical/surgical benefits) covered treatments or services which lack clinical efficacy;

- Internal review to determine that the carrier's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.

Carrier responses for Step 4 for the NQTL of medical necessity criteria repeatedly stated that parity exists between MH/SUD and M/S benefits even if in Step 4 a side-by-side comparison reflected differences in the NQTL. One carrier's response for Step 4 stated, in total:

> [Redacted's] medical necessity coverage policy development and application process is consistent between M/S and MH/SUD. [Redacted] applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services. Compliance is further demonstrated through [Redacted's] uniform definition of Medical Necessity for M/S and MH/SUD benefits.

In this example, evidence-based guidelines would be a factor, but there is no definition, source, or evidentiary standard provided to show how the factor is applied comparably.

The factors listed in Step 2 are clinical efficacy, safety, and appropriateness of the proposed treatment. In Step 3, the carrier stated that it "conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals." The sources and evidentiary standards to determine the evidence-based guidelines would be probative as to whether the process was, in fact, consistent between MH/SUD and M/S, but they were not provided.

The sample carrier response does not follow the MIA's instructions or examples. As with many of the responses, the prior steps do not provide the information to support the conclusion, and if the carrier asserts that an analysis was performed, it is not supplied. Instead, conclusory statements are given with no explanation of the methodology used for the analysis, contrary to the instructions. For some NQTLs, carriers provided a conclusory statement with no additional evidence that a comparative analysis was even performed

Step 5 requires that the carrier provide the comparative analyses performed and relied upon to determine whether the NQTL is comparable and no more stringently applied to MH/SUD than M/S in operation. The MIA's instructions stated that the carrier should include discussions of quality assurance and oversight policies, processes, and metrics that the carrier uses to monitor in operation compliance. The MIA also provided examples of the types of audit reports that were expected in response.

For Step 5, carriers provided more evidence of the analysis conducted to determine compliance. However, responses did not include sufficient detail for the MIA to determine whether the NQTL was applied comparably and no more stringently. Responses usually did not include audits, and lacked specificity as to the type and outcome of the audits that were performed.

For example, one carrier stated that to perform an "in operation" review of the application of the medical necessity NQTL, approval and denial rates for Prior Authorization, Retrospective Review, and Concurrent Review were analyzed across benefit classifications for a sampling of plans. The carrier then stated that the analysis revealed no statistically significant discrepancies in denial rates between MH/SUD and M/S benefits. The carrier concluded that a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits.

In order to assess compliance for this example, the MIA would need to see documentation of the review. The carrier did not provide the size of the sample, the denial rates, or other information. The MIA's instructions for Step 5 state, in part:

> The analyses should include discussion of quality assurance and oversight policies, processes and metrics that the plan applies to monitor in operation compliance. Examples of information to include are results of comparative assessment of denial

rates (both administrative and medical necessity) by service, reviews for correlation between basis for service denials and stated criteria, and internal and/or external appeals and overturn rates.

The sample carrier response provides some results of comparative assessment of denial rates, but not all of the detail requested. There are no audit results provided regarding the frequency of utilization review, or the utilization review documentation requirements, for MH/SUD versus M/S, both examples included in the instructions. The carrier's summary of the review does not include the level of detail and information that would allow the MIA to make a determination of compliance with the Parity Act.

Step 6 applied if a carrier delegated management of MH/SUD benefits to another entity. Most carriers did not. If a carrier delegated some functions, the level of detail varied based on the entity to which the management was delegated, but the carriers still did not follow the instructions to provide sufficient information.

Step 7 of the analysis required disclosure of specific findings and conclusions reached by the carrier that indicated compliance with the Parity Act. The instructions for this step asked carriers to explain why the carrier determined they were in compliance if there were differences between MH/SUD and M/S in previous steps, or if there were disparities in the data supplement forms. The instructions also stated that a general or conclusory statement of compliance was not sufficient.

If the carrier had data that showed a discrepancy, as with some of the data supplement submissions, the carrier generally did not provide an analysis of the discrepancy. Carriers relied on prior guidance from federal agencies that disparities in outcomes are not dispositive of whether there is a violation, and provided no additional explanation for the differences to refute the appearance of potentially greater stringency of application of the NQTL to MH/SUD services. Only general explanations, not tied to an audit or detailed analysis, were provided. Carriers made conclusory statements regarding compliance, but the MIA was not provided sufficient detail to determine if the carriers were in fact in compliance.

Since none of the carriers provided complete analyses for every earlier step for each NQTL, the conclusory statements in Step 7 were particularly problematic and hollow.

Resubmissions

As described previously, the MIA provided detailed guidance to carriers based on its review of the initial filings. Unfortunately, the carriers did not respond to all of the guidance, and did not provide the information requested. In some cases, there was an improvement, and possibly sufficient improvement to determine compliance with regard to specific NQTLs, but not with the entire filing.

There continued to be substantial issues with the identification of factors, sources, and evidentiary standards. If a factor had previously been referred to in Step 4 of the initial filing, but not listed as a factor, it might have been deleted from Step 4 in the resubmission rather than

defined as a factor. Similarly, if the MIA noted that an evidentiary standard was not provided for a listed factor, the carrier may have deleted the factor instead of providing the requested evidentiary standard. Where the MIA had pointed out that a factor that appeared elsewhere in the report was not listed as a factor, the resubmission again did not include the factor. In addition, carriers often failed to provide any narrative response to the MIA's comments to explain why these issues were not addressed in the resubmission. Consequently, it often appeared that the MIA's comments were either overlooked or ignored. As noted previously, without identification of the factors, additional analysis would be unlikely to be able to show compliance.

Carriers did not provide the required analyses with their resubmissions, but continued to rely on conclusory statements. If a copy of the comparative analysis and audits was requested, it typically was not provided. The MIA requested documents to support the findings that led to conclusory statement of compliance, but did not receive the documentation. The MIA met with certain carriers to provide additional guidance, and based on these meetings it did not appear that the failure to file sufficient reports was willful, but the result of failure to fully understand and follow the directions.

Of particular concern, however, is that some carriers not only refused to provide statutorily required information, in disregard of specific instruction from the MIA, but also asserted the information requested is not relevant to a parity determination; this is reflected in the MIA Orders. The *primary* goal of the MIA remains obtaining the information needed in order to make a substantive parity determination, rather than to penalize carriers for incomplete submissions.

However, if carriers continuously refuse to be responsive to the MIA's requests for information or insist upon placing themselves in the role of regulator by determining which regulations require compliance and which do not, the MIA's only recourse to deter such response is to impose significantly higher penalties for future failures to submit complete reports to communicate to the carriers it is in their best interest to comply with the requirements of Maryland law.

Specifically, the amount of the penalty cannot be such that carriers are willing to pay the penalty rather than provide information required on the NQTL reports which could reveal a parity violation—this remains a very real concern of the MIA.

The National Perspective on NQTL Analysis

The MIA's experience reviewing this first round of NQTL reports was characterized by frustratingly slow progress in obtaining necessary information from carriers, resulting in the inability to reach substantive conclusions about parity prior to the submission of this legislative report. While disappointing, the challenges in obtaining sufficient comparative analyses from carriers are not unique to Maryland, and are, in fact, typical of the experiences of other regulators at the state and federal level.

At the state regulator level, the MIA is a member of the NAIC's Mental Health Parity and Addiction Equity Act Working Group, and has participated in numerous group discussions with regulators across the country regarding best practices for NQTL analysis reviews. Various states have developed their own strategies and template reporting forms for NQTL review, but the experience is consistent across states. The MIA has also engaged regulators from specific states in individual discussions about particular carriers, and those discussions revealed that the other states were observing the same problems with those carriers as the MIA. Throughout the nation, carriers appear ill-equipped to provide evidence to regulators that a sufficient comparative analysis of the design and application of NQTLs has been performed. Despite increasingly detailed guidance from regulators, carriers seem to continue to struggle to understand, on the one hand, how to perform a sufficient analysis, and on the other hand, how to adequately document the analysis for regulators when an analysis is in fact performed.

The situation at the federal level parallels the state experience. Following passage of the CAA, compliance with the Parity Act was identified as a top enforcement priority of the Biden Administration. DOL, along with the Departments of Health and Human Services ("HHS") and Treasury jointly published FAQ, Part 45, on April 2, 2021 to provide guidance related to the Parity Act requirements under the CAA.[25] FAQ 45 included very detailed descriptions of carrier practices and procedures that should be avoided in responding to regulator requests for comparative analyses because the information would be considered insufficient. These descriptions were specifically based on the types of responses federal regulators had received in prior NQTL investigations, and they mirrored the types of responses the MIA had received in the past. The MIA adapted and incorporated much of the guidance from FAQ 45 into the MIA's own instructions because the guidance was so germane to the MIA's past experiences.

Unfortunately, the best efforts of state and federal regulators to provide detailed advance guidance to carriers on how to conduct and document a sufficient comparative analysis have not yet yielded the desired results. The DOL's Employee Benefits Security Administration ("EBSA") and the HHS Centers for Medicare & Medicaid Services ("CMS"), are the two federal agencies with primary responsibility to enforce the Parity Act. In 2023, MIA staff met with national and regional EBSA Parity Act advisors to discuss Maryland's experience and share best practices, and those discussions confirmed that federal regulators were following the same review approach as the MIA, with the same frustrating results. Likewise, discussions with consultants who performed Parity Act NQTL reviews for CMS confirmed similar experiences across the board.

The CAA requires DOL, HHS, and Treasury to report to Congress annually on the results of NQTL comparative analyses reviews conducted by the federal agencies. The federal agencies have now published two of these reports, and the latest report was released on July 31, 2023.[26] These reports summarize the Parity Act enforcement activities of EBSA and CMS. The July 31, 2023 report is 119 pages long and describes in detail, with many specific examples, the challenges federal regulators experience in attempting to obtain sufficient NQTL comparative analyses from plans and carriers to demonstrate compliance with the Parity Act. The report

[25] See https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

[26] For the complete report to Congress, refer to https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf

demonstrates that more than two full years after the CAA expressly required all plans and carriers in the nation to perform comparative analyses for any NQTLs imposed by the plans, carriers are still unprepared to provide adequate comparative analyses to federal regulators upon request.

The federal agencies noted in the July 31, 2023 report that they observed no marked improvement in the sufficiency of the comparative analyses they received in the second reporting year as compared to the first reporting year. The examples of the types of deficient responses summarized in the report are remarkably similar to the types of deficiencies the MIA observed in the reports filed under § 15-144. The report indicated that every single comparative analysis received was deficient in some way when it was first filed with EBSA or CMS. As of July 31, 2023, the vast majority of the federal NQTL investigations summarized in the reports are still ongoing, although federal regulators have issued a small number of final determinations that found Parity Act violations. The report explained that a reason investigations remain open is that the federal agencies are committed to determining whether additional Parity Act violations, other than failure to provide an adequate comparative analysis are present. The report concedes that ensuring parity will likely require years of sustained effort, but also stresses that federal agencies will be expecting significantly improved comparative analyses from plans and carriers in future years, and will allow less time and fewer opportunities for corrections before issuing final determinations of noncompliance.

On August 3, 2023, DOL, HHS, and Treasury issued a new 118 page Proposed Rule related to the Parity Act.[27] Though the Rule has not been finalized as of the publication of this report, as proposed, it imposes a significantly increased burden on carriers to demonstrate that NQTLs applied to MH/SUD benefits do not violate the Parity Act. The Proposed Rule includes a new three-pronged test that must be conducted to demonstrate that NQTLs are permissible, which supplements the existing comparability/stringency test that has been described throughout this report by adding a new mathematical test and an analysis of outcomes data. The Proposed Rule is not without flaws, as evidenced by public comments submitted, including from state regulators, carriers, patient advocates, and nonprofit MH/SUD think tanks. The MIA was supportive of, and contributed to, the NAIC comment letter that was submitted for the Proposed Rule. Overall, the MIA strongly supports most of the provisions of the Proposed Rule.

There are several new requirements in the Proposed Rule, however, that need further clarification from the federal agencies to ensure appropriate enforcement by regulators and to close potential loopholes that have been identified. There are also significant operational concerns with the new mathematical test because it will be difficult, and in certain situations likely impossible, to implement it with respect to certain NQTLs, which are, by definition, "non-quantitative." The focus on outcomes data in the proposed rule is significant, and potentially game changing, in Parity Act enforcement because prior federal guidance consistently stated that data disparities were not dispositive of parity. It is noteworthy that the Proposed Rule includes a footnoted reference to the MIA's NQTL reporting framework, specifically, the data supplement forms and instructions. Additionally, a separate Technical Release from the federal agencies was published simultaneously with the Proposed Rule, requesting comments on data requirements for NQTLs. The Technical Release specifically cited the MIA's template forms and instructions, in

[27] See 88 FR 51552, available at https://www.govinfo.gov/content/pkg/FR-2023-08-03/pdf/2023-15945.pdf

addition to models from certain other states and private organizations, as a potential source to inform future federal guidance.

Conclusions and Recommendations

While the MIA has not yet reached substantive conclusions on Parity Act compliance, significant progress has been made in recent months. It is the understanding of the MIA that carriers are learning from each subsequent round of communication, and now have a better idea of what information is required, as the MIA provides additional guidance to carriers that is tailored to the particular responses and unique deficiencies included in each report and for each step of the analysis for every NQTL.

While sufficiently detailed guidance has already been provided by the MIA and by federal regulators, and federal law is clear that carriers are required to have already performed the requested comparative analyses, the reality of the situation is that carriers are struggling to provide the level of detail that regulators have uniformly concluded is necessary to make a parity determination.

It is indeed possible that the failure to provide a sufficient analysis may be willful on the part of certain carriers locally and nationally, but the MIA's experience has been that most carriers are now legitimately attempting to provide the information requested by the MIA. It seems very clear, however, that carriers had not performed a sufficient comparative analysis for most of the NQTLs that were imposed prior to submitting the initial reports. The MIA is imposing significant penalties as a result of the initial failure to provide a sufficient NQTL analysis, but currently lacks the authority to address the deficiencies in any other manner.

It is anticipated that the improved cooperation from carriers combined with the recent additions of new full-time staff and external vendor assistance from a consulting firm will accelerate the timeline for the MIA to begin making substantive parity determinations. However, under the current statutory framework, the review process to complete the analysis of all NQTLs for each plan for every carrier in order to reach parity determinations is expected to remain an arduous and drawn-out process. Consequently, the MIA's recommendations for this interim report focus primarily on potential ways to improve the evaluation process, which will assist the MIA in reaching parity determinations on a greater number of plans and NQTLs in a shorter time period than is possible under the existing statutory scheme. Improvements to the process itself will enable the MIA to obtain a larger volume of relevant information to inform substantive recommendations in the final report regarding the MIA's findings on parity and how to improve access to coverage for MH/SUD services under commercial insurance plans.

House Bill 455/Senate Bill 334 requires the MIA to make specific recommendations based on the reviews of the NQTL reports regarding four broad categories:

(i) the information gained from the reports;
(ii) the value of and need for ongoing compliance and data reporting;
(iii) the frequency of reporting in subsequent years and whether to report on an annual or biennial basis; and

(iv) based on the carrier reports and other guidance from federal regulators and other states, any changes in the reporting and data requirements that should be implemented in subsequent years, including frequency and content and whether additional nonquantitative treatment limitations should be included in the reporting and data requirements.

The MIA submits the following eight recommendations on these categories for this interim report:

Recommendation 1: The MIA, in consideration of materials available from other state and federal regulators and in consultation with other regulators and Parity Act experts should continually develop, publish, and update best practices guidance for carriers on how to conduct and document a sufficient NQTL comparative analysis.

Despite the considerable guidance already available from the MIA and other sources, carriers repeatedly insist that it is not clear what information and documentation is necessary for an analysis to be considered sufficient by regulators. If the goal of reducing the review and analysis burden on regulators and obtaining sufficient analyses from carriers up front is ever to be realized, it is clear that continuously updated and refined guidance with specific examples must be provided by regulators.

Recommendation 2: Until such time that widespread substantive parity determinations have been made by the MIA, compliance and data reporting should continue to be required.

At this time, Maryland carriers have still failed to demonstrate that they have even performed the required analysis for many NQTLs that are subject to reporting. While the MIA is submitting additional recommendation below related to changing the scope of the reporting requirements, ongoing compliance and data reporting in some manner will remain necessary for the foreseeable future due to the inability to draw conclusions on whether carriers are currently providing coverage for MH/SUD benefits at parity with M/S benefits.

Recommendation 3: Section 15-144 should be revised to expressly require carriers to conduct and document comparative analyses for legacy processes impacting NQTLs that were implemented prior to enforcement of the NQTL analysis requirements of the Parity Act.

A longstanding suspicion of MIA staff that was confirmed by the review of the 2022 NQTL reports was that carriers impose many NQTLs on both M/S and MH/SUD based on policies and procedures developed many years in the past, which were not analyzed in depth following enactment of the Parity Act to ensure continued compliance. Federal regulations at 45 CFR §146.136(c)(4)(i) expressly state that "[a]… plan (or health insurance coverage) *may not impose* a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless… any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation… are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." CFR §146.136(c)(4)(i) (emphasis added). It is impossible for a carrier to ensure

compliance with this requirement unless a comparative analysis has been performed. Thus, it should already be clear to carriers that they must perform comparative analyses for every NQTL applied to MH/SUD, regardless of when the underlying processes were originally implemented.

However, during the review process for the 2022 reports, certain carriers expressed hesitation at re-evaluating every existing process due to the difficulty and administrative burden of analyzing legacy processes for Parity Act compliance. Expressly stating this requirement in a Maryland statute will preempt any misguided assumption from carriers that the analysis is not required, obviating the need for the MIA to explain the issue, and helping to reduce associated delays in the review process.

Recommendation 4: Section 15-144 should be revised to reduce the number of NQTLs and plans that must be analyzed each reporting year, and afford the MIA regulatory discretion on which NQTLs to focus on each year.

The immense volume of materials required to be filed under § 15-144 contributed to the prolonged review and analysis process for the reports submitted in 2022. The one significant way that the Maryland reporting requirements differed from national regulatory best practices was the complete removal of regulator discretion to identify and select specific NQTLs and particular plans to review in order to best leverage state resources and ensure the greatest consumer protection impact. Under § 15-144, every carrier is required to submit, and the MIA is required to review, the comparative analyses for every NQTL imposed on MH/SUD benefits for the top five plans by enrollment for each product in each market where the carrier offers coverage. Due to the broad federal definition of "NQTL," the complete universe of provisions, exclusions, restrictions, limitations, standards, practices, etc. that are considered NQTLs is vast. Furthermore, the complexity of the review process and the time and resources required to perform an evaluation of an NQTL analysis are tremendous, as has already been described in detail in earlier sections of this report.

Recognizing the regulator burden of the NQTL analysis process, and consistent with standard market conduct practices, other state and federal regulators have taken a more focused approach to NQTL analysis, limiting reviews and examinations to a subset of plans or NQTLs. Consistently, in private discussions whenever the MIA described the scope of the reporting requirements under § 15-144, other state and federal regulators and Parity Act consultants were taken aback, acknowledging the difficulties of attempting to tackle all NQTLs from so many plans at once. In Maryland, 17 different health insurance carriers were subject to the reporting requirement, and the MIA was required to review all NQTLs across 14 different categories for 213 plans. For comparison purposes, EBSA regulates an estimated 2.5 million health plans, and CMS oversees approximately 90,000 non-federal governmental group health plans, and 41 health insurance issuers in three states.[28] While the CAA placed significant new Parity Act enforcement expectations on these federal agencies, the law only required each agency to request at least 20 NQTL analyses per year. Additionally, even though compliance with the Parity Act

[28] See DOL, HHS, and Treasury MHPAEA Comparative Analysis Report to Congress, July 2023

was identified as a top enforcement priority of the Biden Administration, the federal agencies deliberately focused their initial enforcement efforts on a small subset of four specific NQTLs.[29]

It would be very beneficial for the MIA to have discretion to strategically focus its limited enforcement resources on NQTLs that have the greatest impact on patient access to care. Implementing this recommendation is the MIA's highest priority, and there are various ways that § 15-144 could be amended to provide this flexibility. For example, the legislature could specify a minimum number of NQTLs and plans to be examined each reporting period, and grant the MIA the authority to identify "priority NQTLs" that would be reviewed, based on complaint trends, market concerns, and national discussions. The legislature could also establish a reporting schedule to cycle through all the known NQTL categories on a periodic basis, such as every 5 or 10 years, with discretion for the MIA to substitute requiring reporting for specific NQTLs identified as needing more urgent attention on an off-cycle basis.

Reducing the number of plans and NQTLs that must be reviewed by the MIA each year will be a more effective and efficient use of state resources, and will significantly accelerate the review process, allowing the MIA to reach substantive parity determinations to assist consumers much sooner.

Recommendation 5: The uncodified text in House Bill 455/Senate Bill 334, Section 2 should be amended to remove the requirement that the standard reporting form developed by the MIA must be the (now outdated) NAIC Data Collection Tool, and allow the MIA to consider best practices identified by other state and federal regulators.

As explained in earlier sections of the report, there were valid reasons for requiring the MIA to use the NAIC Data Collection Tool as the template reporting form at the time the law was enacted, but this tool is now outdated. The MIA has attempted to modify the NAIC Data Collection Tool to the greatest extent permitted by the uncodified text in House Bill 455/Senate Bill 334. However, making additional substantive and helpful changes to the standard form is hampered by the prescriptive language in the Acts. Certain aspects of the current standard form are cumbersome and unhelpful, and the MIA would like to be able to eliminate these items and have greater discretion in designing a form that aligns with current federal requirements. Carriers initially advocated for the use of the NAIC Data Collection Tool and expressed opposition to using the analysis process set forth in the DOL Self-Compliance Tool. However, as stated previously, following enactment of House Bill 455/Senate Bill 334, the CAA imposed a requirement for carriers to perform the exact analysis described in the DOL Self-Compliance Tool. To make the NQTL review process under § 15-144 as efficient as possible, it is imperative for the MIA to have the ability to develop a standard form based on current best practices.

