September 28, 2012

Commissioner Joseph G. Murphy
Deputy Commissioner Kevin Beagan
Division of Insurance
1000 Washington Street, 8th Floor
Boston, MA 02118

RE: Comments on Division of Insurance Regulations and Procedures Under Chapter 224 of the Acts of 2012, Sections 23 and 254

Dear Commissioner Murphy and Deputy Commissioner Beagan:

Thank you for inviting members of the public to submit comments to the Division of Insurance (the Division) on the implementation and enforcement of the Massachusetts mental health parity laws and the federal Mental Health Parity and Addiction Equity Act (MHPAEA). At the Division's Special Session on Mental Health Parity, held on September 19, 2012, speakers from the Division explained that in light of your agency's expanded enforcement powers under Chapter 224 of the Acts of 2012, you are now seeking comments on the following topics:

1. Federal parity guidelines: How is the Division to establish state guidelines in conjunction with existing federal guidelines to produce clear and consistent guidance?

2. Process: What suggestions can stakeholders offer for the compliance and enforcement process, both to resolve individual complaints and broader compliance problems?

3. Priorities: What enforcement priorities can stakeholders suggest?

We offer these comments based on our experience working with consumers in need of mental health and substance use disorder treatment, and their providers and advocates. Please accept these comments as a joint submission by Health Law Advocates, Association for Behavioral Healthcare, the Children's Mental Health Campaign, Association for Behavioral Healthcare, the Children's Mental Health Campaign, Community Catalyst, Greater Boston Legal Services on behalf of their clients, Health Care For All, Home Care Alliance of Massachusetts, Massachusetts Association of Behavioral Health Systems, Massachusetts Association of Older Americans, Massachusetts Hospital Association, Massachusetts Organization for Addiction and Recovery (MOAR), Massachusetts Psychiatric Society, Massachusetts Psychological Association, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Mental Health Legal Advisors Committee, National Alliance on Mental Illness of Massachusetts (NAMI Mass), and the National Association of Social Workers, Massachusetts Chapter.

1. State Guidance and Coordination with Federal Parity Guidelines

Massachusetts Regulations

Chapter 224, section 254 directs the Division to issue parity regulations by January 1, 2013. We agree that Massachusetts regulations regarding MHPAEA should address procedural issues, rather than the substantive issues already addressed by the statute itself and federal interim regulations.

We are pleased that the Division has worked so closely with federal regulators who are responsible for enforcement of certain provisions of MHPAEA, including the United States Department of Labor (DOL) and the United States Department of Health and Human Services (HHS). As you know, strong federal interim regulations[1] and sub-regulatory guidance already exist, yet leave certain areas unaddressed such as the scope of services which are to be covered, and any specific details regarding which mental health and substance use disorder conditions are covered by MHPAEA.

We suggest that, in addition to procedural regulations, the Division's regulations, bulletins and any other sub-regulatory guidance should sustain the consumer protections which are provided in the Massachusetts parity laws and are not at this point reflected in the federal laws. The Massachusetts parity laws[2] include strong language stating that intermediate services are to be covered, and the Division also clarified this in a bulletin.[3] Regulations should reinforce this consumer protection. Massachusetts regulations should also reiterate that the carrier is responsible for state and federal parity compliance by any contracted behavioral health plan or "carve-out."

Bulletin

Prior to the release of regulations, a Division bulletin, drafted in consultation with the Department of Mental Health, the Department of Public Health and its Office for Patient Protection, and other partner agencies may be the appropriate vehicle to clarify the relationship between the state and federal parity laws, pending the release of Massachusetts regulations. A bulletin should include the following directives:

[1] We support aggressive enforcement of protections enumerated in the federal MHPAEA regulations, at 45 C.F.R. § 146.136.
[2] G.L. c. 175, §47B(g), G.L. c. 176A, §8A(g), G.L. c. 176B, §4A(g), G.L. c. 176G, §4M(g).
[3] Department of Mental Health and Division of Insurance, "Intermediate Care as part of Mental Health Parity Benefits," Bulletin 2003-11 (Oct. 29, 2003).

