STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

James A. Dodrill
Insurance Commissioner

August 11, 2020

The Honorable Mac Warner
West Virginia Secretary of State
Building 1, Suite 157-K
1900 Kanawha Blvd., East
Charleston, WV 25305

Re: Comments Received Regarding 114 CSR 64

Dear Secretary Warner,

During the public comment period for the above-referenced Legislative Rule relating to mental health parity, the Offices of the Insurance Commissioner (OIC) of the Department of Revenue received one comment letter from UnitedHealthcare (UHC) on behalf of itself and Optum Health regarding the proposed rule. The comment letter is attached, and the comments are individually addressed below.

At the outset, the OIC notes that UHC suggested two small changes to the rule for clarity. Specifically, UHC noted 4.3 and 4.6 appear to be identical. The OIC agrees and will remove 4.6 and renumber the remaining sections and subsections accordingly. UHC requested that the word "maximum" be added after the phrase "out-of-pocket" in 4.13. The OIC also made this change, although it is now in 4.12.

Regarding the critical comments, the OIC notes that several appear to be in response to rule provisions that were taken directly from Senate Bill 291 (2020)(codified, in relevant part, at W. Va. Code §§ 33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r and 33-25A-8u). The OIC recognizes that some of the new provisions in state law diverge from existing federal law. However, the OIC's rule is based upon Senate Bill 291 (2020), which mandated the Insurance Commissioner adopt legislative rules to be considered by the Legislature during the 2021 Legislative Session to comply with the provisions of Senate Bill 291 (2020) regarding mental health parity, and specifically provided that the rule(s) shall specify the information and analyses that carriers shall provide to the OIC necessary for the OIC to complete the required annual report referred to therein. The OIC cannot amend statutory requirements set forth by the Legislature and must collect the data and analyses from carriers as set forth in the rule to prepare the annual report to the Legislature required by Senate Bill 291 (2020).

Initially, in regard to 3.1 and 3.2, UHC noted that the rule requires a carrier to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive than the medical/surgical benefits or coverage provided for any physical illness. UHC posited that screening services do not typically have specific procedure codes and are typically billed under other procedure codes. In regard to 3.3,

UHC recommends the phrase "validated screening tool" be changed to "evidenced based clinical criteria". In response, the OIC notes that Senate Bill 291 (2020) specifically requires that "a carrier shall include coverage and reimbursement for behavioral health screenings using a ***validated screening tool*** for behavioral health, which coverage and reimbursement is no less extensive than coverage and reimbursement for the annual physical examination." Thus, the term "validated screening tool" is taken from the newly enacted statute. UHC further states that it should be permitted to vary reimbursement without violating parity depending on the actual service code and provider type. UHC notes that reimbursement for medical doctors may not be the same as reimbursement for social workers. The OIC does not believe the language in the rule requires different types of providers to be reimbursed in parity, but requires carriers to provide coverage and reimbursement for behavioral health examinations and annual physical examinations in parity.

In regard to 3.4, UHC opines that a carrier will not know that time/distance standards of this rule are not met unless the member notifies the carrier that the time/distance standards are not able to be met by in-network providers. Again, the language in 3.4 requiring procedures for authorizing treatment rendered by non-participating providers comes directly from Senate Bill 291 (2020). The OIC agrees that carriers may not always know when time/distance standards are not being met unless a member notifies the carrier. However, the OIC also notes carriers will be required to comply with network access and adequacy requirements, which have been proposed in 114CSR100.

Regarding 3.5 and 3.6, UHC recommends the word "same" be changed to "comparable." Again, the language in Section 3.5 and 3.6 comes directly from Senate Bill 291 (2020), which states "if a covered person obtains a covered service from a nonparticipating provider because the covered service is not available within the established time and distance standards, reimburse treatment or services for behavioral health, mental health, or substance use disorders required to be covered that are provided by a non-participating provider using the ***same methodology*** that the insurer or carrier uses to reimburse covered medical services provided by non-participating providers and, upon request, provide evidence of the methodology to the person or provider," and "[i]f the carrier offers a plan that does not cover services provided by an out-of-network provider, it may provide the benefits required in subsection (c) of this section if the services are rendered by a provider who is designated by and affiliated with the carrier only if the ***same requirements*** apply for services for a physical illness." Thus, the newly enacted statutes require the same methodology and same requirements, not comparable.