Recommendation 6: The existing data requirements in § 15-144(f) should be reviewed for usefulness and amended or repealed, as appropriate, and the statute should be revised to expressly authorize the MIA to develop and require additional standardized data submissions to evaluate the "in operation" analysis.

[29] See Q8 under FAQs about Mental Health Parity and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45, April 2, 2021

Current federal law and guidance still provide that outcomes are not determinative of a Parity Act violation, but that outcomes do serve as red flags or warning signs that trigger the need for closer review of an NQTL. The federal Proposed Rules published on August 3, 2023 place a significantly higher emphasis on data outcomes and provide that in certain situations, disparate results are considered an indicator of a potential Parity Act violation requiring specific additional actions to remedy the disparity. Regardless of whether the Proposed Rules are finalized in their current posture, examining data outcomes has become a fundamental part of the NQTL analysis review. House Bill 455/Senate Bill 334 recognized the importance of collecting data, and imposed statutory requirements for carriers to report very specific data elements under § 15-144(f).

As explained previously, however, during the implementation phase of § 15-144, the MIA concluded that the particular data points identified in the statute did not align well with the types of data that would be necessary to evaluate the in operation analysis for certain NQTLs. The MIA found it necessary to supplement the NQTL analysis report and the statutorily required data report with four additional data supplements. At the same time, some of the statutory data elements from the data report itself became redundant or extraneous.

It would be advantageous to eliminate unnecessary data requests and have the ability to align the data with the specific NQTLs being examined, incorporating any specific data requirements that are included in the federal rules and related guidance, once finalized.

Recommendation 7: Section 15-144 should be revised to not expressly require plan level reporting, and to instead permit broader reporting, such as at the product level, provided that only plans using the same NQTLs are aggregated.

Eliminating the plan-level reporting requirement would allow for fewer reports to be filed each year, reducing the reporting burden on both carriers and the MIA. More importantly, this change would allow for more robust data samples. Ultimately, a carrier must comply with the Parity Act at the plan level. However, for the purposes of the Maryland reporting requirements, compliance could be determined more efficiently if the comparative analyses were provided at the product level. Most plans offered by carriers within the same product share the same NQTLs. If there is no variation in NQTLs between plans, then the underlying comparative analysis should be the same across those plans.

With the increased focus on data outcomes in parity analyses, it would be helpful to be able to aggregate data across plans that use the same NQTLs. One challenge with the existing reports and data supplements that made it difficult to draw conclusions was that the data sets were so small due to the requirement to report analyses at the plan level. For many plans, the data sets for several of the requested categories consisted of fewer than ten cases. Credibility of the data sets would be significantly improved when aggregated at the product level. It should be noted that existing federal guidance with respect to parity testing for the quantitative measures for financial requirements and quantitative treatment limitations does allow carriers to consider data and experience at the product level, or even broader, when the plan level data is not considered credible.

Recommendation 8: Section 15-144 should be revised to provide the MIA with additional enforcement options if a carrier fails to provide a sufficient comparative analysis to demonstrate parity.

This recommendation, along with Recommendation 4, would likely provide the greatest impact and assistance to the MIA's review and enforcement efforts. As explained previously, under § 15-144, failure to provide a sufficient analysis is not grounds for a determination of substantive noncompliance with the Parity Act. Consequently, under current Maryland law, the MIA's only recourse to address repeated failures by a carrier to provide requested information is to impose penalties for failure to file a complete report. Every Order that the MIA has issued on these grounds as of the date of submission of this legislative report has resulted in a hearing request from the sanctioned carrier, alleging that the penalty amounts are excessive and/or unwarranted. At the same time, there are concerns that the penalty amounts are not sufficiently high enough to discourage carriers from simply paying the penalty instead of providing information that could potentially reveal an actual parity violation.

When potential amendments to House Bill 455/Senate Bill 334 were being discussed during the 2020 legislative session, the MIA proposed amending the bills to place the burden of persuasion for demonstrating parity in the NQTL reports on the carrier. This would have been consistent with the review standard applicable to coverage decisions and adverse decisions under Maryland law.[30] This idea was strongly opposed by carriers and ultimately rejected by the legislature.

Granting the MIA authority to determine that repeated failure by a carrier to provide a sufficient comparative analysis is considered a substantive violation of the Parity Act may create a significant incentive for carriers to provide the required analysis. However, this approach would not necessarily solve all problems.

Notwithstanding the fact that the MIA anticipates carriers would submit hearing requests as a matter of course for such determinations, significantly delaying the review process even further, there are other limitations to this approach. If and when the MIA determines that a carrier has not complied with the provisions of the Parity Act, there must be an appropriate remedy or corrective action. For some NQTLs, the remedy may be straightforward and obvious, such as removing the NQTL and reprocessing claims that were improperly denied. However, for certain NQTLs, if there is not a clear disparity in the application between MH/SUD and M/S, and if the problem is simply that the carrier has been unable to sufficiently demonstrate that the underlying processes and factors for the NQTL were applied comparably and no more stringently to MH/SUD benefits, simply eliminating the NQTL for MH/SUD benefits may not be in the best interests of public policy.

For example, for the NQTLs of medical necessity determinations, provider credentialing, and provider reimbursement, it would not seem beneficial to the market as a whole to, solely because the carrier failed to provide evidence of a comparative analysis and in the absence of obvious disparities: absolutely prohibit carriers from applying any medical necessity criteria to

[30] See §§ 15-10A-03(e) and 15-10D-02(h) of the Insurance Article, Annotated Code of Maryland.

MH/SUD; prohibit carriers from requiring MH/SUD providers to be credentialed to join the network; or require carriers to pay billed charges for all MH/SUD services.

Completely eliminating medical management, quality assurance, and cost-containment techniques for all MH/SUD benefits while those same techniques continue to customarily apply to M/S benefits may appeal to some stakeholders, but it would likely distort the market, creating perverse incentives for price gouging and the provision of excessive/unnecessary services and medications, contributing to increased premiums for all consumers.

To address this issue, it may be helpful to expand the statutory remedies beyond the current compliance plan. For example the MIA could be granted discretion to state that an NQTL may not be used, or must be modified based on the totality of the report and the nature of the NQTL. The MIA could also be granted express authority to require ongoing data reporting to show the effectiveness of a compliance plan, if data reporting is appropriate for an NQTL.

Conclusion: The MIA believes that adoption of some or all of the preceding recommendations will improve the ability of the MIA to reach substantive conclusions on compliance with the Parity Act in a more efficient and effective manner. In furtherance of the goal of enhancing access to coverage for MH/SUD services under commercial insurance plans in the State of Maryland, the MIA urges the General Assembly to consider taking action on these recommendations during the 2024 legislative session to improve the ongoing review process for the NQTL analysis reports.

Appendix A

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 51 Mental Health Benefits and Substance Use Disorder Benefits – Reports on Nonquantitative Treatment Limitations and Data

Authority: Insurance Article, §§2-109(a)(1) and 15-144, Annotated Code of Maryland

.01 Purpose

The purpose of this chapter is to adopt regulations to implement Insurance Article, §15-144, Annotated Code of Maryland to ensure uniform definitions and methodology for the reporting requirements established under this section.

.02 Scope

This chapter applies to carriers that deliver or issue for delivery a health benefit plan in Maryland.

.03 Definitions.

A. In this chapter, the following terms have the meaning indicated.

B. Terms Defined.

(1) "Analysis report" means the report required by Insurance Article, §15-144(c), Annotated Code of Maryland.

(2) "As written" means the written policies, procedures and related documents, including medical necessity criteria or guidelines, used in the development and description of a NQTL and the decision whether to apply a NQTL to a particular benefit by the carrier and/or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier.

(3) "Data report" means the report required by Insurance Article, § 15-144(f), Annotated Code of Maryland.

(4) "Evidentiary standards" means the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates.

(5) "Factor" means a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, and/or implementation of a NQTL.

(6) "In operation" means as used in the implementation and application of NQTLs, including the administration of benefits.

(7) "Medical/surgical benefits" has the meaning stated in Insurance Article, § 15-144(a)(4), Annotated Code of Maryland and may be abbreviated as "med/surg benefits" or "M/S benefits".

(8) "Medical Necessity" means medical necessity as determined by the definition, criteria, or guidelines used by the carrier and/or its private review agent to determine what is necessary, efficient, or appropriate for purposes of coverage of a service or benefit. Insurance Article, § 15-802, Annotated Code of Maryland, requires use of the criteria published by the American Society of Addiction Medicine for the evaluation of the medical necessity, efficiency, or appropriateness of services to treat a substance use disorder.

(9) "Mental health benefits" has the meaning stated in Insurance Article, § 15-144(a)(5), Annotated Code of Maryland.

(10) "MH/SUD" means mental health benefits and substance use disorder benefits as a combined category.

(11) "NQTL" means a non-quantitative treatment limitation as defined in Insurance Article, § 15-144(a)(6), Annotated Code of Maryland.

(12) "Parity Act" has the meaning stated in Insurance Article, § 15-144(a)(7), Annotated Code of Maryland.

(13) "Parity Act classification" has the meaning stated in Insurance Article, § 15-144(a)(8), Annotated Code of Maryland.

(14) "Process" means a series of actions or steps taken during the development, design or implementation/application of a NQTL.

(15) "Provider" means:

(a) A physician;

(b) Hospital;

(c) Facility;

(d) Practitioner; or

(e) Other person who is licensed or otherwise authorized to provide healthcare services.

(16) "Source" means the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises.

(17) "Substance use disorder benefits" has the meaning stated in Insurance Article, § 15-144(a)(9), Annotated Code of Maryland.

(18) "Summary form" means the form required by Insurance Article, § 15-144(g)(5), Annotated Code of Maryland.

.04 Filing of Nonquantitative Treatment Limitation Comparative Analysis Report.

A. For the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets, a carrier that delivers or issues for delivery a health benefit plan in the State shall file a comparative analysis for each nonquantitative treatment limitation specified in the form required by the Commissioner, to demonstrate the carrier's compliance with Insurance Article, §§ 15-144(c) – (e), Annotated Code of Maryland. An analysis report shall be filed with the Commissioner using only the form developed by the Commissioner and posted on the Administration's website.

B. Carriers shall prepare the analysis report in coordination with any entity the carrier contracts with to provide, manage, or administer MH/SUD benefits.

C. Carriers shall follow the instructions posted on the Administration's website to complete the analysis report.

D. A complete analysis report shall include responses to each section of the standardized form, as described in the instructions posted on the Administration's website.

E. Each analysis report shall contain a statement, signed by a corporate officer, attesting to the accuracy of the information contained in the analysis report.

F. Failure to file a complete analysis report shall result in penalties described in Insurance Article, § 15-144 (j), Annotated Code of Maryland.

G. Complete Analysis Report.

(1) The analysis required by Insurance Article, § 15-144(d), Annotated Code of Maryland shall have been performed for processes in place during the calendar year preceding the analysis report.

(2) A carrier shall analyze each NQTL separately for each classification and sub-classification, as applicable, of benefits.

(3) If the carrier delegates administration or management of mental health, substance use disorder, or medical/surgical benefits to another entity (for example, a private review agent specializing in mental health and substance use disorder benefits or a pharmacy benefits manager), the analyses shall be conducted with close and coordinated involvement of both the carrier and the entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier. The carrier is responsible for providing all required information for the analyses, regardless of any delegation arrangement with a subcontracted entity.

(4) The analysis reports shall include the following information to be considered complete.

(a) All of the information identified in Insurance Article, § 15-144(e), Annotated Code of Maryland in the manner and format specified in the standard reporting form and associated instructions provided on the Administration's website;

(b) A response to each step listed in the reporting form, for each NQTL in each classification and sub-classification, as applicable. If a particular item in a step is not applicable (for example, if none of the factors used to determine that the NQTL will apply to a benefit was given more weight than another), an explanation shall be provided as to why the item is not applicable;

(c) A statement as to whether there is any variation in the application of a guideline or standard used by the carrier between MH/SUD and medical/surgical benefits, and, if so, a description of the factors and process used for establishing that variation. Specific definitions of factors, processes, or criteria used to establish or support any variation is required. Any practice guidelines that may be associated with the NQTL shall also be provided;

(d) If the application of the NQTL turns on specific decisions in the administration of the benefits, identification of the basis of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s), including expertise and specialty;

(e) If the analyses rely upon any experts, an assessment of each expert's qualifications, expertise and specialty, and a description of the extent to which the carrier relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits. Any variation in the use of experts (e.g., specialty matching, licensure levels, etc.) for MH/SUD compared to M/S shall be defined and justified;

(f) A description of all exception processes available for each NQTL and when the exception may be applied;

(g) An explanation of how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims;

(h) Documentation of audits, reviews, and analyses to check sample claims or other administrative data to assess how each NQTL operates in practice, and whether written processes are correctly carried out, including the results of the audits and reviews performed on the NQTLs identified in Insurance Article, § 15-144 (c)(2)(ii), Annotated Code of Maryland to conduct the comparative analysis required under Insurance Article, § 15-144 (d)(2), Annotated Code of Maryland as written, and in operation;

(i) Citations to any documents, studies, testing, claims data, or reports that include factors, sources, evidentiary standards, or other evidence relied upon in developing the NQTL (for example, meeting minutes or reports showing how those considerations were applied), with copies of those items available on request; and

(j) A description of the consequences or penalties that apply when the NQTL requirement is not met.

.05 Filing of Data Report.

A. For the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets, a carrier that delivers or issues for delivery a health benefit plan in the State shall submit a data report for the immediately preceding calendar year for mental health benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification.

B. The data report shall be filed with the Commissioner using only the standardized form posted on the Administration's website.

C. Carriers shall follow the instructions posted on the Administration's website to complete the data report.

D. A complete data report shall include responses to each applicable section of the standardized form and follow the instructions posted to the Administration's website.

E. Each data report shall contain a statement, signed by a corporate officer, attesting to the accuracy of the information contained in the data report.

F. Failure to file a complete data report shall result in penalties under Insurance Article, § 15-144 (J), Annotated Code of Maryland.

.06 Summary Form.

A. A carrier subject to Insurance Article, § 15-144, Annotated Code of Maryland shall prepare a summary form using only the template form posted on the Administration's website.

B. The summary form shall be made available to plan members and accessible to the public on the carrier's website no later than April 1, 2022 and April 1, 2024. The carrier shall make the summary form available to plan members in response to a written request within 30 days of the request.

C. Carriers shall follow the instructions for completing the summary form using the instructions posted on the Administration's website.

D. A complete summary form shall include responses to each applicable section of the standardized form, as described in the instructions posted on the Administration's website.

.07 Compliance Plan.

A. If, as a result of the review of the reports described in regulations .02 and .03 of this Chapter, the Commissioner finds that a carrier subject to Insurance Article, § 15-144, Annotated Code of Maryland failed to comply with provisions of the Parity Act, the Commissioner shall notify the carrier and require the carrier to submit a compliance plan pursuant to Insurance Article, § 15-144 (i), Annotated Code of Maryland to correct the noncompliance. The notice shall be in writing, but may be transmitted electronically.

B. The carrier shall have 90 days to file a compliance plan following the date a notice of noncompliance is issued by the Commissioner.

C. The compliance plan shall include:

(1) An acknowledgement of the Commissioner's finding of noncompliance;

(2) A summary of action(s) taken by the carrier to correct the noncompliance prior to the notice from the Commissioner;

(3) A summary of future action(s) to correct the noncompliance and the time frame when the actions will be taken; and

(4) *A summary of amounts owed to members or providers due to violations of the Parity Act, including:*

(a) Any amounts owed to members and payment date(s);

(b) Draft correspondence to members;

(c) Any amounts owed to providers and payment date(s);

(d) Draft correspondence to providers; and

(e) Confirmation of amounts paid to members and providers.

08. Effective date

The regulations in this Chapter are applicable for all reports filed after January 1, 2022.

Appendix B

NQTL Analysis Report Template

Carrier Information:

Name:

Contact Name:

Contact Telephone Number:

Contact Email:

Line of Business:

Contract Type:

Benefit Plan:

Plan Information:

Identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets. Provide the form numbers, approval dates, and SERFF tracking numbers for all forms comprising the entire contract of insurance for the health benefit plan.

Benefit Classifications:

(a) List each covered service under the plan in the table below. Indicate whether the covered service is treated as M/S or MH/SUD, and identify which of the following classifications or sub-classifications the covered service has been assigned to: In Network Inpatient; Out of Network Inpatient; In Network Outpatient (OR: In Network Outpatient-Office; In Network Outpatient-All Other); Out of Network Outpatient (OR: Out of Network Outpatient-Office; Out of Network Outpatient-All Other); Emergency; or Prescription.

Covered Service	M/S or MH/SUD	Benefit Classification

(b) Explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification.

For each NQTL provided below, provide the detailed comparative analysis as described in the template below.

1. **Definition of Medical Necessity**

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6
Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7
Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

2. Prior Authorization Review Process

Include all services for which prior authorization is required. Describe any step therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications

Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

3. Concurrent Review Process

Including frequency and penalties for all services. Describe any step therapy or "fail first" requirements and requirements for submission of treatment required forms or treatment plans.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

4. Retrospective Review Process

Including timeline and penalties.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

5. **Emergency Services**

*The Emergency Services category is intended to encompass NQTLs that are applicable to emergency services, but which are not separately reported under one of the other NQTL categories on the NQTL Analysis Report Template. If the applicability of a particular NQTL to emergency services is being reported under one of the other NQTL categories, do not include information on that NQTL under this separate Emergency Services category.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits in Emergency Classification	NQTL's Applicable to MH/SUD Benefits in Emergency Classification

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to all medical/surgical benefits or all MH/SUD benefits for the Emergency classification, or only to certain services within such classification, in the table above. If the NQTL applies only to certain services within the Emergency classification, list each covered service to which the NQTL applies.

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification of benefits or to apply the NQTL to certain identified services within such classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to the entire Emergency classification or only to certain services within such classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

6. **Pharmacy Services**
   *The Pharmacy Services category is intended to encompass NQTLs that are applicable to pharmacy services, but which are not separately reported under one of the other NQTL categories on the NQTL Analysis Report Template. If the applicability of a particular NQTL to pharmacy services is being reported under one of the other NQTL categories, do not include information on that NQTL under this separate Pharmacy Services category.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits in Prescription Classification	NQTL's Applicable to MH/SUD Benefits in Prescription Classification

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to all medical/surgical benefits or all MH/SUD benefits for the Prescription classification, or only to certain services within such classification, in the table above. If the NQTL applies only to certain services within the Prescription classification, list each covered service to which the NQTL applies.

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification of benefits or to apply the NQTL to certain identified services within such classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to the entire Prescription classification or only to certain services within such classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

7. Prescription Drug Formulary Design

How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions? Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution and step therapy. What disciplines, such as primary care physicians, internists, pediatricians and specialty physicians (e.g., psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health, and substance use disorder conditions?

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits in Prescription Classification	NQTL's Applicable to MH/SUD Benefits in Prescription Classification

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to all medical/surgical benefits or all MH/SUD benefits for the Prescription classification, or only to certain services within such classification, in the table above. If the NQTL applies only to certain services within the Prescription classification, list each covered service to which the NQTL applies.

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification of benefits or to apply the NQTL to certain identified services within such classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to the entire Prescription classification or only to certain services within such classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

8. Case Management

What case management services are available? What case management services are required? What are the eligibility criteria for case management services?

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

9. Process for Assessment of New Technologies

Definition of experimental/investigational. Qualifications of individuals evaluating new technologies. Evidence consulted in evaluating new technologies.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

10. Standards for Provider Credentialing and Contracting

Is the provider network open or closed? What are the credentialing standards for physicians? What are the credentialing standards for licensed non-physician individual providers? What are the credentialing standards for hospitals and facilities? Specify type of provider and standards (e.g., nurse practitioners, physician assistants, psychologists, clinical social workers)?

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-**	Is NQTL applied to **Out of Network Outpatient-**	Is NQTL applied to **In Network Outpatient-All**	Is NQTL applied to **Out of Network Outpatient-All**	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?

		Office sub-classification?	**Office** sub-classification?	**Other** sub-classification?	**Other** sub-classification?		
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

11. Exclusions for Failure to Complete a Course of Treatment

Does the plan exclude benefits for failure to complete a course of treatment?

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

12. Restrictions that Limit Duration or Scope of Benefits for Services

Does the plan restrict the geographic location in which covered services can be received (e.g., service area, within the state, within the U.S.)? Does the plan restrict the type(s) of facilities in which members can receive covered services?

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

13. Restrictions for Provider Specialty

Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD covered services?

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

14. <u>Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)</u>

<u>Step 1</u>

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

Disclosure Requirements

Identify the process used to comply with the Parity Act Disclosure Requirements for MH benefits, SUD benefits, and M/S benefits. (§15-144(e)(7)):

Describe the process for disclosing the criteria used for a medical necessity determination for MH and SUD benefits to current or potential members, or to a contracting provider, upon request.

Describe the process for disclosing the reasons for a denial of benefits for MH and SUD.

Describe the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply a NQTL for MH/SUD and M/S benefits in connection with a member's request for group plan information and for purposes of filing an internal coverage or grievance matter and appeals.