1) An explanation of federal parity requirements for fully-insured plans, using language from the federal regulations and sub-regulatory guidance,

2) Steps that carriers must take to comply with the state and federal parity laws

3) A requirement that carriers send a notice to insureds explaining their rights under the state and federal parity laws, and include this same information in all subsequent notifications of the denial of claims by carriers (see below for additional detail), and

4) Reporting requirements for carriers.

A bulletin from the Division may be particularly necessary, since a question at the September 19 special session raised a concern that health plans may need and appreciate further clear guidance. At the session, a health plan representative asked whether the benchmark plan for Essential Health Benefits, which the Division is in the process of selecting, would also serve as the guide to benefits required for parity compliance. The Division should make clear that, regardless of the benchmark plan that is chosen, certain measures are required for a carrier to demonstrate that it is complying with state and federal parity laws. Since MHPAEA and the Massachusetts parity laws already apply to various plans, and Chapter 224 requires immediate compliance with the parity laws, the Division should offer prompt and clear guidance to the plans for this compliance.

Other Guidance

The US DOL has created a helpful federal parity website.[4] Massachusetts should create a similar web page to include information about state and federal parity laws, internal and external review information, information about any Division parity enforcement processes and procedures, audit results and reports, and data and annual reports submitted by carriers. The Massachusetts web site should also include fact sheets that are written in straightforward language which can be easily understood by people of all reading levels, with information translated into the most common non-English languages spoken by residents of the Commonwealth.

2. Process

At the special session on parity, the Division requested input on the processes that should be used to address parity violations and ensure compliance. Individual complaints and market-wide violations were identified as areas for enforcement.

[4] Currently at http://www.dol.gov/ebsa/mentalhealthparity/index.html.

A. Individual complaints

Complaint Process

The Division should create a parity complaint form for insured individuals who wish to bring possible parity violations to the attention of the Division. The form should be easy for the general public to read, and made available on request and on-line. The form should be available in the most common non-English languages used by residents of the Commonwealth.

If consumers then file a complaint directly with the Division, protections must be put in place for consumers to preserve their internal and external appeal rights with their carriers. We would be concerned that some consumers might file a parity complaint with the Division after receiving an insurance denial, but may mistakenly believe that the complaint was also an appeal of the carrier's decision. It is possible that a consumer who made this error might not realize that he or she had failed to file an internal or external appeal until the appeal deadline had passed. We suggest the following consumer protections:

1) A clear notice on the Division's parity complaint form, explaining that the consumer must also file an appeal directly with the carrier to challenge a carrier's denial of care, and that the consumer may lose the right to continued coverage of services pending resolution of the matter if the consumer does not file an internal appeal;

2) When the Division receives a parity complaint from an individual (whether through a complaint form or other communication), it will reply in writing within seven days with a letter describing how the Division will handle the complaint, and notifying the consumer that he or she may also need to contact the carrier directly to file an internal or external review request; and

3) Postponing or tolling of the consumer's appeal deadline. If the consumer filed a parity complaint with the Division, then the carrier's appeal deadline should be tolled while the Division considers the complaint. A final decision by the Division on the resolution of the complaint would then re-start the 180 day period or other period of time within which the consumer must appeal.

When an insured files a parity complaint with the Division, we suggest the following process:

1) An insured individual may file a complaint directly with the Division. The Division will investigate these individual complaints in a timely manner. The Division will also investigate the carrier's internal appeal process, including that of any carve-out entity, in addition to external review requests filed with the Office for Patient Protection involving denials of coverage for mental health or substance use disorder treatment.

2) After its investigation, the Division shall pursue an enforcement action against the carrier where warranted. In such an action, the Division shall notify the carrier of the alleged

violation, and shall provide the opportunity for a hearing. The hearing would be conducted pursuant to G.L. c. 30A.

3) The Division may, after the hearing, impose a civil administrative penalty on the carrier of up to $10,000 per violation, as well as cease and desist orders and full restitution for the insured individual. In addition, a civil administrative penalty of up to $10,000 per violation may be levied on a carrier for parity violations by the insurer's contracted behavioral health plan administrator or behavioral health carve-out.