Section 3.8 states "an insurer or carrier shall not impose any prior authorization or prospective utilization management requirements on any prescription medication on the insurer's or carrier's formulary that is used to treat substance use disorder when the medication is determined to be medically necessary by the covered person's provider." UHC recommends this prohibition be removed and opines that it circumvents medical management or required trials of therapeutic equivalent drugs. In reply, the OIC agrees that 3.8 limits the broad utilization review permitted by 3.7 in specific regard only to prior authorization or prospective utilization for any prescription medication already on a carrier's formulary that is used to treat substance use disorder. However, the OIC further states that W.Va. Code §§ 33-15-4r, 33-16-3cc, 33-24-7r, 33-25-8o and 33-25A-8r, effective January 1, 2019, already prohibit this practice.

Regarding 4.11, which is now 4.10, UHC states that the rule does not reflect the federal rule for predominant level of financial requirement and recommends the rule to be revised. The OIC believes that 4.10, in conjunction with other sections of 4, do reflect the federal test for calculations of substantially all and predominant level tests. However, the OIC has agreed to rewrite 4.10 section to, hopefully, improve its clarity.

In regard to 5.1, UHC states that compliance with non-quantitative treatment limitation requirements specified in 45 CFR §146.136(c)(4), or any successor regulation, regarding any limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment, which in addition to the limitations and examples listed in 45 CFR §146.136(c)(4)(ii) and (c)(4)(iii), or any successor regulation and 78 FR 68246, include the methods by which the carrier establishes and maintains its provider network and responds to deficiencies in the ability of its networks to provide timely access to care, contradicts the data reporting requirements in Section 7.3. UHC states "that section" should be amended to recognize that denials done pursuant to "this rule" would not produce the data required by 7.3. It is not clear to the OIC to which section of the rule, federal or state, that UHC is referring to when it states "that section" of "this rule" should be amended. Nevertheless, the OIC would state that the requirement in 5.1 for carriers to comply with non-quantitative treatment limitation requirements specified in 45 CFR §146.136(c)(4), or any successor regulation, is specifically set forth in Senate Bill 291 (2020). Furthermore, the data reporting requirements in 7.3 are solely to collect information for the OIC's annual report to the Legislature as required by Senate Bill 291 (2020), specifically the new statutory provisions of W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r or 33-25A-8u.

UHC further asks the OIC to remove "exclusions based upon failure to complete a course of treatment" from the list of non-quantitative treatment limitations set forth in 5.3.3. since UHC believes this non-quantitative treatment limitation is antiquated and that most plans do not currently use it. UHC lodges a similar complaint regarding 5.7.2, which prohibits a carrier from, among other things, regularly negotiating with medical/surgical providers based on the rates for behavioral, mental health, and substance use disorder providers. UHC opines that carriers do not undertake this practice and believes the section is also unnecessary. Nevertheless, the inclusion of these sections in the rule does not adversely affect those carriers who do not undertake these practices and, thus, the OIC believes these provisions should remain.

Section 5.5.1.a provides that carriers or insurers shall not routinely approve a certain number of days without a treatment plan for medical/surgical inpatient services, but approve, on a routine basis, a lesser number of days without a treatment plan for inpatient behavioral, mental health, and substance use disorders. Section 5.5.1.b. provides that carriers or insurers shall not apply concurrent review to inpatient stays with various lengths of stay due to the medical condition, but review all behavioral, mental health, and substance use disorder inpatient stays using a more restrictive review criteria, reviewing the stay more frequently in all cases than commonly used for medical/surgical benefits. UHC has asked that these provisions be removed in their entirety asserting that concurrent reviews are undertaken on evidence based medical criteria and that each service may have different review requirements based upon the medical criteria. The OIC believes that evidence based medical criteria review for all inpatient services, including both medical/surgical services and behavioral, mental health, and substance use disorder services, is appropriate and not prohibited by the rule as drafted. Instead, the rule prohibits carriers or insurers

from routinely or more frequently applying non-quantitative treatment limitations to behavioral, mental health, and substance use disorder inpatient services than is routinely or frequently broadly applied to medical/surgical inpatient services. Furthermore, Senate Bill 291 (2020) provides that a carrier ***may not apply any*** nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits.