MARKET CONDUCT ACTION
CERTIFICATE OF COMPLIANCE

Pursuant to Code of Maryland Regulations ("COMAR") 31.04.20.05 E., I hereby certify to the best of my knowledge, information, and belief, that the information hereto submitted to the Maryland Insurance Administration ("Administration") represents a full, complete and truthful response to the Maryland Insurance Commissioner ("Commissioner") in response to the NQTL report required under § 15-144, Insurance Article, Annotated Code of Maryland.

I further attest that I am an authorized officer/representative of the Company, that I have undertaken an adequate inquiry to provide this certification to the Commissioner, and am authorized to bind the Company to the responses provided.

Company Officer Signature: _____

Print Name: _____

Company: _____

Title: _____

Date: _____

Appendix C

MHPAEA Data Report for Calendar Year Ending January 31, 2021 (§15–144(f))

Health Plan						
Benefit	**Classification**	**# of Authorization Requests Received**	**# of Authorization Requests Approved**	**# of Authorization Requests Denied**	**% Approved**	**% Denied**
Mental Health Benefits	INN-Inpatient					
	OON-Inpatient					
	Emergency Services					
	RX					
	INN-Outpatient-Office					
	OON-Outpatient-Office					
	INN-Outpatient-AllOther					
	OON-Outpatient-AllOther					
Substance Use Disorder Benefits	INN-Inpatient					
	OON-Inpatient					
	Emergency Services					
	RX					
	INN-Outpatient-Office					
	OON-Outpatient-Office					
	INN-Outpatient-AllOther					
	OON-Outpatient-AllOther					
Medical /Surgical Benefits	INN-Inpatient					
	OON-Inpatient					
	Emergency Services					
	RX					
	INN-Outpatient-Office					
	OON-Outpatient-Office					
	INN-Outpatient-AllOther					
	OON-Outpatient-AllOther					

Benefit	Classification	# of Claims Submitted	# of Claims Approved	# of Claims Denied	% Approved	% Denied	Reasons for Denial of Claims
Mental Health Benefits	INN-Inpatient						
	OON-Inpatient						
	Emergency Services						
	RX						
	INN-Outpatient-Office						
	OON-Outpatient-Office						
	INN-Outpatient-AllOther						
	OON-Outpatient-AllOther						
Substance Use Disorder Benefits	INN-Inpatient						
	OON-Inpatient						
	Emergency Services						
	RX						
	INN-Outpatient-Office						
	OON-Outpatient-Office						
	INN-Outpatient-AllOther						
	OON-Outpatient-AllOther						
Medical /Surgical Benefits	INN-Inpatient						
	OON-Inpatient						
	Emergency Services						
	RX						
	INN-Outpatient-Office						
	OON-Outpatient-Office						
	INN-Outpatient-AllOther						
	OON-Outpatient-AllOther						

MHPAEA Summary Form

MHPAEA Summary Form Instructions

The below summary form is prepared to satisfy the requirements of §15-144 (m)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

The MHPAEA Summary Form includes the MHPAEA Data Report.

Carriers must use the terms defined in COMAR 31.10.51 and the *Instructions for MHPAEA NQTL Analysis Report and Data Report* to complete the summary form.

MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), [carrier name] must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

[Carrier name] has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

If you have any questions on this summary, please contact [name] at [email and/or phone number].

If you have questions on your specific health plan, please call [phone number].

Overview:

We have identified the five health benefit plans with the highest enrollment for each product we offer in the individual, small, and large group markets, as applicable. These plans contain items called Non-Quantitative Treatment Limitations (NQTLs) that put limits on benefits paid. What these NQTL's are and how the health plans achieve parity are discussed below.

1. Definition of Medical Necessity

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

2. Prior Authorization Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

3. <u>Concurrent Review Process</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

4. <u>Retrospective Review Process</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

5. <u>Emergency Services</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

6. <u>Pharmacy Services</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

7. Prescription Drug Formulary Design

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

8. <u>Case Management</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

9. <u>Process for Assessment of New Technologies</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

10. <u>Standards for Provider Credentialing and Contracting</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

11. <u>Exclusions for Failure to Complete a Course of Treatment</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

12. <u>Restrictions that Limit Duration or Scope of Benefits for Services</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

13. <u>Restrictions for Provider Specialty</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

14. <u>Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Appendix E

Instructions for MHPAEA NQTL Analysis Report and Data Report

MHPAEA Compliance Reporting for NQTLs

Introduction: The analysis report template and supplements are prepared to satisfy the requirements of §15-144, Insurance Article, Annotated Code of Maryland, to create a standard form for entities to submit the NQTL report in accordance with subsection §15-144(c)-(e).

Complete analysis reports must include all data and information identified in COMAR 31.10.51 and in these instructions in the manner and format specified. Failure to submit a complete report may result in administrative penalties as specified in § 15-144 of the Insurance Article.

Narratives and data shall be entered into the fields of the template or supplemental form.

In completing the analysis report, MH/SUD may be combined when the description and application of factors, processes, strategies, evidentiary standards, and sources are the same for both. If the description and/or application of factors, processes, strategies, evidentiary standards, or sources is different for mental health benefits and substance use disorder benefits as written or in operation, then mental health benefits and substance use disorder benefits shall be reported separately.

The following are examples of responses that may result in a finding that a carrier failed to submit a complete analysis report:

1. Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2. Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3. Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4. Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

5. Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6. Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions;

7. Responses that do not to include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses**;**

8. Analysis that is not for the applicable time period;

9. Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10. Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

Definitions

The terms in the instructions and the analysis report are defined in COMAR 31.10.51 or have the meaning indicated below. Use of these definitions in completing the report is mandatory.

"Case management" means a program to assist a member in accessing necessary medical, substance use disorder, or mental health services, and may include:

(a) Coordinating access to care;

(b) Exploring service and funding source alternatives;

(c) Monitoring progress to established goals (set by a case manager and the patient);

(d) Assisting with coordinating discharge planning and follow-up;

(e) Helping ensure the patient's benefits are used effectively.

"Concurrent Review" means any process used by the carrier or its private review agent to conduct utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

"Emergency Services" means the treatment of a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical attention could reasonably be expected to result in placing the health of the patient, or, in case of pregnancy, the unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Facility" means a person, other than an individual, that provides health care services. "Facility" includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, and residential treatment centers.

"Failure to Complete a Course of Treatment" means a patient's failure to follow a documented treatment plan prescribed or recommended by a healthcare professional, including, but not limited to, on the Uniform Treatment Plan form when the treatment is for mental health or a substance use disorder.

"Measures" means the steps, plan, methods, or course of action taken by a carrier to assess compliance in the development and implementation of an NQTL when the carrier has delegated management of covered benefits to another entity. Measures include written policies, procedures, and guidelines, as well as operational controls, checks, audits, and safeguards.

"Pharmacy services" means any of the following activities:

(a) Providing pharmaceutical care;

(b) Compounding, dispensing, or distributing prescription drugs or devices;

(c) Compounding or dispensing nonprescription drugs or devices;

(d) Monitoring prescriptions for prescription and nonprescription drugs or devices;

(e) Providing information, explanation, or recommendations to patients and health care practitioners about the safe and effective use of prescription or nonprescription drugs or devices;

(f) Identifying and appraising problems concerning the use or monitoring of therapy with drugs or devices;

(g) Acting within the parameters of a therapy management contract, as provided under Subtitle 6A of the Health-Occupations Article;

(h) Administering vaccinations in accordance with § 12–508 of the Health-Occupations Article or self–administered drugs in accordance with § 12–509 of the Health-Occupations Article;

(i) Delegating a pharmacy act to a registered pharmacy technician, pharmacy student, or an individual engaged in a Board approved pharmacy technician training program;

(j) Supervising a delegated pharmacy act performed by a registered pharmacy technician, pharmacy student, or an individual engaged in a Board approved pharmacy technician training program;

(k) Providing drug therapy management in accordance with § 19–713.6 of the Health – General Article; or

(l) Prescribing and dispensing contraceptive medications and self–administered contraceptive devices approved by the U.S. Food and Drug Administration.

"Plan documents" means all documents under which the plan is established or operated in which a carrier describes a requirement related to an NQTL, or the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, including a policy, certificate of coverage, medical policy, medical necessity criteria or guidelines, or provider manual. Plan documents also include any document reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

"Prescription Drug Formulary Design" means a continually updated list of prescription drugs approved for reimbursement, including both generic and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed.

"Prior authorization" means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to, preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. Prior authorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted. A request for prior authorization is one received during the reporting period, regardless of whether or when services are delivered or whether or when a claim is submitted.

"Process for Assessment of New Technology" means a systematic, scientific process to follow for evaluating medical and surgical treatments and mental health and substance use treatment in order to

ensure that members under the carrier's health benefit plan have access to appropriate treatments not previously covered by the carrier.

"Product" means a package of health insurance coverage benefits identified by a particular network type, limited to health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity.

"Provider Credentialing and Contracting" means a carrier's processes and procedures and standards for determining which health care providers to contract with, either directly or through a subcontracting entity, to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

"Reimbursement" means compensation or the amount allowed to a health care provider, member, or other person entitled to reimbursement by a carrier, or the combined amount of the carrier's payment and member's cost-sharing responsibility, for providing health care services, medications, or supplies to enrollees of the health benefit plan. Reimbursement includes, but is not limited to, fee for service payments, capitation payments, bundled or global payments, and bonuses or other incentive payments.

"Restrictions for Provider Specialty" means, for services that are within the scope of practice for a health care provider, restrictions based on the licensure or certification of a health care provider that limit the scope or duration of benefits for services provided under the plan or coverage.

"Restrictions that Limit Duration or Scope of Benefits for Services" means non-numerical limits or restrictions based on geographic location, facility type, provider specialty, and other criteria, including exclusions of a specific or type of MH/SUD treatment, that limit the scope or duration of benefits for services provided under the plan or coverage.

"Retrospective Review" means utilization review of health care that has been provided to an enrollee.

NQTL Analysis Report Template Completion Instructions

Plan Information

Identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets. Provide the form numbers, approval dates, and SERFF tracking numbers for all forms comprising the entire contract of insurance for the health benefit plan. A separate analysis report shall be submitted for each plan.

Benefit Classifications

(a) List each covered service under the plan in the table below. Indicate whether the covered service is treated as M/S or MH/SUD, and identify which of the following classifications or sub-classifications the covered service has been assigned to: In Network Inpatient; Out of Network Inpatient; In Network Outpatient (OR: In Network Outpatient-Office; In Network Outpatient-All Other); Out of Network Outpatient (OR: Out of Network Outpatient-Office; Out of Network Outpatient-All Other); Emergency; or Prescription.

Do not list non-medical dental or vision benefits in the list of covered services, and do not include these benefits in the NQTL analyses. Dental care that is customarily covered under medical policies, e.g. injury to sound natural teeth or treatment for cleft lip/cleft palate, should be included as a medical benefit.

For the purposes of the NQTL analyses for each plan, a carrier may elect to use the outpatient benefit classifications, or divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services." The election to use either the outpatient classifications or the outpatient sub-classifications shall be made at the plan level, and may not vary for different NQTLs under the same plan.

(b) Explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification. Note: Classification of covered services must remain consistent across NQTL analyses within the same plan. In determining the classification in which a particular benefit belongs, the same standards must be applied to M/S benefits and to MH/SUD benefits. Intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) must be assigned to the existing six classifications in the same way that intermediate medical/surgical benefits are assigned to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well

Step 1:

(a) Provide a description of the plan's applicable NQTLs as applied to M/S or MH/SUD benefits in the table below.

Please note that the questions listed under each category of NQTL's on the analysis report template are not exclusive or intended to limit the scope of applicable NQTL's that must be included in the report.

Describe the specific NQTL plan language and procedures, as applied to M/S benefits and as applied to MH/SUD benefits, including identification of associated triggers, timelines, forms, and requirements.

Provide cross references to plan documents that contain language related to application of the NQTLs (i.e., all member documents, posted medical policies, internal documents and applicable provider manual references which are pertinent to providing notice of and information regarding the NQTL requirements). Note that for the purposes of Step 1(a), the term "plan documents" refers only to the documents describing the NQTL itself, and does not include documents reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

Copies of the applicable policy or certificate of coverage should be available, but are not required to be included with the submission. Copy the specific language from the policy or certificate into the report. Provide the page number, section number, and form number where the provision can be found in the policy or certificate.

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies. For the purposes of the NQTL analyses for each plan, if a carrier has elected not to divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services," then the "Outpatient-Office sub-classification" columns shall be used to identify the NQTLs applicable to the outpatient classification in general. In this case, the carrier shall include the following explanation in the "Outpatient-Office sub-classification" columns before identifying whether the listed NQTLs are applicable: "Outpatient sub-classifications were not utilized for the NQTL analysis for this plan. Responses apply to outpatient classification in general."

"Emergency" and "Prescription" are listed as one of the benefit classifications under each NQTL category on the analysis report template, while "Emergency Services" and "Pharmacy Services" are also included as separate NQTL categories on the template. Where "Emergency" and "Prescription" are listed as benefit classifications under a particular NQTL category, information on the applicable NQTLs should be reported in that section. The separate "Emergency Services" and "Pharmacy Services" NQTL categories are intended to encompass only those NQTLs that are not captured elsewhere in the analysis report. Additionally, for the separate "Emergency Services" and "Pharmacy Services" NQTL categories, no information for other benefit classifications and sub-classifications is required to be reported.

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification

Steps 2 – 7 shall be performed for each benefit classification and/or sub-classification.

Step 2:

Appendix D

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification, or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

- Identify the factors that the plan uses to determine whether each benefit, service, or procedure/revenue code, as a matter of plan policy, is deemed subject to the NQTLs.

  Illustrative examples of factors include, but are not limited to:

  - Excessive utilization;
  - High cost of treatment;
  - Recent medical cost escalation;
  - Provider discretion in determining diagnosis, or type or length of treatment;
  - Lack of clinical efficiency of treatment or service;
  - High variability in cost per episode of care;
  - High levels of variation in length of stay;
  - High variability in quality of care;
  - Lack of adherence to quality standards;
  - Claim types with high percentage of fraud;
  - Clinical efficacy of the proposed treatment or service;
  - Severity or chronicity of the MH/SUD or medical/surgical condition;
  - Current and projected demand for services;
  - Licensing and accreditation of providers;
  - Geographic market (i.e., market rate and payment type for provider type and/or specialty);
  - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty;
  - Supply of provider type and/or specialty;
  - Network need and/or demand for provider type and/or specialty;
  - Medicare reimbursement rates;
  - Training, experience, and licensure of provider.

- Identify the sources for the factors that the plan uses to determine whether each service or code is deemed subject to the NQTLs.

  Illustrative examples of sources of factors include, but are not limited to:

- Internal claims analysis;
- Medical expert reviews;
- State and federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules;
- Internal quality standard studies;
- External healthcare claims database;
- Current Medicare Physician Fee Schedule;
- Medicare RVUs for CPT codes.

- Identify factors that were considered, but rejected.
- If a factor was given more weight than another, what is the reason for the difference in weighting?
- **Notes:**
  - For utilization management NQTLs (e.g., prior authorization and concurrent review), it is understood that a determination of medical necessity is required for all services and it does not need to be noted as a factor.
  - The fact that all services in a particular classification or sub-classification are subject to the NQTL does not eliminate the requirement to identify the factors and sources for each factor.

Step 3:

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

For each factor identified in Step 2, identify, define, and provide the source for the evidentiary standard and/or data source, and any other evidence relied upon, to determine that the NQTLs apply to MH/SUD and M/S services.

- Identify any threshold or quantitative evidentiary standard at which each factor will implicate the NQTL.
  - For example, if high cost is identified as a factor used in designing a prior authorization requirement, the carrier would identify and explain:
    - The threshold dollar amount at which prior authorization will be required for any benefit;
    - The data analyses, and methodology and results used to determine the benefit is "high cost"; and how, if at all, the amount that is to be considered "high cost" is different for

MH/SUD benefit as compared with M/S benefits, and how the carrier justifies this difference.

- Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to:
  - Excessive utilization may be considered as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care;
  - Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10% or more per year for two years;
  - Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30% of the time based on clinical chart reviews;
  - High level of variation in length of stay may be considered as a factor when claims data shows that 25% of patients stayed longer than the median length of stay for acute hospital episodes of care;
  - High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period;
  - Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

- If specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided.

- Evidentiary standards and processes that a carrier relies on may include any evidence that a carrier considers in developing its medical management techniques, including internal carrier standards, recognized medical literature and professional standards and protocols (such as comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

- Explain comparability of how the factors are defined and applied between MH/SUD and M/S services (i.e., clearly delineate and explain any differences in factors, definitions of factors, or evidentiary standards used to determine application of the NQTL, and provide an explanation as to why and/or how the factors, definitions of factors, and evidentiary standards are deemed comparable).

- If a source such as NCQA is used in determining comparability, the standards for that source and any analyses developed internally or provided to NCQA or other external agencies must be provided.

- Failure to include all of the information described in the instructions for Step 3 will result in a finding that a carrier failed to submit a complete analysis report and may result in administrative penalties as specified in § 15-144 of the Insurance Article.

Step 4:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

- Indicate how the factors, as defined and explained by the evidentiary standards identified in Step 2 and Step 3, are applied comparably to establish the written policy as to which services, MH/SUD and M/S, are subject to the NQTL.
- Include a brief description of each step, and comparative analysis, for the processes used in applying the NQTLs to MH/SUD and M/S services, and demonstrate comparable and no more stringent application to MH/SUD services at each step.
- Include information on the composition and deliberations of the decision-making staff responsible for the written policies, including the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.
- Demonstrate that there are not arbitrary or unfairly discriminatory differences in the written standards for applying underlying processes and strategies to NQTLs with respect to medical/surgical benefits versus MH/SUD benefits.
- Examples of methods/analyses demonstrating that factors, evidentiary standards, and processes are comparable include, but are not limited to:
    - Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency and magnitude with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL;
    - A consistent methodology (e.g., internal claims analysis) for analyzing which MH/SUD and medical/surgical benefits had "high cost variability" (defined by identical factors and evidentiary standards for all services) and were therefore subject to the NQTL;
    - Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied;
    - Internal Quality Control Reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and medical surgical benefits are comparable and no more stringently applied to MH/SUD benefits;
    - Summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was similarly utilized for both MH/SUD and medical/surgical benefits;

- Internal review of published treatment guidelines by appropriate clinical teams (with comparable compositions and qualifications for both MH/SUD and medical/surgical benefits) to identify (using comparable standards and thresholds for both MH/SUD and medical/surgical benefits) covered treatments or services which lack clinical efficacy;

- Internal review to determine that the carrier's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.

➢ Failure to include all of the information described in the instructions for Step 4 will result in a finding that a carrier failed to submit a complete analysis report and may result in administrative penalties as specified in § 15-144 of the Insurance Article.

Step 5:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

➢ Provide the Carrier's analyses that demonstrate the comparability of the implementation of the written policies and procedures governing application of the NQTL.

➢ The analyses should include discussion of quality assurance and oversight policies, processes and metrics that the plan applies to monitor in operation compliance. Examples of information to include are results of comparative assessment of denial rates (both administrative and medical necessity) by service, reviews for correlation between basis for service denials and stated criteria, and internal and/or external appeals and overturn rates.

➢ **Note**: Disparate results or outcomes between MH/SUD and M/S services are not regarded as dispositive of parity noncompliance; however, disparities constitute a warning sign or red flag of potential noncompliance and warrant further investigation. Conversely, equal or more favorable outcomes for MH/SUD services as compared to M/S is a positive indicator; however, is not necessarily dispositive of parity compliance either.

➢ To ensure uniformity in reporting, the MIA may ask for data using the Medicare provider fee schedules as a metric to measure whether reimbursement rates are comparable. Carriers may also provide other comparative data in addition to Medicare benchmark data to support the comparability analysis.

➢ Examples of comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied in operation include, but are not limited to:

- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable;

- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits;

- Audit results that demonstrate the process of consulting with expert reviewers for MH/ SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved;
- Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews;
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits;
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits;
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category;
- Audit/review of utilization review documentation requirements;
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines;
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/ surgical reviewers.
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification;
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

➢ Failure to include all of the information described in the instructions for Step 5 will result in a finding that a carrier failed to submit a complete analysis report and may result in administrative penalties as specified in § 15-144 of the Insurance Article.

[See Data Supplements 1 – 4 which contain requests for additional required data to supplement the responses provided in Step 5 of the NQTL Analysis Report.]

Step 6:

Identify the measures used to ensure comparable design, development, and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)). This step is only required if administration of a benefit subject to the applicable NQTL has been delegated to another entity, e.g. formulary design of prescription benefits has been delegated to a pharmacy benefits manager.

- If the carrier delegates administration or management of certain benefits to a third party vendor or service provider (for example, a private review agent specializing in mental health and substance use disorder benefits or a pharmacy benefits manager), the carrier is responsible for coordinating with the subcontracted entity on the development and application of NQTLs for MH/SUD and medical/surgical benefits to ensure comparability.
- Include a description of the measures, processes, and standards implemented to ensure collaboration with all vendors and subcontracted entities that exert any influence on the design, development, or application of an NQTL.
- Include any written procedures or guidelines to ensure that that the NQTL is consistently applied to similarly situated individuals.

Step 7:

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with § 15-144 of the Insurance Article, the Parity Act, and other related federal regulations. (§15-144(e)(6)).

- Explain the basis for the Carrier's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits in each classification of benefits in which the NQTL is imposed.

- A general or conclusory statement of compliance is not sufficient.

- The analysis required for this section is not a restatement of prior sections of the report. Instead, carriers shall prepare a detailed summary of specific findings and conclusions demonstrating that the plan is in compliance with the Parity Act both as written and in operation.