Cooperation with the Office for Patient Protection

At the September 19 special session, Deputy Commissioner Beagan explained that the Division has for years worked with the Office for Patient Protection (OPP) to identify trends of insurance denials which may indicate parity violations. We are pleased to hear that this cooperation is taking place. We are interested in obtaining further information about this cooperative arrangement, and possibly formalizing it in regulations. For instance, which staff persons at OPP, the Division and/or other public agencies are designated to identify, forward, and address parity issues? Is this done on a case-by-case basis, or are there regularly scheduled meetings between the two agencies? Is any notice provided to the consumer who filed the appeal?

We propose that a dedicated staff person or persons at each agency be identified to handle parity issues that arise during the external review process. These issues should be addressed promptly as they arise. Additionally, we suggest that the two (or more) agencies schedule quarterly meetings on parity compliance. To address the final question regarding consumer notification, we suggest that a short sentence be added to the "Request for Independent External Review of a Health Insurance Grievance" form and the OPP website, stating that the appeal will also be reviewed by the Division for parity compliance.

B. Carrier Compliance

Our suggestions to encourage carrier compliance include notifications for health plan consumers, further audits, the creation of a compliance checklist, and detailed reporting requirements.

Within the next 45 days, carriers should promptly issue notice to insureds describing in clear language their rights under state and federal parity laws. In addition, plans should include information about rights under the federal and state parity laws with every insurance denial or appealable action. This information should be added to the appeal information already sent out

by plans along with or as part of insurance claim denial letters. Carriers should add the following information, or something similar, to these notices:

> ***Your Rights under the Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act***
>
> *You may have rights under the Massachusetts mental health parity laws. The Massachusetts parity laws protect your rights to insurance coverage for mental health and substance use disorder treatment. Under these laws, most health insurance plans cannot provide fewer outpatient visits, fewer days in the hospital, or a smaller amount of benefits for the diagnosis and treatment of most mental illnesses and substance use disorders.*
>
> *You may also have rights under the federal Mental Health Parity and Addiction Equity Act (the federal parity law). The federal parity law states that most health insurance plans must provide benefits for mental health and substance use disorders in the same way that they provide benefits for medical and surgical conditions.*
>
> *For more information about the Massachusetts and federal parity laws, or to file a complaint, contact the following agencies:*
> *Massachusetts Division of Insurance at _____*
> *United States Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.askebsa.dol.gov*
> *United States Department of Health and Human Services at 1-877-267-2323 extension 6-1565 or at phig@cms.hhs.gov*
>
> *A parity complaint is <u>not</u> the same as an insurance appeal. You may still need to file an insurance appeal. An insurance appeal may be necessary to protect your right to challenge the health insurance company's decision, and to protect your right to continued coverage of treatment while you wait for an appeal decision. Contact the Office for Patient Protection at 1-800-436-7757, and your health plan right away for more information about filing an appeal.*

We are pleased that the Division has taken steps to identify carrier-wide and market wide parity violations through the current audit of carriers and certain prior authorization practices. We appreciate that the Division undertook this audit even before the passage of Chapter 224. In your continuing efforts to identify carrier-wide and market-wide parity violations, we encourage the Division to continue to conduct similar audits of carriers. We request that the audit reports be

made available to the public by request on the Division's web page. The audit reports should contain a summary which can be easily understood by the general public.

The Division should develop appropriate compliance tools. The US DOL has created a parity compliance checklist, and has made it publicly available for consumers, employers, and carriers.[5] The DOL checklist addresses MHPAEA compliance on pages 22 through 29, and addresses other federal laws in the rest of the document. The Division should develop a similar checklist for federal parity, state parity, and other state law requirements.

Chapter 224, Section 254 requires annual reporting by carriers to document their compliance with the state and federal parity laws, beginning July 2014. In the interim, we suggest that the Division request a letter from each carrier documenting that the carrier is in full compliance with state and federal parity laws. These letters should be made available on a Division web page, as well as on each carrier's web site.

We are pleased that carriers will report annually on their compliance, and we have a number of suggestions for reporting requirements. In general, data reported by the carriers should be readily available to the public, and in a form that is easy for the general public to understand. If data regarding individuals is included in these reports, then identifying information should be redacted but without deleting details relevant to parity compliance. Data and reports should be publicly available on the websites of the Division and the Office of the Attorney General.