Regarding 6.3.2, UHC asks the OIC to change this section to remove the requirement of providing the current mailing address of the OIC's Consumer Services Division on written notices of claim denials for behavioral health, mental health, and/or substance use disorder services. UHC believes that providing the Consumer Services Division's tollfree number and email address are sufficient. The OIC declines to make this change as it does not believe that the requirement of providing its mailing address in addition to a tollfree number and e-mail address on written claim denial notices to be onerous, since the written claim denial notices must be sent regardless, and believes that providing the mailing address will be helpful to consumers because the OIC's Consumer Services Division still receives a very significant amount of written mail.

Section 7.1. sets forth information that must be in a carrier's or insurer's annual attestation to the OIC. Section 7.1.3 requires the carrier or insurer to attest that its plans use the same benefits for emergency room benefits, including all ancillary services provided as part of the emergency room benefits, for medical/surgical and behavioral, mental health, and substance use disorders. Section 7.1.5. requires the carrier or insurer to attest that its plans utilize the same penalties for failure to obtain prior authorization for behavioral, mental health, and substance use disorders as it does for medical/surgical procedures within the same classification of benefits. UHC requests that, in both 7.1.3. and 7.1.5., the word "same" be changed to "comparable." In response, the OIC notes that Senate Bill 291 (2020) does not require comparative benefits, but requires a carrier to provide coverage for the treatment of behavioral health, mental health, and substance use disorders that is ***no less extensive*** than the coverage provided for any physical illness and provides that a carrier ***may not apply any*** nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits.

In regard to 7.2, UHC requests the OIC to develop a form attestation for carriers to use and seek input from stakeholders in developing the form. The OIC will take this request under consideration and may develop a form attestation for all carriers to use. The OIC believes this is permitted under the rule as drafted.

Sections 7.3 and 8 generally address data reporting and comparative analyses reporting for non-quantitative treatment limitations. UHC objected to certain fields in 7.3.3. regarding information that will be in the OIC's annual data call to carriers or insurers, including adverse determinations and treatment limitations. UHC further noted what it perceived as an overlap between 8 and 7.3.3, and recommended that the scope of 8 be narrowed or limited since the data requested and produced will be voluminous. UHC also seeks the elimination of non-quantitative treatment limitations in the comparative analysis reporting required by 8.2.3 and 8.2.4. Again, the OIC responds by stating that Senate Bill 291(2020) mandates the OIC to prepare an annual report to the Legislature. The requirements for the annual report are set forth below:

(g) On or after June 1, 2021, and annually thereafter, the Insurance Commissioner shall submit a written report to the Joint Committee on Government and Finance that contains the following information on plans which fall under this section regarding plans offered pursuant to this section:

(1) Data that demonstrates parity compliance for adverse determination regarding claims for behavioral health, mental health, or substance use disorder services and includes the total number of adverse determinations for such claims;

(2) A description of the process used to develop and select:

(A) The medical necessity criteria used in determining benefits for behavioral health, mental health, and substance use disorders; and

(B) The medical necessity criteria used in determining medical and surgical benefits;

(3) Identification of all nonquantitative treatment limitations that are applied to benefits for behavioral health, mental health, and substance use disorders and to medical and surgical benefits within each classification of benefits; and

(4) The results of analyses demonstrating that, for medical necessity criteria described in subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in subdivision (3) of this subsection, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders within each classification of benefits 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 corresponding classification of benefits.

(5) The Insurance Commissioner's report of the analyses regarding nonquantitative treatment limitations shall include at a minimum:

(A) Identifying factors used to determine whether a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions reached by the Insurance Commissioner that the results of the analyses indicate that each health benefit plan offered under the provisions of this section complies with subsection (c) of this section.

The OIC recognizes that the information it is requesting from carriers will be voluminous and will require analyses to be undertaken by carriers. However, the information requested in 7.3 and 8 tracks directly with the reporting requirements in Senate Bill 291 (2020). The OIC is solely asking for data and/or analyses from carriers that is required to be in its annual report to the Legislature.