- To the extent there are differences noted between MH/SUD and M/S in the foregoing steps, delineate these in the summary and note how they were reconciled in the reporting. For example, if different factors were utilized to determine services to which the NQTLs would apply, explain how the processes, strategies, evidentiary standards, and other factors were determined to be comparable and applied no more stringently as written and in operation.

- To the extent there are disparities in any comparative data analyses, including quantitative disparities shown in the required data supplement forms or other in operation analyses, explain in detail how these disparities are not evidence of parity non-compliance, and whether steps will be taken to reduce these disparities. Include whether steps have been taken to ensure/improve access to in-network M/S providers and whether the same or comparable steps have been taken for MH/SUD.

Disclosure Requirements

Identify the process used to comply with the Parity Act Disclosure Requirements for MH/SUD and M/S Benefits.

Describe the process for disclosing the criteria used for a medical necessity determination for MH/SUD benefits to current or potential members, or to a contracting provider, upon request.

- Carriers shall report any instructions, guidance or information available to the public concerning the carrier's obligation to respond to disclosure requests, including where requests must be sent and what information is available in response to disclosure requests.

- Carriers shall report whether the designated division and/or individual(s) responsible for responding to disclosure requests.
- Carriers shall indicate whether it responded to any disclosure requests by denying access to the requested information and the basis for such denial.

- Carriers shall report any internal review process used to respond to disclosure requests for medical necessity criteria.

- Carriers shall report any template form response used to explain medical necessity criteria in response to a participant, beneficiary, provider, or authorized representative of the beneficiary or participant.

Describe the process for disclosing the reasons for a denial of benefits for MH/SUD.

- Carriers shall report any internal review process used to respond to disclosure requests for denials of benefits.

- Carriers shall report the criteria for responding to a disclosure request based on a denial of benefits for any applicable plan.

- Carriers shall report the number of disclosure requests received for denials of benefits and the number of instances when it failed to provide a response to a participant beneficiary, provider, or authorized representative of the beneficiary or participant within 30 days of the request.

Describe the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply a NQTL for MH/SUD and M/S benefits in connection with a member's request for group plan information and for purposes of filing an internal coverage or grievance matter and appeals.

- A carrier shall report how its procedures ensure that the following information is disclosed:
    - any information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the applicable plan.
    - any records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits under any applicable plan.
    - any available details as to how the standards were applied, and any internal testing, review, or analysis done by the applicable plan to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.

- A carrier shall report how its procedures ensure that any plan materials related to the plan's compliance with MHPAEA are disclosed in compliance with 45 C.F.R § 146.136, including the following:
    - any references to provisions as stated on specified pages of the policy or certificate, or other underlying guidelines or criteria not included in the policy or certificate that the plan has consulted or relied upon;
    - any information regarding specific related factors or guidelines, such as applicable utilization review criteria;
    - any factors, such as cost or recommended standards of care, that are relied upon by an applicable plan for determining which M/S or MH/SUD benefits are subject to a specific requirement or limitation;
    - a description of the applicable requirement or limitation that the applicable plan believes has been used in any given MH/SUD service adverse decision within the relevant classification; and
    - the medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

- A carrier shall provide a list of the responses provided in the prior calendar year to requests from a member or a member's authorized representative for a copy of the NQTL comparative analysis. The actual responses are not required to be included with the initial submission, but shall be available to the Commissioner upon request.

[Add Data Supplements 1 – 4 here - which contain requests for additional required data to supplement the responses provided in Step 5 of the NQTL Analysis Report.]

Appendix D

MHPAEA Compliance Reporting for Data Report

Introduction: The data collection tool is prepared to satisfy the requirements of §15-144, Insurance Article, Annotated Code of Maryland, to create a standard form for entities to submit the data report in accordance with subsection §15-144(f).

Complete data reports must include all data and information identified in COMAR 31.10.51 and in these instructions in the manner and format specified. Failure to submit a complete report may result in administrative penalties as specified in § 15-144 of the Insurance Article.

The terms in the instructions and the data report are defined according to COMAR 31.10.51.

Data Report Template Completion Instructions

- Enter the health benefit plan name in the yellow cell next to "Health Plan."
- For the first table, enter the # of Authorization Requests Received, # of Authorization Requests Approved, and the # of Authorization Requests Denied for each of the classifications (INN-Inpatient, OON-Inpatient, Emergency Services, RX, INN-Outpatient-Office, OON-Outpatient-Office, INN-Outpatient-AllOther, and OON-Outpatient-AllOther) for mental health benefits, substance use disorder benefits, and medical/surgical benefits.
- For the second table, enter the # of Claims Submitted, # of Claims Approved, and # of Claims Denied for each of the classifications (INN-Inpatient, OON-Inpatient, Emergency Services, RX, INN-Outpatient-Office, OON-Outpatient-Office, INN-Outpatient-AllOther, and OON-Outpatient-AllOther) for mental health benefits, substance use disorder benefits, and medical/surgical benefits.
- For the second table, also enter all of the applicable reasons for denial of claims in the far right column for each benefit and each of the classifications. Carriers shall also include a summary defining each applicable code listed in this column.
- When reporting the data for each plan, if, for purposes of the corresponding NQTL analyses performed on the plan, a carrier has elected not to divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services," then the "INN-Outpatient-Office" and "OON-Outpatient Office" categories shall be used to report data for the outpatient classification in general, and "N/A" shall be entered for the "INN-Outpatient-AllOther" and "OON-Outpatient-AllOther" categories.
- In counting the # of Authorization Requests Received and the # of Claims Submitted, use the number of requests received or claims lines (e.g. CPT code) submitted during the prior calendar year. The number of approvals and denials shall be those arising from the reported requests and claims.

NQTL Report – Data Supplement 1 Report Form

Hospital Inpatient					
		In-Network		**Out-of-Network**	
		Med/Surg	**MH/SUD**	**Med/Surg**	**MH/SUD**
(1)	**Out of Network exceptions pursuant to Ins. Art. § 15-830**				
(A)	Number of requests to see an out-of-network provider as in-network				
(B)	Number of approved requests to see an out-of-network provider as in-network				
(2)	**Prior authorizations**				
(A)	Number of prior authorizations requested				
(B)	Number of prior authorizations approved in line (2)(A)				
(C)	Number of prior authorization requests subject to a fail-first requirement in line (2)(A)				

(D)	Number of prior authorization requests that were denied as adverse decisions in line (2)(A)				
(3)	**Concurrent review**				
(A)	Number of requests for concurrent review				
(B)	Number of concurrent reviews that were approved in line (3)(A)				
(C)	Number of concurrent reviews that were denied as adverse decisions in line (3)(A)				
(4)	**Retrospective review**				
(A)	Number of retrospective reviews of medical necessity				
(B)	Number of retrospective reviews that were approved in line (4)(A)				
(C)	Number of retrospective reviews that were denied as adverse decisions in line (4)(A)				

Other Inpatient					
		In-Network		**Out-of-Network**	
		Med/Surg	**MH/SUD**	**Med/Surg**	**MH/SUD**
(1)	**Out of Network exceptions pursuant to Ins. Art. § 15-830**				
(A)	Number of requests to see an out-of-network provider as in-network				
(B)	Number of approved requests to see an out-of-network provider as in-network				
(2)	**Prior authorizations**				
(A)	Number of prior authorizations requested				
(B)	Number of prior authorizations approved in line (2)(A)				
(C)	Number of prior authorization requests subject to a fail-first requirement in line (2)(A)				
(D)	Number of prior authorization requests that				

	were denied as adverse decisions in line (2)(A)				
(3)	**Concurrent review**				
(A)	Number of requests for concurrent review				
(B)	Number of concurrent reviews that were approved in line (3)(A)				
(C)	Number of concurrent reviews that were denied as adverse decisions in line (3)(A)				
(4)	**Retrospective review**				
(A)	Number of retrospective reviews of medical necessity				
(B)	Number of retrospective reviews that were approved in line (4)(A)				
(C)	Number of retrospective reviews that were denied as adverse decisions in line (4)(A)				

		Outpatient							
		In-network				Out-of-network			
		Med/Surg (office visits)	Med/Surg (all other)	MH/SUD (Office Visits)	MH/SUD (all other)	Med/Surg (office visits)	Med/Surg (all other)	MH/SUD (Office Visits)	MH/SUD (all other)
(1)	**Out of Network exceptions pursuant to Ins. Art. § 15-830**								
(A)	Number of requests to see an out-of-network provider as in-network								
(B)	Number of approved requests to see an out-of-network provider as in-network								
(2)	**Prior authorizations**								
(A)	Number of prior authorizations requested								
(B)	Number of approved prior								

	authorizations in line (2)(A)								
(C)	Number of prior authorization requests subject to a fail-first requirement in line (2)(A)								
(D)	Number of prior authorization requests that were denied as adverse decisions in line (2)(A)								
(3)	**Concurrent review**								
(A)	Number of requests for concurrent review								
(B)	Number of concurrent reviews that were approved in line (3)(A)								
(C)	Number of concurrent reviews that								

	were denied as adverse decisions in line (3)(A)								
(4)	**Retrospective review**								
(A)	Number of retrospective reviews of medical necessity								
(B)	Number of retrospective reviews that were approved in line (4)(A)								
(C)	Number of retrospective reviews that were denied as adverse decisions in line (4)(A)								

Prescription Drug NQTL

Prescription Drugs			
		Med/Surg	**MH/SUD**
(1)	**Prior authorizations**		
(A)	Number of prior authorizations requested		
(B)	Number of prior authorizations approved in line (1)(A)		
(C)	Number of prior authorization requests that were subject to a fail-first requirement in line (1)(A)		
(D)	Number of prior authorization requests that were denied as adverse decisions in line (1)(A)		
(2)	**Retrospective Review**		
(A)	Number of retrospective		

	reviews of medical necessity		
(B)	Number of retrospective reviews that were approved in line (2)(A)		
(C)	Number of retrospective reviews that were denied as adverse decisions in line (2)(A)		

Instructions for Completing Data Supplement 1 Report Form for Utilization Review

The instructions provided below pertain to a supplemental request for in-operation data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article.

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL report, this supplemental report of data standardized among carriers is a required portion of the NQTL analysis report.

A supplemental data report is required for the NQTLs of prior authorization, concurrent review, retrospective review, and pharmacy services.

Carriers are required to enter data in the supplemental data report form, organized by classification, based on the definitions and instructions provided below.

Section 15-830 of the Insurance Article requires carriers to have a process for members to request referrals to an out of network provider. Section 15-830(d)(5) of the Insurance Article requires carriers to have a system in place to document all requests to obtain such a referral, and to provide the information to the Commissioner on request. The out of network exceptions requests under line 1 refer to the provisions of § 15-830 of the Insurance Article.

Carriers should refer to the definitions below when preparing the supplemental data report:

"Prior authorization" has the meaning stated in the instructions for completing the MHPAEA NQTL Analysis Report and Data Report.

"Approved" means that the request was approved in full or the provider agreed to accept the carrier's approval of a modification of the request. "Approved" does not include a request for which an adverse decision or coverage decision was issued.

"Adverse decision" has the definition in § 15-10A-01(b) of the Insurance Article.

"Concurrent review" has the meaning stated in the instructions for completing the MHPAEA NQTL Analysis Report and Data Report.

"Hospital inpatient" means inpatient care following admission to a hospital, usually designated with place of service code 21 on a claim.

"Other inpatient" means care in an inpatient facility that is not a hospital. Examples include a skilled nursing facility, hospice, or residential treatment center.

Outpatient care is divided into office visits and all other. "Office visits" refers to health care services provided in a health care provider's office, usually designated on a claim with place of service code 11.

"Other outpatient" services are outpatient services that are not provided in a health care provider's office. Examples include an ambulatory surgical center or non-residential substance abuse treatment facility.

“Fail-first” means a protocol established by a carrier that a member must unsuccessfully attempt a different drug or treatment before the health benefit plan provides coverage for the recommended drug or treatment.

In counting the numbers of requests for authorization, use the number of requests received during the prior calendar year. The number of adverse decisions shall be those arising from the reported requests.

Any disparities in the data between M/S and MH/SUD providers should be explained in Step 7 of the NQTL Analysis Report Template for the applicable NQTL.

Data Supplement 2, Formulary Exception Requests, Report Form

		Med/Surg	MH/SUD
1	Number of requests received pursuant to § 15-831(c)(1) for coverage of a drug that is not on the formulary		
(a)	Number of requests in line 1 that were denied as adverse decisions		
(b)	Number of requests in line 1 that were approved		
2	Number of requests received pursuant to § 15-831(c)(2) for coverage of a drug at a tier with a lower level of cost-sharing		
(a)	Number of requests in line 2 that were denied as adverse decisions		
(b)	Number of requests in line 2 that were approved		

Instructions for Data Supplement 2, Formulary Exception Requests

The instructions provided below pertain to a supplemental request for data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article.

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL analysis report and the reviews required by the NQTL analysis report, this supplemental report of data standardized among carriers is a required portion of the NQTL analysis report.

A supplemental data report is required for the NQTL of prescription drug formulary design.

Carriers are required to follow the instructions below in completing the supplemental data report.

Section 15-831 of the Insurance Article requires carriers that have formularies to implement procedures for members to request exceptions to the formulary. Section 15-831(c)(1) of the Insurance Article requires carriers to have a procedure to allow a member to receive a prescription drug that is not in the carrier's formulary and is therefore not covered. Section 15-831(c)(2) of the Insurance Article requires carriers to have a procedure to allow a member to continue to receive a prescription drug at lower cost-sharing if the drug is moved to a tier with higher cost-sharing.

The number of requests received refers to requests received during the prior calendar year. The number of adverse decisions refers to the outcome of requests received and reported on lines 1 or 2.

Approved means that the request was approved in full.

Adverse decision has the meaning in § 15-10A-01(b) of the Insurance Article.

Any disparities in the data between M/S and MH/SUD providers should be explained in Step 7 of the NQTL Analysis Report Template for the NQTL of Prescription Drug Formulary Design.

Data Supplement 3, Provider Credentialing, Report Form

	Med/Surg facility	MH/SUD Facility	Med/Surg Practitioner	MH/SUD Practitioner
Mean number of days from first submission of an application to the later of the effective date or date of execution of contract				
Median number of days from first submission of an application to the later of the effective date or date of execution of contract				
Percentage of providers that submitted an initial application, but withdrew or failed to complete the credentialing process by not responding				
Percentage of providers that completed the process and executed a contract				
Percentage of providers that submitted an initial application or request for application that were rejected due to a full network				
Percentage of providers that submitted an	[redacted]			

initial application or request for application that were notified that the carrier would not proceed with the application	[redacted]		

Instructions for Data Supplement 3, Provider Credentialing

The instructions provided below pertain to a supplemental request for data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article.

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL analysis report and reviews required by the NQTL analysis report, this supplemental report of data standardized among carriers is a required portion of the NQTL analysis report.

A supplemental data report is required for the NQTL of provider credentialing.

Carriers are required to follow the instructions below in completing the supplemental data report. The report shall be based on the applications submitted by providers from January 1 to September 1 of the prior calendar year.

For this supplemental data report, a carrier shall include in its calculations all applications submitted to the carrier, including through an entity that arranges provider panels on behalf of the carrier, and the results of that application. "An entity that arranges provider panels on behalf of the carrier" means an entity that falls within the definition of a carrier in § 15-112(a)(5) of the Insurance Article, but is not required to file a report pursuant to § 15-144 of the Insurance Article, such as an entity that creates and leases specialty provider panel networks. The date of submission of a provider application means the date that a carrier receives notice of an application through CAQH or a written request for participation in the provider panel, including through electronic means.

The date of execution of the provider contract is the day that either the provider or carrier signs the contract and the carrier considers the contract to be executed. The same method of determining the date of execution shall be used for all calculations of the number of days.

The effective date of the provider contract is the day that the provider is able to submit claims and be reimbursed according to the terms of the provider contract.

In lieu of reporting the number of days from the first submission of an application to the later of the effective date or the date of execution of the contract, a carrier may report the number of days from the first submission of an application to the date of receipt of a completed application, as well as the number of days from receipt of a completed application to the date of execution of a contract, so long as both are reported. A carrier shall use a consistent reporting method for all reports.

The mean number of days shall be calculated by adding together the number of days for all applicants, and dividing by the number of applicants. The median number of days shall be determined by arranging the number of days each application was pending in ascending or descending number; if there is an odd number of numbers of days, then the middle number is the median. If there is an even number of number of days, then the average of the two middle numbers is the median.

"Providers that submitted an initial application but withdrew or failed to complete the credentialing process by not responding" includes any provider that submitted an application, but either gave written notice that they were withdrawing from the process, or failed to respond to requests from the carrier for information or action that was necessary to complete the process.

To determine the number of providers that were rejected due to a full network, carriers shall count all providers rejected for this reason, regardless of whether the notice of rejection stated that this was the reason. To determine the percentage of providers rejected due to a full network, the numerator is the total number of providers rejected for this reason, and the denominator is the total number of providers that submitted an application in the same time period.

Section 15-112(g) of the Insurance Article requires that carriers send a notice to providers that the carrier will not proceed with processing the application to be on the provider panel. In determining the percentage of providers that were notified that the carrier would not proceed with the application, the numerator is the total number of providers that received a notice pursuant to § 15-112(g) of the Insurance Article, and the denominator is the number of providers that submitted an application to whom the provisions of § 15-112 of the Insurance Article apply.

A separate data supplement shall be submitted for each plan described in § 15-144(c)(1)(i) of the Insurance Article that uses a distinct provider network with different credentialing and contracting standards from the other plans. If multiple plans described in § 15-144(c)(1)(i) use the same provider network, the carrier may submit one data supplement that aggregates the data for those plans. When a carrier elects to aggregate data in this manner, the carrier shall identify the specific plans to which the data supplement applies, and shall attest that the provider network is the same for the applicable plans.

Any disparities in the timeframes for provider admission between M/S and MH/SUD providers should be explained in Step 7 of the NQTL Analysis Template for the NQTL of Standards for Provider Credentialing and Contracting.

Table A - Medical/Surgical Physicians compared to Psychiatrists - Data for January 1, 2021 through December 31, 2021			
	Description	Column A	Column B
	In-Network Office Visits Only (non-facility based)	CPT Code 99213	CPT Code 99214
1	Weighted average allowed amount for primary care physicians (PCPs)		
2	Weighted average allowed amount for non-PCP, non-psychiatrist medical/surgical specialist physicians		
3	Weighted average allowed amount for PCPs and non-psychiatrist medical/surgical specialist physicians (combined)		
4	Weighted average allowed amount for psychiatrists, including child psychiatrists		
5	Percentage by which allowed amounts for PCPs and nonpsychiatrist medical/surgical specialist physicians (combined) were higher compared to psychiatrists, i.e. ((Row 3 / Row 4) – 1) x 100 = ____%		

Table B (1) - Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99213 & 90834, Indexed to National Medicare Fee Schedule - Data for January 1, 2021 through December 31, 2021

		Column A	Column B	Column C
Provider Type	CPT Codes	Plan Weighted Average Allowed Amount	National Medicare Fee Schedule Amount	Plan Weighted Average Allowed Amount as a Percentage of Medicare
PCPs and non-psychiatrist M/S specialist physicians (combined)	99213		$ 76.15	0%
Psychologists	90834		$ 94.56	0%
Clinical Social Workers	90834		$ 70.92	0%

Table B (2) - Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99214 & 90837, Indexed to National Medicare Fee Schedule - Data for January 1, 2021 through December 31, 2021				
		Column A	Column B	Column C
Provider Type	CPT Codes	Plan Weighted Average Allowed Amount	National Medicare Fee Schedule Amount	Plan Weighted Average Allowed Amount as a Percentage of Medicare
PCPs and non-psychiatrist M/S specialist physicians (combined)	99214		$ 110.43	0%
Psychologists	90837		$ 141.47	0%
Clinical Social Workers	90837		$ 106.10	0%

Instructions for Data Supplement 4, IN-NETWORK REIMBURSEMENT

For In-Network provider office visits only, for the CPT codes provided in Tables A, B (1) and B (2), provide the weighted average allowed amounts for the specific groups of providers listed in the tables.

Please complete Tables A, B (1) and B (2) for claims data for Calendar Year 2021, or *for the period January 1, 2021, through the latest month in 2021 for which reasonably complete claims data is available.*

A separate data supplement shall be submitted for each plan described in § 15-144(c)(1)(i) of the Insurance Article that uses a distinct provider network with different reimbursement arrangements from the other plans. If multiple plans described in § 15-144(c)(1)(i) use the same provider network and reimbursement arrangements, the carrier may submit one data supplement that aggregates the allowed amount claims data for those plans. When a carrier elects to aggregate data in this manner, the carrier shall identify the specific plans to which the data supplement applies, and shall attest that the provider network and reimbursement arrangements are the same for the applicable plans.

Instructions for completing Table A follow:

• In Rows 1– 4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column B (99214). This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213 and 99214 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• In Row 5, insert the percentage amount (if any) by which the in-network reimbursement for PCPs and other non-psychiatrist M/S specialist physicians (combined) was greater than for psychiatrists.

Instructions for completing Tables B (1) and B (2) follow:

• In Rows 1– 3, Column A of Tables B (1) and B (2), insert the weighted average allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A CPT Codes listed. This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213, 99214, 90834, and 90837 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• Rows 1 - 3, Column C of Tables B (1) and B (2), insert weighted average allowed amount as a percentage of the Medicare Fee schedule amount.