At a minimum, carriers should be required to include the following data[6] in their annual reports to the Division and the Office of the Attorney General:

(a) The standards used to define which services constitute mental health and substance use disorder services and those constituting medical/surgical services;
(b) A list of all mental health and/or substance use disorder benefits (services) that are covered under the plan and those that are excluded from coverage;
(c) The standards for classifying mental health/substance use disorder benefits and medical benefits as outpatient, inpatient or intermediate care services;
(d) The source of the plan cost data used to determine the "substantially all" and "predominant" standards for all financial requirements and quantitative treatment limitations and the relevant values;

[5] The self-compliance checklist is available at http://www.dol.gov/ebsa/pdf/cagappa.pdf
[6] Based in part on a list compiled by Prof. Ellen Weber, Drug Policy Clinic, Univ. of Maryland Carey School of Law. See Ellen Weber, Data Points for Parity Compliance Review (Aug. 2012).

(e) All cumulative financial requirements and treatment limitations and verification that a single value is applied to both behavioral health and medical benefits;
(f) Annual and lifetime dollar limits that are placed on mental health/substance use disorder benefits and medical benefits;
(g) All criteria used to determine medical necessity (e.g., level of care guidelines, medical necessity criteria);
(h) All criteria and procedures used for utilization review, approval and prior approval processes;
(i) All standards for requiring and granting prior authorization for services;
(j) All other non-quantitative treatment limitations (NQTLs) by health service;
(k) The processes used to develop each NQTL standard and the factors that are considered in applying the NQTL to behavioral health and medical benefits;
(l) All clinical guidelines that are relied upon to justify a different NQTL standard for behavioral health benefits;
(m) Provider reimbursement rates for relevant CPT codes and "usual and customary rates" for services provided by out-of-network providers;
(n) Standards for participation in provider networks;
(o) Formulary rules for the coverage medications used to treatment mental health and substance use disorders;
(p) The plan's coverage exclusions;
(q) The number and type of requests for internal review filed by insureds and providers for both mental health/substance use disorder and medical surgical claims, including the type of services at issue, the resolution of the internal review, and a comparison of the two categories (mental health/substance use disorder and medical surgical claims);
(r) The number and type of denials of insurance coverage for mental health/substance use disorder and medical surgical claims;
(s) The number and type of modifications requested and/or received of requests for prior authorization, for mental health/substance use disorder and medical surgical claims; and
(t) All standards for granting authorization for out-of-network services, for mental health/substance use disorder and medical surgical claims.

C. Additional Enforcement Issues

Where this is not a clear "individual" or "carrier-wide" parity issue, but a problem arises which appears to be a hybrid of the two, then processes should be in place to identify these issues and channel them to the proper enforcement personnel. Further, Division investigators should continue to work closely with the Department of Public Health (including its licensing division and the OPP), the Department of Mental Health, and other partner agencies to collaborate on enforcement.

3. Priorities

We suggest the following areas as priorities for enforcement and compliance: non-quantitative treatment limitations (NQTL's), case management standards, standards for classifying treatment as behavioral health treatment, and continued enforcement of Massachusetts parity standards in addition to federal parity law.

A. Non-Quantitative Treatment Limitations Must Be at Parity

Under MHPAEA, treatment limitations (including NQTL's) that apply to coverage for mental health and substance use disorder care must be no more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits. The MHPAEA regulations contain a non-comprehensive list of NQTL's, including:

a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
b) Formulary design for prescription drugs;
c) Standards for provider admission to participate in a network, including reimbursement rates;
d) Plan methods for determining usual, customary, and reasonable charges;
e) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
f) Exclusions based on failure to complete a course of treatment.[7]

Consumers continue to experience difficulty accessing mental health and substance use disorder treatment, and disparities in NQTL's are likely part of the reason. We are concerned about all disparities, but particularly those in prior authorization requirements, utilization review policies and practices, and medical necessity criteria.