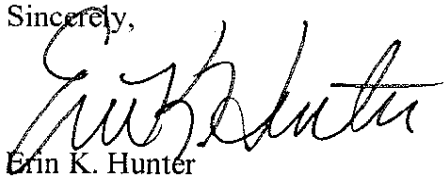
UHC is seeking removal of 7.5 which states that the Commissioner may ask a qualified actuary to certify that the calculations of the carrier, in regard to its data reporting to the OIC, are accurate and true to the best of the actuary's knowledge and have been appropriately calculated in accordance with Actuarial Standards of Practice. UHC also seeks that the requirement for

calculations for the substantially all and predominant level tests to conform with Actuarial Standards of Practice be removed from 4.9. The OIC responds that 7.5 does not require an annual actuarial certification from the carrier, but states that the Commissioner may ask a qualified actuary for one. Further, 4.9.1 only requires the carrier to utilize a method to calculate claims costs that is reasonable, verifiable and conforms with actuarial standards of practice. The OIC believes that it is imperative for the carriers to provide reliable and verifiable data for the OIC to complete the annual report to the Legislature and to ensure the mandates of the state's new mental health parity law are being met by carriers.

Finally, UHC offered a strongly supportive comment of 9.1 regarding confidentiality as the information submitted to the OIC from carriers is proprietary. The OIC appreciates this comment and agrees that maintaining confidentiality is very important.

The OIC would like to thank UHC for its submitted comments. UHC's attention and time spent on this matter is greatly appreciated.

Sincerely,



Erin K. Hunter
Deputy Commissioner/General Counsel
West Virginia Offices of the Insurance Commissioner

Attachments

VIA ELECTRONIC MAIL

Mr. Victor Mullins
900 Pennsylvania Ave
Charleston, WV 25302
victor.a.mullins@wv.gov

RE: Comments to Proposed Rule 114-64 on Mental Health Parity

Dear Mr. Mullins –

Please accept these comments on behalf of UnitedHealthcare and OptumHealth. In general, we would like to state that as companies which do business across the country, the value of uniform requirements and regulations in complex areas such as mental health parity cannot be overestimated. To the extent that the Department can stay consistent with the federal rules, it benefits UHC and Optum in streamlining its operations and ensures compliance. It is recommended that the Department consider this in enacting its rules on mental health parity to provide a balance between providing important protections to the public while recognizing the costs and complexities associated with complying with such requirements across the country.

§114-64-3. Mental Health Parity and Required Coverage

3.1 – 3.2

This rule would require a carrier to provide coverage for the prevention of, screening for, and treatment of behavioral health, mental health, and substance use disorders that is no less extensive that the medical/surgical benefits or coverage provided for any physical illness.

Comment - Screening services do not typically have specific procedure codes assigned and are typically billed under other procedure codes. As such, it is difficult to understand how parity would be provided for screenings. It is requested that additional guidance be provided as to how to comply with this rule when the screenings do not have a separate code and are provided incidental to other services with separate codes.

3.3

Comment – It is recommend that the phrase "validated screening tool" be changed to "evidenced based clinical criteria". Further, it should be noted that the reimbursement may vary (and wouldn't violate parity) depending on the actual service (code) and provider type – for example an annual physical done by a MD will not have same reimbursement as an annual behavioral screening done by a social worker.

3.4.

Comment – A carrier will not know that time/distance standards of this rule are not met unless the member notifies the carrier that the time/distance standards are not able to be met by in-network providers.

3.5

Comment – It is recommended that the word "same" be changed to "comparable".

3.6

Comment – It is recommended that the word "same" be changed to "comparable".

3.8

Comment - As currently worded, this rule prohibits a carrier from requiring prior authorization for a drug used for substance use disorder if deemed medically necessary by the provider. It is recommended that this prohibition be removed as it circumvents medical management or required trials of therapeutic equivalent drugs. To deny the use of medical management for drugs used for substance use disorder goes well beyond what parity would dictate.

§114-64-4. Financial Requirements and Quantitative Treatment Limitations

4.6

Comment – This section appear to be identical to Section 4.3 and suggest removing this one.

4.9.1

Comment – It is recommended that the last sentence of this Rule requiring that the methodology conform with Actuarial Standards of Practice be removed. The Actuarial Standards of Practice requirement is NOT part of federal parity and is contradictory to the federal rules which require calculation of substantially all based on the plan and for some segments as the plan may not have actuarially valid data.

4.11

Comment – This Rule does not accurately reflect the federal rule for predominant level of financial requirement. It is recommended that this rule be revised to be consistent with the federal rules.

4.13

Comment – It is recommended that the word "maximum" be added after the phrase "out-of-pocket" for clarity.