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION 200 ST. PAUL PLACE, SUITE 2700 BALTIMORE, MARYLAND 21202	*	
vs.	*	
FREEDOM LIFE INSURANCE COMPANY OF AMERICA 300 BURNETT STREET, SUITE 200 FORT WORTH, TX 76102	*	MIA FILE NO: MIA-2022-07-026
NAIC# 62324	*	

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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that FREEDOM LIFE INSURANCE COMPANY OF AMERICA ("Freedom Life") has failed to comply with the Parity Act reporting requirements as provided in § 15-144(c)(1) and (f) of the Insurance Article. Freedom Life has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act:

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:
>
> > (i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and

(ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.

* * *

(f) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall submit a report for the health benefit plans identified under subsection (c)(1)(i) of this section to the Commissioner on the following data for the immediately preceding calendar year for mental health benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification:

(1) the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year; and

(2) the number of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year and the number and rates of, and reasons for, denial of claims.

A "carrier" is defined in § 15-144(a)(2) to include providers of health benefit plans.

A "health benefit plan," per § 15-144(a)(3), includes short-term limited duration insurance as defined in § 15–1301(s).

II. FINDINGS

2. Freedom Life currently holds a Certificate of Authority from the State of Maryland to act as an insurer.

3. Freedom Life offers health benefit plans providing short-term limited duration insurance in the State of Maryland in the individual market.

4. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022, due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

5. On March 1, 2022, Freedom Life reached out to the Maryland Insurance Administration ("the Administration") by telephone and requested an extension of time to file the reports required by § 15-144 of the Insurance Article.

6. On March 1, 2022, the Administration denied Freedom Life's extension to the March 1, 2022 due date required by § 15-144 of the Insurance Article.

7. On March 10, 2022, Freedom Life submitted one NQTL analysis report for its Short-Term Limited Duration Insurance Plan. The corresponding data report required by § 15-144(f) of the Insurance Article was not included in the filing.

8. On April 12, 2022, the Administration sent a letter to Freedom Life requesting the data reports required by §15-144(f) of the Insurance Article.

9. On April 19, 2022, Freedom Life sent an email response to the Administration stating that ".....the absence of a Data Report was an oversight in our initial submission."

10. On April 26, 2022, Freedom Life submitted the data reports to the Administration.

III. CONCLUSIONS OF LAW

11. The Commissioner finds that Freedom Life failed to submit the required reports for the health benefit plans identified above by the March 1, 2022 due date, and therefore, has not complied with § 15-144(c)(1) and (f) of the Insurance Article.

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this 26th day of July, **ORDERED:**

That, pursuant to § 4-113 of the Insurance Article, based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30)

days of the date of this Order, Freedom Life pay an administrative penalty of $30,000 for violation of § 15-144 of the Insurance Article.

Kathleen A. Birrane
INSURANCE COMMISSIONER

By: David Cooney
Associate Commissioner
Life & Health

Date: 7/26/22

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Melanie Gross. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Melanie Gross, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION*
200 ST. PAUL PLACE, SUITE 2700 *
BALTIMORE, MARYLAND 21202 *
*
vs. *
*
*
NATIONAL HEALTH INSURANCE COMPANY*
4455 LBJ FREEWAY, SUITE 375 *
DALLAS, TX 75244 * MIA FILE NO: MIA-2022-06-007
*
NAIC# 82538 *
*

****

ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that NATIONAL HEALTH INSURANCE COMPANY ("National Health") has failed to comply with the Parity Act reporting requirements as provided in § 15-144(c)(1) and (f) of the Insurance Article. National Health has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act:

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:
>
> > (i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and
> >
> > (ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.

* * *

(f) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall submit a report for the health benefit plans identified under subsection (c)(1)(i) of this section to the Commissioner on the following data for the immediately preceding calendar year for mental health benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification:

(1) the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year; and

(2) the number of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year and the number and rates of, and reasons for, denial of claims.

A "carrier" is defined in § 15-144(a)(2) to include providers of health benefit plans.

A "health benefit plan," per § 15-144(a)(3), includes short-term limited duration insurance as defined in § 15–1301(s).

II. FINDINGS

2. National Health currently holds a Certificate of Authority from the State of Maryland to act as an insurer.

3. National Health offers health benefit plans providing short-term limited duration insurance in the State of Maryland in the individual market.

4. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022, due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

5. On April 6, 2022, having received no reports from National Health, the Maryland Insurance Administration ("Administration") sent an email to National Health

reiterating the reporting requirements and the submission method for the reports required by § 15-144 of the Insurance Article.

6. On April 11, 2022, the Administration received an email response from Alicia Blake, Manager AH Product Compliance, stating: "I apologize as we overlooked this reporting requirement. We have begun work on the report now and will submit it to the email below as quickly as possible."

7. As of the date of this Order, National Health has not submitted the reports required by § 15-144 of the Insurance Article.

III. CONCLUSIONS OF LAW

8. The Commissioner finds that National Health failed to submit the required reports for the health benefit plans identified above by the March 1, 2022 due date, and therefore, has not complied with § 15-144(c)(1) and (f) of the Insurance Article.

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this 7th day of June, **ORDERED:**

a) That, pursuant to § 4-113 of the Insurance Article based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30) days of the date of this Order, National Health pay an administrative penalty of $35,000 for violation of § 15-144 of the Insurance Article.

b) That National Health shall submit the required reports as described herein within sixty (60) days of the date of this Order.

Kathleen A. Birrane
INSURANCE COMMISSIONER

By: David Cooney
Associate Commissioner
Life & Health

Date: 6/7/22

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Melanie Gross. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Melanie Gross, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION 200 ST. PAUL PLACE, SUITE 2700 BALTIMORE, MARYLAND 21202 vs. MAMSI LIFE AND HEALTH INSURANCE COMPANY 9800 HEALTH CARE LANE MN006-W500 MINNETONKA MN 55343 NAIC# 60321 OPTIMUM CHOICE, INC. 2020 INNOVATION COURT WI054-1000 DE PERE WI 54115 NAIC# 96940 UNITEDHEALTHCARE INSURANCE COMPANY 185 ASYLUM AVENUE HARTFORD CT 06103 NAIC# 79413 UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC. 2020 INNOVATION COURT WI054-1000 DE PERE WI 54115 NAIC# 95025	*	MIA FILE NO: MIA-2022-07-025

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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that MAMSI LIFE AND HEALTH INSURANCE COMPANY ("MLHIC"), OPTIMUM CHOICE, INC. ("OCI"), UNITEDHEALTHCARE

INSURANCE COMPANY ("UHIC"), and UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC. ("UHCMA") (collectively ""UnitedHealthcare") have failed to comply with the Parity Act reporting requirements as provided in § 15-144(c)(1) and (f) of the Insurance Article. UnitedHealthcare has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article and § 19-732 of the Health-General Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act:

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:
>
> > (i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and
> >
> > (ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.
>
> * * *
>
> (f) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall submit a report for the health benefit plans identified under subsection (c)(1)(i) of this section to the Commissioner on the following data for the immediately preceding calendar year for mental health benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification:
>
> > (1) the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year; and
> >
> > (2) the number of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits

in each Parity Act classification during the immediately preceding calendar year and the number and rates of, and reasons for, denial of claims.

A "carrier" is defined in § 15-144(a)(2) to include insurers that provide health insurance, organizations that that provide health benefit plans, and health maintenance organizations.

A "health benefit plan" is defined in § 15-144(a)(2) to include large group plans, small group plans, individual plans, and student health plans.

II. FINDINGS

2. MLHIC and UHIC each currently hold a Certificate of Authority from the State of Maryland to act as an insurer.

3. OCI and UHCMA each currently hold a Certificate of Authority from the State of Maryland to act as a health maintenance organization.

4. MLHIC offers health benefit plans in the State of Maryland in the small group market; UHCMA offers health benefit plans in the State of Maryland in the small and large group markets; and OCI and UHIC offer health benefit plans in the State of Maryland in the individual, small, and large group markets. The health benefit plans offered by UHIC in the individual market are student health plans.

5. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022 due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

6. On March 1, 2022, UnitedHealthcare submitted NQTL analyses and data reports ("reports") for twenty-one health benefit plans.

7. On March 1, 2022, UnitedHealthcare stated in an email to the Maryland Insurance Administration ("the Administration") that "... there was an error in identifying

the top ranking plans by enrollment for each product; this error was discovered on 2/28/22.... We are in the process of correcting our error, identifying the remaining top plans, and providing the required analyses." The email did not identify the number of additional plans and products for which reports were not submitted by the March 1, 2022 due date.

8. On March 11, 2022, the Administration sent letters to MLHIC, OCI, UHIC, and UHCMA regarding deficiencies in the reports filed on March 1, 2022. In addition, each letter stated "...we are aware that there was an error in identifying the top ranking plans by enrollment for each product and that you are in the process of identifying the remaining top plans, and providing the required analyses. The Administration expects that the analysis reports for the remaining top ranking plans be filed in the manner set forth in this correspondence."

9. **Findings Related to UHIC**

a. The reports submitted on behalf of UHIC were for three student health plans, one preferred provider organization ("PPO") health benefit plan in the small group market, and three PPO health benefit plans in the large group market.

b. On March 21, 2022, in response to the Administration's March 11, 2022 letter, UHIC submitted an updated NQTL analysis report master document and an updated data report for one of the large group health benefit plan reports filed on March 1, 2022. The master document was identified in the header of the report as an NQTL Analysis Report Template for "Line of Business: Large Group, Contract Type: PPO, and Benefit Plan: Plan Code KY-1." No explanation or context was provided for the master document or the updated data report, and no other reports or documents were included with the response.

c. On March 22, 2022, the Administration sent a letter to UHIC requesting clarification and additional information regarding the reports filed on March 21, 2022 and reminding UHIC that the Administration expected that the remaining products and top ranking plans be identified and filed in the manner described in the Administration's March 11, 2022 correspondence.

d. On April 1, 2022, UHIC submitted to the Administration NQTL analyses and data reports for the health benefit plans not previously identified. This included four PPO small group health benefit plan reports, two PPO large group health benefit plan reports, and five exclusive provider organization ("EPO") large group health benefit plan reports. The letter accompanying the submission stated that "…. inaccuracies were discovered in our prescription data in the Data Reports for UnitedHealthcare Insurance Company (Student Resources) plans. Given this, amended Data Reports for this entity have also been attached."

10. **Findings Related to MLHIC**

a. The reports submitted by UnitedHealthcare on behalf of MLHIC were for one small group EPO health benefit plan and three small group point-of-service ("POS") health benefit plans.

b. On March 21, 2022, in response to the Administration's March 11, 2022 letter, MLHIC submitted three new data reports for small group PPO health benefit plans, three "updated" analysis reports that were identical to the analysis reports for the POS health benefit plans filed on March 1, 2022, and a new Master NQTL Analysis Report Template for a PPO product. The master document was identified in the header of the report as an NQTL Analysis Report Template for "Line of Business: Large Group, Contract Type: PPO, and Benefit Plan: Plan Code CCM5." Other than stating the

reports were "updated" or "new," no explanation or context was provided for the submitted materials.

c. On March 23, 2022 the Administration sent a letter to MLHIC requesting clarification and additional information regarding the reports filed on March 21, 2022 and reminding MLHIC that the Administration expected that the remaining products and top ranking plans be identified and filed in the manner described in the Administration's March 11, 2022 correspondence.

d. On April 1, 2022, MLHIC submitted to the Administration a corrected NQTL analysis report and data report for the EPO product reports originally submitted on March 1, 2022, four NQTL analysis reports and data reports for EPO health benefit plans not previously identified, and five NQTL analysis reports and data reports for PPO health benefit plans not previously identified. The reports for the three small group POS health benefit plans originally submitted on March 1, 2022 were withdrawn.

11. **Findings Related to OCI**

a. The reports submitted on behalf of OCI were for five individual HMO health benefit plans and one large group HMO health benefit plan.

b. On March 21, 2022, in response to the Administration's March 11, 2022 letter, OCI submitted an updated NQTL analysis report master document for a large group HMO health benefit plan. The master document was identified in the header of the report as an NQTL Analysis Report Template for "Line of Business: Large Group, Contract Type: HMO, and Benefit Plan: Plan Code BBQY." No explanation or context was provided for the master document, and no other reports or documents were included with the response.

c. On March 23, 2022 the Administration sent a letter to OCI requesting clarification and additional information regarding the reports filed on March 21, 2022 and reminding OCI that the Administration expected that the remaining products and top ranking plans be identified and filed in the manner described in the Administration's March 11, 2022 correspondence.

d. On April 1, 2022, OCI submitted to the Administration revised NQTL analyses and data reports for the five HMO individual health benefit plans previously submitted on March 1, 2022 and NQTL analyses and data reports for health benefit plans not previously identified. This included five small group HMO health benefit plans and four large group HMO health benefit plans.

e. On April 6, 2022, the Administration sent a letter to OCI advising that the Administration was aware that OCI offers health benefit plans that are POS products in both the large and small group markets in the State and that the reporting required by § 15-144 of the Insurance Article was incomplete. The letter specified that OCI is required to identify the five health benefit plans with the highest enrollment in the POS products in the small and large group markets in the State and to submit the NQTL analysis and data reports for these POS plans.

f. On April 29, 2022, OCI submitted to the Administration NQTL analysis and data reports for three small group POS health benefit plans and five large group POS health benefit plans. There were only three POS health benefit plans in the small group market with enrollment in the State.

12. **Findings Related to UHCMA**

a. The reports submitted on behalf of UHCMA were for one small group and three large group HMO health benefit plans.

b. On March 21, 2022, in response to the Administration's March 11, 2022 letter, UHCMA submitted an updated NQTL analysis report master document. The master document was identified in the header of the report as an NQTL Analysis Report Template for "Line of Business: Large Group, Contract Type: HMO, and Benefit Plan: Plan Code ASON." No explanation or context was provided for the master document, and no other reports or documents were included with the response.

c. On March 23, 2022 the Administration sent a letter to UHCMA requesting clarification and additional information regarding the reports filed on March 21, 2022 and reminding UHCMA that the Administration expected that the remaining products and top ranking plans be identified and filed in the manner described in the Administration's March 11, 2022 correspondence.

d. On April 1, 2022, UHCMA submitted to the Administration revised NQTL analyses and data reports for the one small group and three large group HMO health benefit plans previously submitted on March 1, 2022 and NQTL analyses and data reports for health benefit plans not previously identified. This included four small group HMO health benefit plans and two large group HMO health benefit plans.

e. On April 6, 2022, the Administration sent a letter to UHCMA advising that the Administration was aware that UHCMA offers health benefit plans that are POS products in both the large and small group markets in the State and that the reporting required by § 15-144 of the Insurance Article was incomplete. The letter specified that UHCMA is required to identify the five health benefit plans with the highest enrollment in the POS products in the small and large group markets in the State and to submit the NQTL analysis and data reports for these POS plans.

f. On April 29, 2022, UHCMA submitted NQTL analysis and data reports for two small group POS health benefit plans and three large group POS health benefit plans. These were the only POS health benefit plans with enrollment in the State.

13. The Administration is in receipt of the reports submitted on April 1, 2022 and April 29, 2022 which are required by § 15-144(c)(1) and (f), and issues this Order solely in response to the late filing in violation of the Insurance Article and Bulletin 22-04. It should be noted, however, that this Order in no way precludes the Administration from determining whether the content of the reports is sufficient or reflects additional violations of the Insurance Article.

III. CONCLUSIONS OF LAW

14. **UHCMA and OCI: Health Maintenance Organizations**

a. Section 19-729(a) of the Health-General Article states in pertinent part:

(a) A health maintenance organization may not:

(1) Violate any provision of this subtitle or any rule or regulation adopted under it[.]

b. The Commissioner finds that UnitedHealthcare, through the actions of OCI and UHCMA, failed to submit the required reports for the health benefit plans identified above by the March 1, 2022 due date, and therefore, has not complied with § 15-144(c)(1) and (f) of the Insurance Article, which for OCI and UHCMA constitutes a violation of § 19-729(a) of the Health General Article.

15. **UHIC and MLHIC: Insurers.** The Commissioner finds that UnitedHealthcare, through the actions of UHIC and MLHIC, failed to submit the required

reports for the health benefit plans identified above by the March 1, 2022 due date, and therefore, has not complied with § 15-144(c)(1) and (f) of the Insurance Article.

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this 26th day of July, **ORDERED:** That, pursuant to § 4-113 of the Insurance Article and § 19-730 of the Health-General Article, based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30) days of the date of this Order, UnitedHealthcare pay an administrative penalty of $100,000 for violation of § 15-144 of the Insurance Article.

Kathleen A. Birrane
INSURANCE COMMISSIONER

By: David Cooney
Associate Commissioner
Life & Health

Date: 7/26/22

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Melanie Gross. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to

contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Melanie Gross, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202** **vs.** **CAREFIRST OF MARYLAND, INC.** **ATTN LEGAL MAIL STOP CT10 06** **OWINGS MILLS, MD 21117** **NAIC# 47058** **CAREFIRST BLUECHOICE, INC.** **840 FIRST STREET NE** **WASHINGTON, DC 20065** **NAIC# 96202** **GROUP HOSPITALIZATION** **AND MEDICAL SERVICES, INC.** **840 FIRST STREET NE** **WASHINGTON, DC 20065** **NAIC# 53007**	* *	**MIA FILE NO:** MIA-2023-03-020

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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that CAREFIRST OF MARYLAND, INC. ("CFMI"), GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC. ("GHMSI") and CAREFIRST BLUECHOICE, INC. ("CFBC) (collectively "CareFirst") have failed to comply with the Parity Act[1] reporting requirements as provided in § 15-144(c)(1) through (e) of the Insurance Article. CareFirst has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

[1] "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act. These reports are known as Non-Quantitative Treatment Limitation Analysis Reports ("NQTL reports").

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:
>
> (i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and
>
> (ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.
>
> (2) The report submitted under paragraph (1) of this subsection shall include the following information for the health benefit plans identified under item (1)(i) of this subsection:
>
> (i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;
>
> (ii) 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;
>
> (iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in documents and instruments under which the plan is established or operated; and
>
> (iv) the results of the comparative analysis as described under subsections (d) and (e) of this section.
>
> (d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section shall demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the same Parity Act classification.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors;

(ii) the factors that were considered but rejected; and

(iii) if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(3) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as written;

(4) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as in operation;

(5) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier

> to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;
>
> (6) disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations; and
>
> (7) identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:
>
> (i) the criteria for a medical necessity determination;
>
> (ii) reasons for a denial of benefits; and

A "carrier" is defined in § 15-144(a)(2) to include insurers that provide health insurance, nonprofit health service plans, organizations that provide health benefit plans, and health maintenance organizations.

A "health benefit plan" is defined in § 15-144(a)(3) to include large group plans, small group plans, individual plans, and student health plans.

2. According to Code of Maryland Regulations ("COMAR") 31.10.51, carriers are required to use the template form on the Administration's website ("the template;" COMAR 31.10.51.04, §§ 15-144(g)(1) and 15-144(m)(1) of the Insurance Article). There are 14 different NQTLs on the template. Each NQTL category has 7-steps in the analysis. Additionally, there are two initial questions regarding Plan Information and Benefit Classification. The 14 NQTLs include: definition of medical necessity; prior authorization review process; concurrent review process; retrospective review process; emergency services; pharmacy services; prescription drug formulary design; case management, process for assessment of new technologies; standards for provider credentialing and contracting; exclusions for failure to complete a course of treatment; restrictions that limit

duration or scope of benefits for services; restrictions for provider specialty; and reimbursement for in-network providers, out-of-network providers, in-network facilities and out-of-network facilities ("Provider Reimbursement".)

3. The 7 steps on the template are:

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient-Office sub-classification?	Is NQTL applied to Out of Network Outpatient-Office sub-classification?	Is NQTL applied to In Network Outpatient-All Other sub-classification?	Is NQTL applied to Out of Network Outpatient-All Other sub-classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2
For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3
Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4
Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5
Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6
Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7
Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

4. Carriers are required to provide complete answers for each NQTL category.

COMAR 31.10.51.04G sets forth the specific information that must be included in an

NQTL report for it to be considered complete, and this includes "all of the information identified in Insurance Article, §15-144(e), Annotated Code of Maryland, in the manner and format specified in the standard reporting form and associated instructions provided on the Administration's website." The instructions on the Administration's website include the following specific examples of responses that may result in a finding that a carrier failed to submit a complete NQTL report:

> 1) Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;
>
> 2) Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;
>
> 3) Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;
>
> 4) Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;
>
> 5) Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;
>
> 6) Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions;
>
> 7) Responses that do not to [sic] include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses;
>
> 8) Analysis that is not for the applicable time period;
>
> 9) Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10) Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

II. FINDINGS

5. CFMI and GHMSI currently hold Certificates of Authority from the State of Maryland to act as nonprofit health service plans. CFBC currently holds a Certificate of Authority to act as a health maintenance organization.

6. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022 due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

7. On March 1, 2022, CareFirst submitted NQTL analysis and data reports ("reports") for 57 plans.

8. On March 9, 2022, the Administration sent a follow-up letter to CareFirst advising them that their reports failed to provide necessary information and documentation for the Administration to begin to conduct an adequate evaluation of the responses provided in the reports.

9. On March 17, 2022, CareFirst provided "revised" reports. These reports contained some of the information requested in the Administration's March 9th letter.