Several of us communicated our concerns about prior authorization requirements to you previously, and we are encouraged by the actions that the Division has taken. We remain concerned that prior authorization requirements differ for behavioral health and for medical/surgical care. Prior authorization requirements may surface for outpatient care, inpatient

[7] 45 C.F.R. § 146.136 (c)(4)(ii).

care, or intermediate care. Even if a health plan requires prior authorization for both behavioral health and medical/surgical treatments, MHPAEA is violated if the prior authorization requirements are applied in a more stringent manner to behavioral health treatment. A related issue is the requirement to obtain a referral, and health plan rules for when referrals are needed. We encourage the Division to examine prior authorization requirements for all levels of care, to identify disparities that exist either in writing or in practice.[8]

Similarly, we believe that there are disparities in the utilization review practices used by health plans. If a plan uses prior authorization and concurrent utilization review for behavioral health treatment, but less stringent review or retrospective review for medical or surgical treatment, this would present a disparity in violation of MHPAEA.

Medical necessity criteria, the guidelines used by health plans to decide whether to authorize coverage of care, present another area of concern. While some health plans make their medical necessity criteria publicly available, others refuse to disclose criteria to the public and will release criteria only to a consumer who has been denied coverage for treatment and then only upon request and only the criteria used in that consumer's case.[9] We encourage the Division to work with the Department of Mental Health to review medical necessity criteria, and determine whether criteria for behavioral health treatment is more excessive, burdensome, or lacking a sufficient basis in available medical evidence and research, when compared with medical and surgical criteria from the same health plans.

B. Case Management Standards

Plans may provide the benefit of case management services for insureds with severe medical conditions, and in some instances for serious behavioral health conditions. We ask the Division to investigate whether standards for offering these case management services differ for behavioral health and for medical/surgical care. Further, we ask the Division to investigate whether the policies, practices, and outcomes indicate that these case management services are for the purpose of improving patient care, or whether they are intended primarily to reduce costs and utilization of services.

[8] This effort is consistent with new reforms and standardization of the prior authorization process. See Chapter 224 of the Acts of 2012, Section 207A.

[9] Chapter 224, Section 202, expands public access to these criteria. The law amends G.L. c. 176O, § 16, and states in part, "Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public." Chapter 224 of the Acts of 2012, Section 202.

C. Standards for Classifying Treatment as Mental Health/Substance Use Disorder Treatment or as Medical/Surgical Treatment

It is an extremely frustrating experience for consumers to be sent back and forth between their health plan and its behavioral health carve-out because neither entity can agree on whether a particular treatment or condition should be considered behavioral health or medical/surgical. Consumers in need of autism treatment, eating disorder treatment, neuropsychological testing, or other testing and treatment may encounter these problems.

Where a health plan uses a behavioral health contractor, it should submit to the Division its standards for determining which conditions, testing, and treatments fall into the behavioral health category. If there is wide variation between plans, the Division may consider issuing uniform standards.

D. Protections from Massachusetts Parity Laws Should be Retained

As noted earlier, the Massachusetts parity laws contain protections in some areas left unaddressed by federal law, including coverage of intermediate care, the scope of services generally, and continuity of care for adolescents who turn nineteen during a course of treatment. These protections, as well as the consumer protections enumerated in G.L. c. 176O, §§ 12-14, must be retained and reinforced in regulations.

Thank you for soliciting comments on these important issues, and we look forward to providing further feedback as the process moves forward and Chapter 224 is implemented. If you have any questions regarding this letter or need more information, please contact Jenifer Bosco at 617-275-2845 or jbosco@hla-inc.org, or any of the undersigned organizations.

Sincerely,

Health Law Advocates

Association for Behavioral Healthcare

Children’s Mental Health Campaign

Community Catalyst

Greater Boston Legal Services on behalf of our clients

Health Care For All

Home Care Alliance of Massachusetts

Massachusetts Association of Behavioral Health Systems

Massachusetts Association of Older Americans

Massachusetts Hospital Association

Massachusetts Organization for Addiction and Recovery (MOAR)

Massachusetts Psychiatric Society

Massachusetts Psychological Association

Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)

Mental Health Legal Advisors Committee

National Alliance on Mental Illness of Massachusetts (NAMI Mass)

National Association of Social Workers, Massachusetts Chapter