§114-64-5. Non-Quantitative Treatment Limitations

5.1

Comment – This rule appears to contradict the requirement in Section 7.3 Data Reporting that requires the carrier to provide data for denials and prior authorization denials. That Section should be amended to recognize that denials done pursuant to this rule would not produce the data required by 7.3.

5.3.3.

Comment – It is recommended that the inclusion of exclusions based on failure to complete a course of treatment in the non-quantitative treatment limitations should be changed and removed. This is an antiquated provisions most plans don't use anymore. This provision hasn't been a part of our plans for over ten years.

5.5.1.a and b

Comment – It is recommended that these provisions be removed as it ignores that when performing concurrent review, the carrier would perform the review based on the evidence based medical criteria. Each service may have different review requirements based on the medical criteria. It is felt that these are appropriate actions taken by the carrier which would be restricted by this rule as currently written.

5.7.2

Comment – It is recommended that this section be removed as unnecessary. Carriers do not use behavioral health rates to set rates for or negotiate with med/surg providers.

§114-64-6. Concurrent Review and Denial of Benefits

6.3.2

Comment – It is recommended that this section be changed to remove the requirements of providing the current mailing address of the Consumer Services Division. It is believed that providing the Division's toll free number and email address are two items which seldom change and would provide everyone with an ability to contact the Division and receive additional information from the Division such as its mailing address if that is desirable.

§114-64-7. Annual Reporting to the Commissioner

7.1.3

Comment – It is recommended that the word "same" be changed to comparable". Further, it is requested that the Department provide guidance on the ancillary services referenced in this section.

7.1.5

Comment – It is recommended that the word "same" be changed to comparable".

7.2

Comment – It is requested that the Department establish a form attestation for carriers to use rather than carriers guessing what will be considered sufficient. It is recommended that the Department seek input from stakeholders in developing the form.

7.3.2

Comment – This rule appears to contradict the requirement in Section 5.1. This Section should be amended to recognize that denials done pursuant to this rule would not produce the data required by this section. Further, it is recommended that this section be changed with respect to the timing of the reporting. The section currently requires the data for a specified period of the immediately preceding twelve (12) months. However, there should be an allowance for claims run out such that the data will be reasonably able to be completed by the due date of the filing. For example if the data call is due July 31st for data from the preceding July 1 – June 30. That's only 30 days after and would not capture claims experience accurately.

7.3.3.a

Comment – It is recommended that the references to Medical Management and Non Quantitative Treatment Limitations should be removed as they are not "data related". In addition, the term "Medical Management Evaluation" is not a defined term in the rule. Further, it does not make sense to include the inclusion of "Parity Compliance for Adverse Determinations, including the total number of adverse determinations of such claims" as an adverse determination is an outcome and are expressly not required to have parity under MHPAEA.

7.3.3.b

Comment – It is believed that the inclusion of data for non quantitative treatment limitations contradicts the fact that such actions will not include numerical data and should be removed. Should the Department consider this appropriate, however, it is recommended that the Department discuss with stakeholders the appropriate info and data elements for this reporting, and consider the use of the NAIC's NQTL Data Collection Tool.

7.5

Comment – It is recommended that this section be removed. The Actuarial Standards of Practice requirement is NOT part of federal parity and is contradictory to the federal rules which require calculation of substantially all based on the plan and for some segments as the plan may not have actuarially valid data.

§114-64-8. Comparative Analysis Reporting for Non-Quantitative Treatment Limitations

Comment – There appears to be an overlap between section 7.3.3 and this section as both relate to info for NQTLs. It is recommended that these two sections should be confined to avoid confusion and the potential for contradictory requirements. Also, it is recommended that the scope of this section should be more focused than every NQTL in every classification – the amount of info and data to be reported and analyzed would be voluminous and not serve purpose of effective oversight. The section's scope should be narrowed to a subset of key NQTLs based on most material issues (e.g. network access, prior authorization etc.)

8.2.3-4

Comment – It is recommended that the inclusion of non quantitative treatment limitations in the comparative analysis required by this section be removed as the data from NQTLs are non-numeric.

§114-64-9. Confidentiality

9.1

Comment – This provision is very important to protect the information required to be provided under this rule as it is considered very proprietary and, as such, is strongly supported.

Again, UnitedHealthcare appreciates the opportunity to provide these comments. We would welcome any questions by the Department or opportunity to discuss on these important issues.

Sincerely,

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