10. On August 3, 2022, the Administration sent a follow-up letter to CareFirst informing them that their revised reports were insufficient to show compliance with 15-144 of the Insurance Article. The Administration requested additional information on each NQTL. The letter included 113 comments, which focused on Plan 27 for the CFMI BluePreferred PPO Gold $1750 product. The comments provided detailed guidance on the precise additional information that was needed for the reports to be considered complete, and the letter cited the specific sections of the instructions on the

Administration's website that required this information to be submitted. In comment 109 of the letter, it was advised that the comments for Plan 27 were also applicable for all other plans. The letter also stated, in pertinent part:

> "We have reviewed the revised NQTL Analysis Reports submitted on March 17, 2022 in response to our letter dated March 9, 2022. The information provided in the reports does not appear sufficient to demonstrate compliance with § 15-144(c)-(e) of the Insurance Article, Annotated Code of Maryland. Refer to COMAR 31.10.51.04A. Furthermore, certain responses appear contrary to the instructions for completing the analysis reports, which are posted on the Maryland Insurance Administration's website. Refer to COMAR 31.10.51.04C and D. Please address the following issues.
>
> As explained more fully below, the filing appears to be incomplete, and therefore may be subject to penalties described in § 15-144(j) of the Insurance Article.
>
> * * *
>
> Additionally, please note that by requesting additional information and giving a deadline for the response, the Administration is not extending the deadline under the statute for submission of a complete report."

The letter included a staggered due date, with NQTLs 10 and 14 due within 45 days, and the remaining NQTLs due within 60 days.

11. While the specific comments included in the Administration's August 3, 2022 letter focused on Plan 27 for the CFMI BluePreferred PPO Gold $1750 product, Administration staff compared the NQTL report for Plan 27 to the NQTL reports for all the other plans submitted by CareFirst, and confirmed that the nature and extent of the deficiencies noted for the Plan 27 report were common across the reports for all 57 plans.

12. Prior to the response deadlines for the Administration's letter of August 3, 2022, CareFirst and the Administration agreed that CareFirst would submit one sample report for each type of product by the response deadlines, and submit the remaining

reports after the Administration determined that the sample reports contained sufficient information and analysis to be considered complete.

13. On September 17, 2022, CareFirst provided a response to the Administration that included revised NQTL reports that addressed NQTLs 10 and 14 for three sample plans.

14. On October 3, 2022, CareFirst provided revised NQTL reports that addressed the remaining NQTLs for the same three sample plans.

15. Even after receiving specific additional guidance in the Administration's August 3, 2022 letter explaining the failure to include information required by the instructions on the Administration's website, CareFirst's responses were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if CareFirst is in compliance with the Parity Act for any of the NQTLs that were audited.

16. CareFirst's response to the August 3, 2022 letter failed to include a comprehensive narrative response to the deficiencies noted in the letter, and, therefore, except for situations where there was a clear attempt to address a noted deficiency in the revised reports, many of the Administration's requests for additional information were not addressed in any capacity. Additionally, in a number of circumstances, rather than providing clarifying information in the revised reports, CareFirst simply omitted, without explanation, statements appearing in the original report that were specifically questioned by the Administration in the August 3, 2022 letter. The responses were deficient for every NQTL category in the submitted reports, and the Administration is providing examples of the most common types of deficiencies. However, this is not an exhaustive list of noncompliant responses.

A. <u>Example A:</u> failure to follow the instructions for Step 2; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 3 and 5 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the analysis of the "Definition of Medical Necessity" NQTL, CareFirst provided the following response for Step 2 of its March 17, 2022 report: "CareFirst requires that all services be medically necessary in order to be covered services. This is industry standard for health insurance coverage."

In Comment 12 of the Administration's August 3, 2022 letter, the Administration advised CareFirst that the instructions specifically state: "For utilization management NQTLs (e.g., prior authorization and concurrent review), it is understood that a determination of medical necessity is required for all services and it does not need to be noted as a factor;" and "The fact that all services in a particular classification or sub-classification are subject to the NQTL does not eliminate the requirement to identify the factors and sources for each factor." Additionally, the Administration stated: "CareFirst's response to Step 1(a) identified four criteria/requirements used for determination of medical necessity for MH/SUD (BH) and for M/S. These four criteria must be listed as factors in Step 2, along with any other applicable factors, as well as the <u>source</u> for each factor."

In its October 3, 2022 response, the same four criteria continued to be referenced in step 1(a), but CareFirst again failed to list these factors in Step 2, and did not identify the source for each factor in disregard of the Administration's repeated instruction.

B. <u>Example B:</u> failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 3, and 5 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the analysis of the "Definition of Medical Necessity" NQTL, CareFirst provided the following response for Step 3 of its March 17, 2022 report: "CareFirst requires that all services be medically necessary in order to be covered services. This is industry standard for health insurance coverage."

Comment 13 of the Administration's August 3, 2022 letter expanded upon comment 12 described in Example A above, and the Administration advised CareFirst that "[o]nce the factors and sources are appropriately described in Step 2 as requested above, the required details for the evidentiary standards for those factors must be added to Step 3, as explained in the instructions. Carriers are expected to identify and explain specific thresholds and quantitative evidentiary standards at which each factor will implicate the NQTL. If specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided." The Administration also requested specific information and provided examples of expected responses with respect to evidentiary standards for the four criteria CareFirst listed in Step 1(a), which the Administration had identified in Comment 12 as unreported "factors."

In its October 3, 2022 response, CareFirst cited five evidentiary standards for the three factors that were identified in Step 2, and then repeated the same five items as the sources for the evidentiary standards. All five items were general statements without specificity as to how the standards support the factors, or from where the sources were generated. No quantitative thresholds were provided, nor, in the absence of specific thresholds, was an explanation provided of how CareFirst ensures the factors are being applied comparably and no more stringently to MH/SUD services. CareFirst did not provide responses to any of the Administration's comments requesting additional information with respect to evidentiary standards for the four criteria CareFirst listed in Step 1(a).

C. <u>Example C:</u> failure to follow the instructions for Step 4; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 4, 5, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

In CareFirst's March 17, 2022 report, in response to Step 4 for the "Definition of Medical Necessity" NQTL, CareFirst provided a high-level, four-paragraph summary of its process for conducting medical necessity review, including its process for developing, reviewing and updating utilization review criteria. The summary was supplemented with an attachment listing the names and designations of individuals on CareFirst's Care Management Committee Roster, and an attachment listing the names, certifications, practice interests, and contact information for CareFirst's Provider Panel MH Specialists.

Comment 14 of the Administration's August 3, 2022 letter included a detailed recitation of the specific requirements for a sufficient "as written" comparative analysis, as outlined in COMAR 31.10.51.04G(4) and in the instructions on the Administration's website. The Administration noted: "CareFirst's report does not appear to include the required information. Specifically, the report does not appear to include a comparative analysis of the processes used in development of medical necessity criteria, or the methodology used to complete a comparative analysis." The Administration also asked specific questions and requested specific additional information related to certain statements appearing in the four-paragraph summary.

In its October 3, 2022 response, CareFirst revised the high-level summary provided in the March 17, 2022 report to include a marginal amount of increased detail, but did not address any of the specific questions and requests for additional information from the Administration's August 3, 2022 letter. CareFirst also provided the following generalized conclusory statement without specific supporting evidence and clear and detailed explanations of comparative analyses:

> CareFirst follows the same model of care and utilization management processes for both medical and behavioral health and substance use disorder services. Clinical criteria, clinical policy, and the qualification of clinical reviewers are identical for M/S and MH/SUD, (except for where a difference such as a MH/SUD Medical Director reviewing MH/SUD services), is warranted and appropriate. Accordingly, CareFirst has performed an analysis in writing and has determined that Medical Necessity is no more stringently applied to MH/SUD benefits, than it is to M/S benefits.

D. <u>Example D:</u> failure to follow the instructions for Step 5; non-responsiveness to a specific request for follow-up information; removal, without explanation, of statements appearing in the original report that were specifically questioned by the Administration in the August 3, 2022 letter; and a response identified in Examples 2, 4, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

In CareFirst's March 17, 2022 report, in response to Step 5 for the "Definition of Medical Necessity" NQTL, CareFirst provided a description of its interrater reliability (IRR) monitoring program for staff with decision-making responsibilities for medical necessity criteria. CareFirst also described the methodology used to conduct a comparative analysis of in operation compliance of this NQTL, and included a conclusory statement indicating that the data analysis demonstrates the NQTL is comparable and no more stringent for MH/SUD than it is for medical/surgical.

Comment 15 of the Administration's August 3, 2022 letter included examples of the specific data and information required for a sufficient "in operation" comparative analysis, as outlined in COMAR 31.10.51.04G(4) and in the instructions on the Administration's website. The Administration noted that certain statements in the March 17, 2022 report appeared to be conclusory statements without supporting documentation, and advised CareFirst that methodology and results for all the audits referenced by CareFirst must be provided. The Administration also advised CareFirst that "while an IRR monitoring program may assess how consistently medical or behavioral reviewers apply the medical necessity criteria, this does not address the comparability of the actual criteria

themselves." Finally, the Administration requested the results from an in operation comparative analysis for specific medical necessity criteria, or an explanation of why the analysis was not available.

In its October 3, 2022 response, CareFirst provided results from recent audits of the IRR monitoring program, but did not discuss how the comparability of the actual criteria was analyzed in operation. CareFirst removed the explanation of the methodology for other in operation audits that was included in the March 17, 2022 report without explanation. CareFirst also removed the specific conclusory statement the Administration questioned in the August 3, 2022 letter without an explanation, and without providing the additional information requested by the Administration. A new conclusory statement indicating "there are no disparate outcomes of concern" related to utilization management with medical necessity and "[a]ccordingly, CareFirst concludes that the application of Medical Necessity is no more stringent for MH/SUD benefits, than it is for M/S benefits, in operation" was added without production of any data results from audits or other supporting documentation. Finally, CareFirst did not address the Administration's request for results from specified in operation comparative analyses, or provide an explanation for the unavailability of such analyses.

E. <u>Example E</u>: failure to follow the instructions for Step 7; non-responsiveness to a specific request for follow-up information; removal, without explanation, of statements appearing in the original report that were specifically questioned by the Administration in the August 3, 2022 letter; and a response identified in Examples 2, 4, 5, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

In CareFirst's March 17, 2022 report, in response to Step 7 for the "Definition of Medical Necessity" NQTL, CareFirst provided a short paragraph of general and conclusory statements indicating that medical necessity criteria and utilization management activities are the same for MH/SUD and medical/surgical services. The paragraph stated that CareFirst conducts audits to help ensure that all criteria are applied in a consistent and impartial manner, and that data analysis suggests that all services have denial rates that are comparable and not more stringent for MH/SUD and medical/surgical services.

In Comment 17 of the Administration's August 3, 2022 letter, the Administration advised CareFirst that the instructions require the carrier to explain the basis for the carrier's conclusion regarding comparability and stringency, and that a general or conclusory statement of compliance is not sufficient. The Administration also noted that the analysis required for Step 7 is not a restatement of prior sections of the report. The Administration specifically asked CareFirst to provide copies of the results from all of the annual reviews of the MH/SUD and medical/surgical criteria and all of the care management audits cited by CareFirst in the response for Step 7, and asked CareFirst to explain the statement that CareFirst uses the same criteria for all medical necessity reviews.

In its October 3, 2022 response, CareFirst removed the conclusory statements questioned by the Administration in the August 3, 2022 letter without explanation, and provided new conclusory statements without any supporting documentation. CareFirst did not provide copies of the results of any annual reviews or audits mentioned in the March 17, 2022 reports, as requested in the Administration's August 3, 2022 letter.

F. Example F: failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; removal, without

explanation, of statements appearing in the original report that were specifically questioned by the Administration in the August 3, 2022 letter; and a response identified in Examples 3 and 6 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

In CareFirst's March 17, 2022 report, in response to Step 3 for the "Prior Authorization Review Process" NQTL, CareFirst cited six evidentiary standards for the six items identified as factors in Step 2 and listed sources for these standards. All six items were general statements without specific definitions or quantitative thresholds.

In comment 23 of the Administration's August 3, 2022 letter, the Administration noted that it appeared CareFirst transposed responses for Steps 2 and 3, where sources for factors were cited in Step 3 and definitions for factors were noted in Step 2. The Administration instructed CareFirst to address this perceived error, and then, for each factor cited in the revised response for Step 2, to identify, define, and provide the source for the evidentiary standard and/or data source, and any other evidence relied upon, to determine that the NQTLs apply to MH/SUD and M/S services. The Administration instructed CareFirst to provide specific quantitative thresholds for the factors or evidentiary standards listed in the March 17, 2022 report that could be measured or applied in a quantitative manner. The Administration also requested documentation and specific information for particular factors listed in the March 17, 2022 report.

In its October 3, 2022 response, the factors listed in Step 2 were reduced to three factors, which were not consistent with the items listed in either Step 2 or Step 3 of the March 17, 2022 report. CareFirst provided definitions for evidentiary standards for the three new

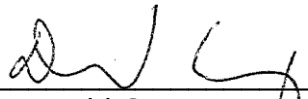
factors, but the definitions included general statements with a lack of specificity in evidentiary standards and sources, and no quantitative thresholds. The revised response to Step 3 also stated: "CareFirst is currently in the process of defining specific numerical benchmarks to assist with illustrating the application of the factors." For the particular factors listed in the March 17, 2022 report where the Administration requested documentation and specific information, the revised response to Step 3 no longer cited these factors or sources, without any explanation for this omission.

III. CONCLUSIONS OF LAW

CareFirst's responses were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if CareFirst is in compliance with the Parity Act for any of the NQTLs that were audited. The Commissioner finds that CareFirst failed to submit the complete reports identified above and, therefore, has not complied with § 15-144(c)(1) through 15-144(e) of the Insurance Article,

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this 13th day of March, **ORDERED:** That, pursuant to § 4-113 of the Insurance Article based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30) days of the date of this Order, CareFirst pay an administrative penalty of $250,000 for violation of § 15-144 of the Insurance Article.

Kathleen A. Birrane
INSURANCE COMMISSIONER



By: David Cooney
Associate Commissioner
Life & Health

Date: March 13, 2023

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Melanie Gross. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Melanie Gross, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202** **vs.** **MAMSI LIFE AND HEALTH INSURANCE COMPANY** **9800 HEALTH CARE LANE** **MN006-W500** **MINNETONKA MN 55343** **NAIC# 60321** **OPTIMUM CHOICE, INC.** **2020 INNOVATION COURT** **WI054-1000** **DE PERE WI 54115** **NAIC# 96940** **UNITEDHEALTHCARE INSURANCE COMPANY** **185 ASYLUM AVENUE** **HARTFORD CT 06103** **NAIC# 79413** **UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC.** **2020 INNOVATION COURT** **WI054-1000** **DE PERE WI 54115** **NAIC# 95025**	*	**MIA FILE NO: MIA-2023-06-023**

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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that MAMSI LIFE AND HEALTH INSURANCE COMPANY ("MLHIC"), OPTIMUM CHOICE, INC. ("OCI"), UNITEDHEALTHCARE

INSURANCE COMPANY ("UHIC"), and UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC. ("UHCMA") (collectively ""UnitedHealthcare") have failed to comply with the Parity Act[1] reporting requirements as provided in § 15-144(c)(1) through (e) of the Insurance Article. UnitedHealthcare has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act. These reports are known as Non-Quantitative Treatment Limitation Analysis Reports ("NQTL reports").

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:
>
> (i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and
>
> (ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.
>
> (2) The report submitted under paragraph (1) of this subsection shall include the following information for the health benefit plans identified under item (1)(i) of this subsection:
>
> (i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;
>
> (ii) 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;
>
> (iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in

[1] "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

documents and instruments under which the plan is established or operated; and

(iv) the results of the comparative analysis as described under subsections (d) and (e) of this section.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section shall demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the same Parity Act classification.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors;

(ii) the factors that were considered but rejected; and

(iii) if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(3) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as

written;

(4) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as in operation;

(5) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

(6) disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations; and

(7) identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

A "carrier" is defined in § 15-144(a)(2) to include insurers that provide health insurance, nonprofit health service plans, organizations that provide health benefit plans, and health maintenance organizations.

A "health benefit plan" is defined in § 15-144(a)(3) to include large group plans, small group plans, individual plans, and student health plans.

2. According to Code of Maryland Regulations ("COMAR") 31.10.51, carriers are required to use the template form on the Administration's website ("the template;" COMAR 31.10.51.04, §§ 15-144(g)(1) and 15-144(m)(1) of the Insurance Article). There are 14 different NQTLs on the template. Each NQTL category has 7-steps in the analysis. Additionally, there are two initial questions regarding Plan Information and Benefit

Classification. The 14 NQTLs include: definition of medical necessity; prior authorization review process; concurrent review process; retrospective review process; emergency services; pharmacy services; prescription drug formulary design; case management; process for assessment of new technologies; standards for provider credentialing and contracting; exclusions for failure to complete a course of treatment; restrictions that limit duration or scope of benefits for services; restrictions for provider specialty; and reimbursement for in-network providers, out-of-network providers, in-network facilities and out-of-network facilities ("Provider Reimbursement".)

3. The 7 steps on the template are:

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient-Office sub-classification?	Is NQTL applied to Out of Network Outpatient-Office sub-classification?	Is NQTL applied to In Network Outpatient-All Other sub-classification?	Is NQTL applied to Out of Network Outpatient-All Other sub-classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?

[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7
Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

4. Carriers are required to provide complete answers for each NQTL category. COMAR 31.10.51.04G sets forth the specific information that must be included in an NQTL report for it to be considered complete, and this includes "all of the information identified in Insurance Article, §15-144(e), Annotated Code of Maryland, in the manner and format specified in the standard reporting form and associated instructions provided on the Administration's website." The instructions on the Administration's website include the following specific examples of responses that may result in a finding that a carrier failed to submit a complete NQTL report:

1) Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2) Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3) Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4) Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

5) Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6) Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions;

7) Responses that do not to [sic] include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses;

8) Analysis that is not for the applicable time period;

9) Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10) Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

II. FINDINGS

5. MLHIC and UHIC each currently hold a Certificate of Authority from the State of Maryland to act as an insurer. OCI and UHCMA each currently hold a Certificate of Authority from the State of Maryland to act as a health maintenance organization.

6. MLHIC offers health benefit plans in the State of Maryland in the small group market; UHCMA offers health benefit plans in the State of Maryland in the small and large group markets; and OCI and UHIC offer health benefit plans in the State of Maryland in the individual, small, and large group markets. The health benefit plans offered by UHIC in the individual market are student health plans.

7. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022 due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

8. On March 1, 2022, UnitedHealthcare submitted NQTL analyses and data reports ("reports") for twenty-one health benefit plans.

9. On March 1, 2022, UnitedHealthcare stated in an email to the Maryland Insurance Administration ("the Administration") that "… there was an error in identifying

the top ranking plans by enrollment for each product; this error was discovered on 2/28/22…. We are in the process of correcting our error, identifying the remaining top plans, and providing the required analyses." The email did not identify the number of additional plans and products for which reports were not submitted by the March 1, 2022 due date.

10. Between March 11, 2022 and April 29, 2022, the Administration corresponded with UnitedHealthcare regarding the reports that were not submitted by the March 1, 2022 due date, and UnitedHealthcare submitted additional reports on April 1, 2022 and April 29, 2022.

11. On July 26, 2022, the Administration issued Order MIA-2022-07-025 against UnitedHealthcare, imposing an administrative penalty of $100,000 for failure to submit the required reports by the March 1, 2022 due date, in violation of § 15-144(c)(1) and (f) of the Insurance Article. The Order stated, in pertinent part, that the Administration "issues this Order solely in response to the late filing in violation of the Insurance Article and Bulletin 22-04. It should be noted, however, that this Order in no way precludes the Administration from determining whether the content of the reports is sufficient or reflects additional violations of the Insurance Article."

12. On November 28, 2022, the Administration sent a follow-up letter to UnitedHealthcare informing them that their reports were insufficient to show compliance with 15-144 of the Insurance Article. The Administration requested additional information on each NQTL. The letter included 105 comments, which focused on the UHIC Large Group PPO products Plan Code KYG and Plan Code KYI. The comments provided detailed guidance on the precise additional information that was needed for the reports to be considered complete, and the letter cited the specific sections of the instructions on

the Administration's website that required this information to be submitted. In comment 100 of the letter, it was advised that the comments for Plan Code KYG and Plan Code KYI were also applicable for all other plans. The letter also stated, in pertinent part:

> "We have reviewed the revised NQTL Analysis Reports submitted on April 1, 2022 in response to our letters dated March 22 and March 23, 2022. The information provided in the reports does not appear sufficient to demonstrate compliance with § 15-144(c)-(e) of the Insurance Article, Annotated Code of Maryland. Refer to COMAR 31.10.51.04A. Furthermore, certain responses appear contrary to the instructions for completing the analysis reports, which are posted on the Maryland Insurance Administration's website. Refer to COMAR 31.10.51.04C and D. Please address the following issues.
>
> As explained more fully below, the filing appears to be incomplete, and therefore may be subject to penalties described in § 15-144(j) of the Insurance Article.
>
> * * *
>
> Additionally, please note that by requesting additional information and giving a deadline for the response, the Administration is not extending the deadline under the statute for submission of a complete report."

The letter included a staggered due date, with NQTLs 10, 12, and 14 due within 45 days, and the remaining NQTLs due within 60 days.

11. While the specific comments included in the Administration's November 28, 2022 letter focused on the UHIC Large Group PPO products Plan Code KYG and Plan Code KYI, Administration staff compared the NQTL reports for Plan Code KYG and Plan Code KYI to the NQTL reports for all the other plans submitted by UnitedHealthcare, and confirmed that the nature and extent of the deficiencies noted for the Plan Code KYG and Plan Code KYI reports were common across the reports for all submitted plans.

12. Between December 13, 2022 and December 22, 2022, UnitedHealthcare communicated with the Administration via email to discuss requests for extensions of the

resubmission deadlines. The Administration agreed to extend the deadlines for the resubmissions as follows:

- January 31, 2023 - NQTLs 10, 12, and 14 due for UHIC only;
- February 15, 2023 – Half of the remaining NQTLs due for UHIC only;
- March 1, 2023 – Remaining NQTLs due for UHIC only;
- March 22, 2023 – All NQTLs due for UHCMA, OCI, and MLHIC.

13. On January 18, 2023, the Administration sent a follow-up letter to UnitedHealthcare providing additional guidance on the expected format for UnitedHealthcare's responses to the November 28, 2023 letter.

14. On January 31, 2023, February 15, 2023, March 1, 2023, and March 22, 2023, UnitedHealthcare provided responses to the Administration for specific NQTLs in accordance with the deadline extensions granted by the Administration on December 22, 2022.

15. Even after receiving specific additional guidance in the Administration's November 28, 2022 letter explaining the failure to include information required by the instructions on the Administration's website, UnitedHealthcare's responses were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if UnitedHealthcare is in compliance with the Parity Act for any of the NQTLs that were audited. The responses were deficient for every NQTL category that was audited, and the Administration is providing examples of the most common types of deficiencies. However, this is not an exhaustive list of noncompliant responses.

A. <u>Example A:</u> failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; and a response

identified in Examples 3, 5, and 6 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, UnitedHealthcare failed to define the three items identified as factors and failed to define and explain the evidentiary standards for these factors in Step 3.[2]

In Comment 14 of the Administration's November 28, 2022 letter, the Administration noted the required information was missing, requested definitions for the factors, and advised UnitedHealthcare that "[i]f specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided." The Administration also requested specific additional information and provided examples of expected responses with respect to explanations and definitions for the evidentiary standards listed in the April 1, 2022 report for M/S and MH/SUD.

In its March 1, 2023 response, UnitedHealthcare provided definitions for the three items listed as factors. The response stated that the evidentiary standards are not defined in a quantitative manner, but failed to include the required specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD. Additionally, the response did not address any of the Administration's specific requests for additional information, nor the examples of expected

[2] See UnitedHealthcare's April 1, 2022 report.

responses with respect to explanations and definitions for the evidentiary standards, as described in comment 14(c) of the Administration's November 28, 2022 letter.

B. <u>Example B:</u> failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 3 and 4 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Standards for Provider Credentialing and Contracting" NQTL, UnitedHealthcare failed to include the required definitions and sources for the evidentiary standards in Step 3.[3]

In comment 75 of the Administration's November 28, 2022 letter, the Administration noted that the response provided by UnitedHealthcare on April 1, 2022, included sources cited for factors in Step 2 which were then also listed as evidentiary standards in Step 3, without any additional required explanation or definition for the standards.

The Administration instructed UnitedHealthcare to provide the requested missing information and also noted that one of the evidentiary standards listed for the third factor mentioned "NCQA." The Administration advised UnitedHealthcare that the instructions for Step 3 specifically state: " 'If a source such as NCQA is used in determining comparability, the standards for that source and any analyses developed internally or provided to NCQA or other external agencies must be provided.' "

[3] See UnitedHealthcare's April 1, 2022 report.

In its January 31, 2023 response, UnitedHealthcare failed to provide the missing detail for the evidentiary standards, and continued to list the same items both as sources for the factors in Step 2 and as evidentiary standards in Step 3.[4] UnitedHealthcare stated that the evidentiary standards are not defined in a quantitative manner, but did not provide a specific, detailed, and reasoned explanation of how the carrier ensures that factors are being applied comparably and no more stringently to MH/SUD services.

UnitedHealthcare added a cross-reference to a source that did not actually cite NCQA; the language for the NCQA standard was not provided; and no analyses were included that were developed internally or provided to NCQA or other external agencies.

C. <u>Example C:</u> failure to follow the instructions for Step 4; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 5, and 7 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Standards for Provider Credentialing and Contracting" NQTL, UnitedHealthcare failed to provide required comparative analysis information required for Step 4.[5]

Comment 76 of the Administration's November 28, 2022 letter noted that the response to Step 4 appeared to be more appropriate for Step 5 and did not include all the required information noted in the instructions. The Administration specifically noted the absence of a comparative analysis for the information in the UHC and UBH credentialing plans "as

[4] For example, for Step 2, of this NQTL, UnitedHealthcare lists one of the factors as "[t]he provider or facility continue to meet the requirements set forth in the credentialing plan while they are contracted with the Plan." It notes one of the sources for this factor is Section 6 of the Medicare Managed Care Manual. In Step 3, Section 6 of the Medicare Managed Care Manual is also listed a definition of a specific evidentiary standard for this factor.
[5] See UnitedHealthcare's April 1, 2022 report.

written," and the methodology used to complete such a comparative analysis. The Administration requested specific information on the composition and deliberations of the decision-making staff responsible for the credentialing plans and the annual review, expressly required by the instructions for Step 4. The Administration requested the results of the comparative analyses performed for the past two years which UnitedHealthcare claimed it conducts annually. Finally, the Administration requested additional information on delegated credentialing arrangements, including identification of the factors considered in determining whether an entity is eligible.

In its January 31, 2023 response, UnitedHealthcare provided a side-by-side comparison of M/S and MH/SUD credentialing application and required documentation, as well as excerpts from the M/S and MH/SUD credentialing plans documenting the written policies related to delegated credentialing. The comparison incorporated conclusory statements indicating that the comparative analyses confirmed parity between M/S and MH/SUD for: credentialing committee structure, credentialing plans, credentialing application/documentation requirements, and credentialing delegation pre-assessment.

UnitedHealthcare did not provide the specific information on the composition and deliberations of the decision-making staff requested by the Administration, and asserted that the information "is not relevant to the parity analysis of this NQTL and not indicative of or material to whether the Plan is compliant not relevant to the parity analysis." Additionally, the comparative analysis for the credentialing plans identified differences in the frequency of reviews of the plans and in the scheduling for appeal hearings, while the comparative analysis for credentialing delegation pre-assessment identified a different scoring methodology for MH/SUD. An analysis of these differences in accordance with

COMAR 31.10.51.04G(4)(c) was not provided to support UnitedHealthcare's conclusory statements of parity.

D. <u>Example D:</u> failure to follow the instructions for Step 5; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 5, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, UnitedHealthcare failed to provide the information regarding results of comparative analyses required in Step 5.[6]

Comment 16 of the Administration's November 28, 2022 letter included examples of the specific data and information required for a sufficient "in operation" comparative analysis, as outlined in COMAR 31.10.51.04G(4) and in the instructions on the Administration's website. The Administration noted that *no results* were provided even though UnitedHealthcare stated that a comparative analysis was conducted, and instructed UnitedHealthcare to provide both the methodology and results.

The Administration also advised UnitedHealthcare that while its interrater reliability (IRR) auditing program is a positive step in validating consistency in how reviewers interpret and apply M/S and MH/SUD criteria, it does not address the comparability of the actual criteria themselves. The Administration requested the results from an in operation comparative analysis for specific medical necessity criteria, or an explanation of why the analysis was not available. Finally, the Administration identified specific results included in the MHPAEA Data Report for UHIC Large Group PPO KYG potentially indicating

[6] See UnitedHealthcare's April 1, 2022 report.

greater stringency in application of medical necessity criteria in operation for MH/SUD services.

UnitedHealthcare's March 1, 2023 response addressed these issues as follows:

(i) UnitedHealthcare rephrased the statement indicating that a comparative analysis had been performed, and included additional information about the responsibilities and protocols of the committees overseeing the M/S and MH/SUD medical/clinical policy development.

(ii) In response to the request for comparative analyses, UnitedHealthcare stated: "The completion of the NQTL Analysis Report Template itself serves as the responsive analysis which identifies the results of the analysis. The comparative analysis outcome summary is listed in Steps 4 and 5." *Results of the comparative analyses were not provided in Step 5 of the template*, however, except for a high level summary for all prescription drugs.

(iii) In response to the MIA's comment that IRR does not address the comparability of the actual criteria themselves, UnitedHealthcare stated: "The Plan generally assesses the stringency of its application of its medical necessity criteria in operation by comparing the results of its mandatory M/S and MH/SUD IRR testing outcomes, and by conducting comparative analyses of the Plan's medical necessity denial rates for M/S and MH/SUD services within each classification of benefits." *The results of these analyses were not provided* with the response.

(iv) *UnitedHealthcare did not provide any results for an in operation comparative analysis for the specific medical necessity criteria requested* by the Administration, and stated that they were unable to provide the results because they had not conducted the

specifically requested comparative analyses as federal regulations and guidance do not explicitly require an analysis for these specific services.

(v) In response to the comment about disparate results in the MHPAEA Data Report for UHIC Large Group PPO KYG, UnitedHealthcare asserted that the sample sizes were too small to draw meaningful conclusions and that disparate results alone are not dispositive of Parity Act compliance, but provided no explanation for the differences to refute potential greater stringency of application of the NQTL to MH/SUD services.

E. Example E: failure to follow the instructions for Step 7; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 4, 5, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Standards for Provider Credentialing and Contracting" NQTL, UnitedHealthcare failed to provide the information required in Step 7, including instead conclusory, unsupported statements in its responses to the Administration.

In Comment 79 of the Administration's November 28, 2022 letter, the Administration noted that UnitedHealthcare's response was a conclusory statement without documentation. The Administration advised UnitedHealthcare repeatedly[7] that the carrier must explain the basis for its conclusion regarding comparability and stringency; and that a general or conclusory statement of compliance is not sufficient. The analysis required for Step 7 is not a restatement of prior sections of the report; and the carrier must provide a detailed summary of specific findings and conclusions.

[7] Comment 79 of the Administration's November 28, 2022 letter mistakenly referred to earlier comments under "NQTL 18" instead of "comment 18."

The Administration also directed UnitedHealthcare to ensure the revised response addressed the requirement from the instructions for Step 7 that to the extent there are disparities in any comparative data analyses, including quantitative disparities shown in the required data supplement forms or other in operation analyses, the carrier must explain in detail how these disparities are not evidence of parity non-compliance, and indicate whether steps have been taken to ensure/improve access to in-network M/S providers and whether the same or comparable steps have been taken for MH/SUD.

In its January 31, 2023 response, UnitedHealthcare expanded the findings section for Step 7 to refer to the specific steps in the prior sections of the report on which the conclusions of comparability were based, but again provided conclusory statements of compliance without a detailed summary of the findings. Furthermore, the prior sections referenced in Step 7 included sections that were noted as deficient in the April 1, 2022 reports, as described in comments 75-77 of the Administration's November 28, 2022 letter. Deficiencies included a lack of detailed analysis and disparate data results requiring explanation. These prior sections were revised to include some additional analysis in the January 31, 2023 response, but the additional analyses remained deficient and revealed further disparities that were not sufficiently described, as noted above for comment 76 under Example C. The revised explanation for Step 7 did not address any of these disparities or explain steps that would be taken to reduce the disparities.

III. CONCLUSIONS OF LAW

UnitedHealthcare's reports and subsequent responses to the Administration's requests for additional or revised information were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if UnitedHealthcare is in compliance with the Parity Act for any of the NQTLs that were

audited. The Commissioner finds that UnitedHealthcare failed to submit the complete reports identified above and, therefore, has not complied with § 15-144(c)(1) through 15-144(e) of the Insurance Article,

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this _8_ day of June 2023, **ORDERED:** That, pursuant to § 4-113 of the Insurance Article based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30) days of the date of this Order, UnitedHealthcare pay an administrative penalty of $500,000 for violation of § 15-144 of the Insurance Article.

Kathleen A. Birrane
INSURANCE COMMISSIONER

By: David Cooney
Associate Commissioner
Life & Health

Date: June 8, 2023

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be

addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Angelique Jones. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Angelique Jones, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202** **vs.** **KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.** **2101 EAST JEFFERSON STREET** **ROCKVILLE, MD 20852** **NAIC# 95639**	*	**CASE NO: MIA-2023-09-010**

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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC. ("Kaiser") has failed to comply with the Parity Act[1] reporting requirements as provided in § 15-144(c)(1) through (e) of the Insurance Article. Kaiser has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act. These reports are known as Non-Quantitative Treatment Limitation Analysis Reports ("NQTL reports").

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:

[1] "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and

(ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.

(2) The report submitted under paragraph (1) of this subsection shall include the following information for the health benefit plans identified under item (1)(i) of this subsection:

(i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(ii) 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;

(iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in documents and instruments under which the plan is established or operated; and

(iv) the results of the comparative analysis as described under subsections (d) and (e) of this section.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section shall demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and

each nonquantitative treatment limitation to medical and surgical benefits within the same Parity Act classification.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors;

(ii) the factors that were considered but rejected; and

(iii) if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(3) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as written;

(4) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as in operation;

(5) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

(6) disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations; and

(7) identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

A "carrier" is defined in § 15-144(a)(2) to include insurers that provide health insurance, nonprofit health service plans, organizations that provide health benefit plans, and health maintenance organizations.

A "health benefit plan" is defined in § 15-144(a)(3) to include large group plans, small group plans, individual plans, and student health plans.

2. According to Code of Maryland Regulations ("COMAR") 31.10.51, carriers are required to use the template form on the Administration's website ("the template;" COMAR 31.10.51.04, §§ 15-144(g)(1) and 15-144(m)(1) of the Insurance Article). There are 14 different NQTLs on the template. Each NQTL category has 7-steps in the analysis. Additionally, there are two initial questions regarding Plan Information and Benefit Classification. The 14 NQTLs include: definition of medical necessity; prior authorization review process; concurrent review process; retrospective review process; emergency services; pharmacy services; prescription drug formulary design; case management; process for assessment of new technologies; standards for provider credentialing and contracting; exclusions for failure to complete a course of treatment; restrictions that limit duration or scope of benefits for services; restrictions for provider specialty; and reimbursement for in-network providers, out-of-network providers, in-network facilities and out-of-network facilities ("Provider Reimbursement".)

3. The 7 steps on the template are:

<u>Step 1</u>

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient-Office sub-classification?	Is NQTL applied to Out of Network Outpatient-Office sub-classification?	Is NQTL applied to In Network Outpatient-All Other sub-classification?	Is NQTL applied to Out of Network Outpatient-All Other sub-classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3
Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4
Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5
Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6
Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7
Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

4. Carriers are required to provide complete answers for each NQTL category. COMAR 31.10.51.04G sets forth the specific information that must be included in an NQTL report for it to be considered complete, and this includes “all of the information identified in Insurance Article, §15-144(e), Annotated Code of Maryland, in the manner and format specified in the standard reporting form and associated instructions provided on the Administration’s website.” The instructions on the Administration’s website include the following specific examples of responses that may result in a finding that a carrier failed to submit a complete NQTL report:

1) Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2) Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3) Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4) Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

5) Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6) Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions;

7) Responses that do not to [sic] include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses;

8) Analysis that is not for the applicable time period;

9) Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10) Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

II. FINDINGS

5. Kaiser holds a Certificate of Authority from the State of Maryland to act as a health maintenance organization.

6. Kaiser offers health benefit plans in the small group, large group and individual markets.

7. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022 due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

8. On March 1, 2022, Kaiser submitted NQTL analyses and data reports ("reports") for 136 plans.

9. On March 16, 2022, the Administration sent Kaiser a letter informing them that their analysis reports and data reports submitted on March 1, 2022, failed to provide the NQTL analysis reports and data reports in the manner required by § 15-144 of the Insurance Article, COMAR 31.10.51, and the instructions and the reporting requirements FAQ posted on the Administration's website. Specifically, Kaiser did not file separate NQTL analysis reports for the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets in the State.

10. On March 25, 2022, Kaiser submitted revised versions of its reports.

11. On March 28, 2022, the Administration sent Kaiser another follow-up letter informing them that their March 25, 2022 submission appeared to be incomplete since it did not include reports for the five health benefit plans with the highest enrollment in each "non-embedded" POS plan in the individual, small, and large group markets in the State.

12. On April 13, 2022, Kaiser submitted analysis and data reports for the three non-embedded jointly filed Small Group POS plans noted in the Administration's letter, and the five health benefit plans with the highest enrollment from among the non-embedded jointly filed Large Group POS plans.

13. On January 25, 2023, the Administration sent a follow-up letter to Kaiser informing them that their revised reports submitted on March 25, 2022, were insufficient

to show compliance with 15-144 of the Insurance Article. The Administration requested additional information on each NQTL. The letter included 107 comments, focusing on Appendix 2. The comments provided detailed guidance on the precise additional information that was needed for the reports to be considered complete, and the letter cited the specific sections of the instructions on the Administration's website that required this information to be submitted. In comment 103 of the letter, it was advised that the comments for Appendix 2 were also applicable to the analysis reports for all other plans. The letter also stated, in pertinent part:

> We have reviewed the revised NQTL Analysis Reports submitted on March 25, 2022, in response to our letter dated March 16, 2022. The information provided in the reports does not appear sufficient to demonstrate compliance with § 15-144(c)-(e) of the Insurance Article, Annotated Code of Maryland. Refer to COMAR 31.10.51.04A. Furthermore, certain responses appear contrary to the instructions for completing the analysis reports, which are posted on the Maryland Insurance Administration's website. Refer to COMAR 31.10.51.04C and D. Please address the following issues.
>
> As explained more fully below, the filing appears to be incomplete, and therefore may be subject to penalties described in § 15-144(j) of the Insurance Article.
>
> * * *
>
> Additionally, please note that by requesting additional information and giving a deadline for the response, the Administration is not extending the deadline under the statute for submission of a complete report.

The letter included a staggered due date, with NQTLs 10 and 14 due within 45 days, and the remaining NQTLs due within 60 days.

14. On March 10, 2023, Kaiser provided a response to the Administration that included revised NQTL reports that addressed NQTLs 10 and 14 for three sample plans.

15. On March 24, 2023, Kaiser provided revised NQTL reports that addressed the remaining NQTLs for the same three sample plans.

16. While the specific comments included in the Administration's January 25, 2023 letter focused on Appendix 2, Administration staff compared the NQTL reports for Appendix 2 to the NQTL reports for all the other plans submitted by Kaiser, and confirmed that the nature and extent of the deficiencies noted for the Appendix 2 reports were common across the reports for all submitted plans.

17. Even after receiving specific additional guidance in the Administration's January 25, 2023 letter explaining the failure to include information required by the instructions on the Administration's website, Kaiser's responses were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if Kaiser is in compliance with the Parity Act for any of the NQTLs that were audited. The responses were deficient for every NQTL category that was audited, and the Administration is providing examples of the most common types of deficiencies. However, this is not an exhaustive list of noncompliant responses.

Example A: failure to follow the instructions for Step 2

For the "Definition of Medical Necessity" NQTL, Kaiser's report that was filed on March 25, 2022, did not include *any* sources for the factors listed in Step 2, and failed to include several of the factors identified in Step 1 and Step 4.

In Comment 9 of the Administration's January 25, 2023 letter, the Administration noted that the instructions for Step 2 require the carrier to identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each

classification, sub-classification, or certain services within such classification or sub-classification for both MH/SUD and M/S.

The Administration also noted that the additional factors from Step 1 and Step 4 were not included at all in Step 2. The Administration gave a specific list of these additional factors and requested all sources associated with each of the additional factors.

In its March 24, 2023 response, Kaiser did not include the additional factors or sources for the additional factors from Step 1 and Step 4. Instead, Kaiser stated that no other factors were considered, and that the items listed in Steps 1 and 4 "are embedded in clinical criteria such as MCG and ASAM, and are considered during development of internal policies as elements to be considered when reviewing for medical necessity." This is in disregard of specific instructions from the Administration as well as the definition of "factor" from COMAR 31.10.51.03B(5), which includes "any other consideration that contributes to the development, design, or implementation of a NQTL."

<u>Example B:</u> failure to follow the instructions for Step 3; and a response identified in Examples 3, 4, and 6 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, Kaiser's report did not appear to provide definitions and evidentiary standards for all factors listed in step 2. The reports filed by Kaiser on March 25, 2022, in fact contain almost the exact same response for Step 3 and Step 2—as if the information from Step 2 was simply copied and pasted into Step 3.

In Comment 10 of the Administration's January 25, 2023 letter, the Administration noted the information missing in Step 3 for the factors outlined in Step 2, and indicated that definitions, sources, and evidentiary standards are also needed for the additional factors from Step 1.

In its March 24, 2023 response, Kaiser provided definitions and evidentiary standards for some of the additional factors listed in the Administration's January 25, 2023 follow-up response, but many of the responses were incomplete or introduced new vague and undefined terminology. For example, for the factor "severity or chronicity of an illness," Kaiser defined "severity," but not "chronicity," and referenced "minor, moderate, major, and extreme" levels of severity without defining or providing thresholds for each severity classification. Additionally, as stated in Example A above, Kaiser incorrectly concluded that the additional items listed in Step 1 and Step 4 were not "factors," and therefore no evidentiary standards are required to be provided for these items.

Example C: failure to follow the instructions for Step 4); non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 4, 5, and 7 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, Kaiser's report does not provide comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The reports filed on March 25, 2022, also include conclusory statements (wholly unsupported by any data required in Step 4) assuring that the process of determining criteria for Medical Necessity "is no more stringent" for mental health-related services than it is for other healthcare services.

In Comment 11 of the Administration's January 25, 2023 letter, the Administration noted in detail the information that is missing, including, specifically, a comparative analysis of the processes used in development of medical necessity criteria, or the methodology used to complete a comparative analysis.

In its March 24, 2023 response, Kaiser did not include a comparative analysis, instead noting none are available.

Example D: failure to follow the instructions for Step 5); non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 4, 5, and 7 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, Kaiser's report did not provide comparative analyses that included the results of any audits and reviews, and an explanation of the methodology that was provided to demonstrate comparability in operation.

Comment 12 of the Administration's January 25, 2023 letter identified specific issues that Kaiser must address in providing a comparative analysis, and indicated that, in reviewing the MHPAEA Data Report for Kaiser's Large Group HMO MAS, there were significant differences in requests for authorizations and denial rates between MH/SUD and M/S services in the out-of-network outpatient classifications which may indicate greater stringency in application of Medical Necessity criteria in operation for MH/SUD services.

In its March 24, 2023 response, Kaiser failed to provide any explanation for the difference in denial rates between MH/SUD and medical/surgical services in the out-

of-network outpatient classifications, despite the Administration's explicit request. Instead, Kaiser provided explanations for less significant disparities in other benefit classifications, such as in-network inpatient services, out-of-network inpatient services, and in-network outpatient services.

Example E: failure to follow the instructions for Step 7); non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2 and 5 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Prior Authorization Review Process" NQTL, Kaiser's response regarding the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act appear to be mostly identical to its response for the Medical Necessity NQTL.

Additionally, In Comment 24 of the Administration's January 25, 2023 letter it was noted that the response appeared to be a generalized statement about compliance without specific supporting evidence or detailed explanations of comparative analyses. The Administration's letter requested that Kaiser review the instructions and the considerations of the analysis for Kaiser's response to Step 7 for the NQTL of Medical Necessity

In its March 24, 2023 response, Kaiser again provided a response that, while containing additional information, remained a generalized statement about compliance. For example, the following conclusory statements were provided; "The plan is in compliance for Prior Authorization through the use of medical necessity criteria…" and "Comparative analysis…reveal[s] that prior authorization is comparable and not more

limiting or restrictive for MH/SUD than M/S services in the applicable classifications. It does so…by using comparable methodologies to make a determination…and through the use of appropriate professionals who demonstrate consistency in applying criteria which is validated annually through the IRR and through the review of data." These statements were not accompanied by the required detailed summary of the specific findings to support the conclusions. Additionally, although the revised response for Step 7 concluded that a review of Approval and Denial data presented in Step 5 of the analysis demonstrated comparability, no explanation was provided for quantitative disparities in required data supplements that were noted by the Administration in Comment 22 of the January 25, 2023 letter. Therefore, Kaiser did not fully address the Administration's specific concerns.

Example F: failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 3, 4, 5, and 6 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)" NQTL, Kaiser's report failed to include the required definitions for several of the factors listed in Step 2 and did not appear to include evidentiary standards for any of the factors.

In the second Comment 98[2] of the Administration's January 25, 2023 letter, the Administration directed Kaiser to review prior comments related to thresholds and definitions of evidentiary standards, and identified specific factors that were missing

[2] The Administration's January 25, 2023 letter mistakenly numbered two successive comments as "98."

sources, evidentiary standards, or thresholds. For example, “geographic area” is a factor listed in Step 2, and the entire definition in Step 3 is “[g]eographic area in which services are delivered.” The Administration also directed Kaiser to provide definitions, evidentiary standards, and sources for additional factors not currently listed in Step 2, which were noted by the Administration in the first Comment 98(c).

In its March 24, 2023 response, Kaiser provided definitions for all the factors originally identified in Step 2. However, many of the definitions included general statements that the definitions or factors were the same for M/S and MH/SUD, and Kaiser did not provide thresholds or evidentiary standards for any of the factors to identify the level of evidence necessary to evaluate whether the given factor is established, present, or utilized in accordance with the definition of “evidentiary standard” in COMAR 31.10.51.03B(4) and the instructions for Step 3. Additionally, the response did not address the Administration’s request for definitions, evidentiary standards, and sources for the additional factors not currently listed in Step 2.

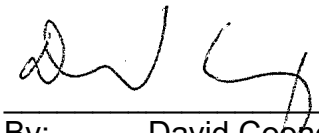
III. CONCLUSIONS OF LAW

Kaiser’s reports and subsequent responses to the Administration’s requests for additional or revised information were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if Kaiser is in compliance with the Parity Act for any of the NQTLs that were audited. The Commissioner finds that Kaiser failed to submit the complete reports identified above and, therefore, has not complied with § 15-144(c)(1) through 15-144(e) of the Insurance Article,

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this 13th day of September, **ORDERED:** That, pursuant to § 4-

113 of the Insurance Article based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30) days of the date of this Order, Kaiser pay an administrative penalty of $150,000 for violation of § 15-144 of the Insurance Article.

Kathleen A. Birrane
INSURANCE COMMISSIONER



By: David Cooney
Associate Commissioner
Life & Health

Date: September 13, 2023

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Angelique Jones. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Angelique Jones, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.

OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Access to Behavioral Health Services Second Market Scan

January 10, 2020

www.insurance.wa.gov

Table of Contents

Background & Instructions

NOTE: Any individual or entity that is preparing a response to this second market scan should be given this background and instructions section to guide their preparation of responses.

The Office of Insurance Commissioner (OIC) has been awarded a $284,000 grant from the Centers for Medicare and Medicaid Services (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO) through its State Flexibility to Stabilize the Market grant program. The goal of this project is to confirm that health insurers offer comprehensive and affordable health benefit designs by examining access to mental health and substance use disorder treatment in the fully-insured individual, small group and large group health insurance markets.

The grant provides for, among other activities, review of insurers' implementation of state and federal behavioral health parity statutes and rules. The project will provide the OIC with information needed to determine whether there are gaps in access to behavioral health services coverage, and if there are, their causes and actions needed to address them. The project period is August 2018 to July 2020.

The project is assessing whether comprehensive and affordable behavioral health services are offered through the examination of health benefit plan design, health insurers' policies and procedures, and claims data related to access to mental health and substance use disorder treatment services.

- The first phase of the project has focused on creating and issuing two successive market scans that will be used to identify any barriers, including access barriers, to mental health and substance use disorder treatment services as well as modalities for treatment of pain. The First Market Scan was issued on March 1, 2019. Analysis of the responses to that scan began in May 2019.

- In May 2019, OIC contracted with the University of Washington, School of Medicine, Department of Psychiatry and Behavioral Sciences to assist in review of the First Market Scan responses. The First Market Scan responses and recommendations of the clinical consultants have informed the focus areas for the Second Market Scan.

- This document is the Second Market Scan conducted under the project. The focus of this scan is the impact of carrier NQTL policies and procedures "in operation" and carrier completion of full NQTL parity compliance analyses.

- The second phase of the project, occurring in the second year, will involve detailed claims analysis, also informed by the results of the market scans and the consultant's findings. OIC issued the data call to obtain necessary claims data for this analysis on July 26, 2019. Carriers submitted responsive claims data in October 2019.

The outcome of the project activities will be compiled in a report detailing any issues detected and recommended solutions.

Definitions & Instructions:

- **Definitions**: **For the purposes of the market scan,** the following terms have the following meaning:

    - *Mental health benefits*[1] (MH) means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being, or as not being, a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or state guidelines).

    - *Substance use disorder benefits*[2] (SUD) means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).
    - *Medical/Surgical benefits*[3] (M/S) means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and

[1] "Parity in mental health and substance use disorder benefits," GPO, https://www.ecfr.gov/cgi-bin/text-idx?SID=539345d289e73ac7cb97f5c5220d75e7&mc=true&node=se45.1.146_1136&rgn=div8
[2] Id.
[3] Id.

state law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a M/S condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

Where a treatment can be used for both M/S and MH/SUD conditions, carriers are to define the treatment as a M/S or MH/SUD benefit by whether the enrollee's provider is a MH/SUD specialist provider or a M/S provider.

Instructions:

- The MHPAEA standard for analysis for NQTL's is as follows:

  A health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.[4]

  The questions and data requests in this scan are designed to elicit the information necessary to determine whether carriers offering coverage in Washington state are in compliance with this standard through NQTL analyses using existing compliance and reporting tools.

  OIC acknowledges that policies, strategies, evidentiary standards or other factors used in applying NQTL's to M/S, MH and SUD services in the same classification do not have to be identical. However, where there is a difference that impacts access to M/S and MH or SUD services, the carrier needs to explain how the difference in policy or processes is comparable to and applied no more stringently than the policy or processes applicable to accessing M/S benefits.

- In responding to the questions A. through E. of this scan, the carrier should conduct the analysis with respect to the following products:

[4] 45 CFR 146.136(c)(4)

a. The individual market health product offered by the carrier that is sitused in Washington state for coverage of Washington state residents with the highest enrollment in Washington state;

b. The fully-insured small group market health product offered by the carrier that is sitused in Washington state for coverage of Washington state residents with the highest enrollment in Washington state;

c. The fully insured large group market health product offered by the carrier that is a PPO plan sitused in Washington state for coverage of Washington state residents with the highest enrollment in Washington state.

Using the table below, for each of the health products described above, insert the product name, the SERFF number and the total average monthly enrollment in 2018 for all of the plans that are sold under the product name.

	Product Name	***Product type, e.g. EPO, HMO, PPO***	***SERFF Number***	***HIOS Number***	***Average monthly enrollment CY 2018***
Individual Market					
Small Group Market					
Large Group Market					

- In conducting the analyses described in questions A. through E. below, please base the response on policies or procedures that were in effect during calendar year 2018. If there have been changes to policies or procedures subsequent to December 31, 2018 that materially impact the results of the analysis, the carrier can note those changes.
- When responding to the questions below that specify service classifications, please use the same classifications provided in your response to Part II of the First Market Scan.
- Carriers are strongly advised to carefully review these Best Practices Examples of Compliant NQTL Analyses, Testing and Documentation (http://www.mhtari.org/Best_Practice_Examples_NQTL_Compliance.pdf) in responding to Questions A., B. and E.

- The carrier must respond to all questions completely, and cannot decline to respond to a question based upon the fact that any responsibility has been delegated to a benefit manager or any other subcontracted entity. Failure to respond completely to the questions will be considered a non-responsive answer. OIC expects that the analyses conducted under this Second Market Scan will require and be undertaken with close and coordinated involvement of both the carrier and any relevant subcontracted entities.
- This Second Market Scan directs carriers to use behavioral health parity compliance analysis tools that are in use nationally, and which carriers in Washington state may have already used or completed in response to requests from health care purchasers. Carrier responses to this Second Market Scan must be submitted to OIC using the templates prepared by OIC staff as Response Worksheets imbedded in the questions below. While OIC will accept additional information/documents for supplementary information purposes, there must be sufficient information imbedded in each of the Response Worksheets to be responsive to each question posed in the Response Worksheets.

A. Prior Authorization for Inpatient Services

For purposes of this question, per WAC 284-43-0160(34), **"prior authorization"** means a mandatory process that a carrier or its designated or contracted representative or agent requires a provider or facility to follow to determine if a service is a benefit and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan. Prior authorization occurs before the service is delivered. For purposes of WAC 284-43-2050 and 284-43-2060, any term used by a carrier or its designated or contracted representative to describe this process is prior authorization. For example, prior authorization has also been referred to as "prospective review," "preauthorization," or "precertification." "Prior authorization" processes include but are not limited to medical necessity and level of care determinations, treatment plan requirements, and fail first policies.

1. For all of the products identified on page 6 collectively, conduct a non-quantitative treatment limitation parity compliance analysis for NQTL's that involve prior authorization for inpatient services. Use the "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements (Parity Compliance Guide). Conduct an analysis for each NQTL related to prior authorization for services in the inpatient classification. Complete a separate template at Response Worksheet A-1 for each prior authorization NQTL analyzed. [NOTE: The carrier may want to make a copy of the blank template, as it will be used multiple times to respond to this question.]

A-1.xlsx

2. The carrier also must measure Out of Network (OON) utilization related to inpatient services separately for each of the 3 products identified on page 6, regardless of whether the product offers out of network coverage (e.g. is a PPO, HMO or EPO). OON utilization must be calculated as directed in Section I of the Model Data Definitions and Methodology form (pp. 1-3) (see MDDM form attached below on page 9) using Response Worksheets A-2. [Note that the MDDM references reporting OON utilization for inpatient facility, outpatient facility and office visits. For purposes of this response, complete the analysis for inpatient services only as classified in your response to the service classification question in the First Market Scan.]

model-data-definitions-method.pdf

If, after completing the measurement of OON utilization, there are OON disparities greater than 5 percentage points, this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in applying certain NQTLs is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps to improve parity could include, for example:

- Increasing in-network reimbursement rates;
- Reducing utilization review requirements for MH/SUD providers, such as frequency of reviews, that are not required for M/S providers;
- Increasing similarity in credentialing and contracting requirements between M/S and MH/SUD providers;
- Increasing in-network reimbursement rates; and
- Increasing similarity in credentialing and contracting requirements between M/S and MH/SUD providers.

A-2 Individual.xlsx

A-2 Small Group.xlsx

A-2 Large Group.xlsx

3. The carrier also must measure denial rates for inpatient services separately for each of the 3 products identified on page 6. Denial rates must be calculated as directed in Section III of the Model Data Definitions and Methodology form (pp. 9-11) using Response Worksheets A-3 for inpatient services only. [Note that the MDDM references reporting denial rates for inpatient facility, outpatient facility and office visits. For purposes of this response, complete the analysis for inpatient services as classified in your response to the service classification question in the First Market Scan.]

   If, after completing the measurement of denial rates, there are disparities greater than 5 percentage points, this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in applying certain NQTLs is warranted to determine whether they are comparable and no more stringent both as written and as

applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps to improve parity could include, for example:

- The use of generally accepted standards of care criteria and guidelines;
- Reducing utilization review requirements for MH/SUD providers, such as frequency of reviews, that are not required for M/S providers;
- Reducing or eliminating benefit exclusions for intermediate levels of care and provider types for MH/SUD benefits that are not on par with coverage for intermediate levels of care and provider types for M/S benefits.


A-3 Individual.xlsx


A-3 Small Group.xlsx


A-3 Large Group.xlsx

B. Concurrent Review for Inpatient and Outpatient Services

Concurrent review for inpatient classification and outpatient classifications

For purposes of this question, "Concurrent review" means any process used by a carrier or its delegate in reviewing a request for an extension of a previously authorized inpatient stay or a previously authorized ongoing outpatient service (See WAC 284-43-200). Concurrent review includes but is not limited to periodic medical necessity reviews for continued services and policies through which a carrier identifies services that are beyond the typical treatment duration or costs, i.e. outliers, for review and the substantive clinical standards used to review the "outlier".

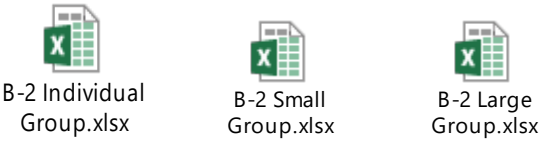
1. For all of the products identified on page 6 collectively, conduct a non-quantitative treatment limitation parity compliance analysis for NQTL's that involve concurrent review for inpatient and outpatient services. Use the "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements (Parity Compliance Guide). Conduct an analysis for each NQTL related to concurrent review for inpatient and outpatient services. Complete a separate template at Response Worksheet B-1 for each NQTL analyzed. [NOTE: The carrier may want to make a copy of the blank template, as it will be used multiple times to respond to this question.]


B-1.xlsx

2. The carrier also must measure denial rates for continued inpatient stay and denials of outpatient services separately for the each of the 3 products identified on page 6. Denial rates must be calculated as directed in Section III of the Model Data Definitions and Methodology form (pp. 9-11) using Response Worksheets B-2.

   If, after completing the measurement of denial rates, there are disparities greater than 5 percentage points, this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in applying certain NQTLs is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps to improve parity could include, for example:

- The use of generally accepted standards of care criteria and guidelines;
- Reducing utilization review requirements for MH/SUD providers, such as frequency of reviews, that are not required for M/S providers;
- Reducing or eliminating benefit exclusions for intermediate levels of care and provider types for MH/SUD benefits that are not on par with coverage for intermediate levels of care and provider types for M/S benefits.



C. Reimbursement Rates

1. For each of the products identified on page 6, conduct a non-quantitative treatment limitation parity compliance analysis for NQTL's related to reimbursement methodologies, i.e. the processes, strategies, evidentiary standards and factors that are used to determine the level/amount of reimbursement that a provider will receive. Complete the template at Response Worksheet C-1, which is an excel spreadsheet based upon the "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements designed specifically for analysis of provider reimbursement-related NQTL's. Complete a separate template at Response Worksheet C-1 for each NQTL analyzed. [NOTE: The carrier may want to make a copy of the blank template, as it will be used multiple times to respond to this question.]

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C-1 Individual.xlsx


C-1 Small Group.xlsx


C-1 Large Group.xlsx

2. Review Section II of the Model Data Definitions and Methodology form, including the instructions on pp. 4-8. Using Response Worksheets C-2, complete the "Section II. Reimbursement Rates" tables, as directed in the instructions in the MDDM form. A separate table should be completed for each of the 3 products identified on page 6. [NOTE: Complete both of the tabs on the attached C-2 Response Worksheets.]
    a. In completing the form, include the following providers in the calculation of "clinical social worker" reimbursement rates: Mental health counselors, marriage and family therapists, independent clinical social workers, and advanced social workers (i.e. professions licensed under Chap. 18.225 RCW).


C-2 Individual.XLSX


C-2 Small Group.xlsx


C-2 Large Group.xlsx

If any of the C-2 Physicians Response Worksheets demonstrates that PCPs and non-psychiatrist medical/surgical specialist physicians (combined) receive higher allowed amounts than psychiatrists, this disparity suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in developing and applying in-network reimbursement rates is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities

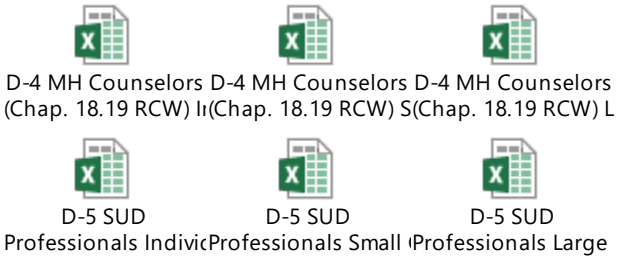
have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps could include, for example, increasing in-network reimbursement rates for psychiatrists.

If any of the C-2: Other providers Response Worksheets demonstrate that PCPs and non-psychiatrist medical/surgical specialist physicians (combined) receive higher allowed amounts relative to the National Medicare Fee Schedule than psychologists and/or clinical social workers, this suggests that a closer audit of the processes, strategies, evidentiary standards and other factors used in developing and applying in-network reimbursement rates is warranted to determine whether they are comparable and no more stringent both as written and as applied, in operation. If such disparities have been found, please advise whether you plan to engage in a closer audit, and if after completion of the audit, you are planning to take any actions to reduce the disparities. If so, provide details regarding the steps you deem necessary and your intended timetable. Such steps could include, for example, increasing in-network reimbursement rates for psychologists and/or social workers.

D. Provider Network Directory Accuracy

1. Review Section IV of the Model Data Definitions and Methodology form, including the instructions on pp. 12-13. Using Response Worksheets D-1 through D-15, complete the worksheet as directed in the instructions on pp.12-13 of the MDDM for each of the health care provider groupings listed in Item 2 below, with a separate table for each of the 3 products identified on page 6 of the Second Market Scan. This will result in a total of 15 worksheets. Base your analysis upon providers listed as participating in the applicable health product network during the period of July 1, 2018 through December 31, 2018.

2. A separate analysis is required for each of the following groups of providers:
    a. Psychiatrists (Chap. 18.71 RCW, Chap. 18.57 RCW)
    b. Psychologists (Chap. 18.83 RCW)
    c. Mental health counselors, marriage and family therapists, independent clinical social workers, advanced social workers (Chap. 18.225 RCW) (NOTE: if the carrier contracts with state licensed or certified behavioral health agencies that serve persons with mental disorders, substance use disorders, or both, these agencies should be included in the analysis)
    d. Mental Health Counselors (Chap. 18.19 RCW) (NOTE: if the carrier contracts with state licensed or certified behavioral health agencies that serve persons with mental disorders, substance use disorders, or both, these agencies should be included in the analysis)
    e. Substance Use Disorder (SUD) professionals (Chap. 18.205 RCW) (NOTE: if the carrier contracts with state licensed or certified behavioral health agencies that serve persons with mental disorders, substance use disorders, or both, these agencies should be included in the analysis)



For each of the provider groupings listed in item 2. above, if the total number of providers who submitted zero claims and submitted claims for 1-4 unique enrollees constitutes more than 10% of the number of providers listed as participating in your provider network during the period of July 1, 2018 through December 31, 2018, include your explanation as to how the in-operation processes that led to this result are comparable and applied no more stringently than the processes applicable to medical/surgical services, or provide your corrective action plan if you have determined that the in-operation processes were not comparable and/or were applied more stringently.

Such steps could include, for example:

- Monitoring actual in-network provider participation in providing services to your enrollees; and

- Correcting directory inaccuracies.

E. Provider Credentialing for Inpatient Services

For purposes of this question, "provider credentialing" means any requirement related to an inpatient services provider's participation in the carrier's provider network. This includes but is not limited the application process(es) to participate in a carrier's provider network, facility licensure, program certification, staffing, and any other conditions that an inpatient service provider must meet in order to participate in a carrier's provider network.

1. For all of the products identified on page 6 collectively, conduct a non-quantitative treatment limitation parity compliance analysis for NQTL's related to provider credentialing for inpatient services. Use the "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements (Parity Compliance Guide). Conduct an analysis for each NQTL related to provider credentialing for inpatient services. Complete a separate template at Response Worksheet E-1 for each NQTL analyzed. [NOTE: The carrier may want to make a copy of the blank template, as it will be used multiple times to respond to this question.]

E-1.xlsx