



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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June 18, 2020

Ms. Katie Dzurec, Chair
Ms. Jane Beyer, Vice Chair
Mental Health Parity and Addiction Equity Act (B) Working Group
National Association of Insurance Commissioners
444 North Capitol Street, N.W.
Suite 700
Washington, D.C. 20001-1512

Submitted via email to Jolie Matthews (JMatthews@naic.org)

RE: BCBSA Comments on Draft Quantitative Treatment Limitation (QTL) Template and Instructions

Dear Ms. Dzurec and Ms. Beyer:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide comments on the draft quantitative treatment limitation (QTL) template and instructions shared by the National Association of Insurance Commissioners (NAIC) on May 28, 2020.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively provide healthcare coverage for one in three Americans. For more than 90 years, Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America – serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid.

We share NAIC's commitment to ensuring clarity on the requirements established by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including consistent and transparent guidance on how QTL and non-quantitative treatment limitation (NQTL) requirements are reviewed for compliance. However, we believe that additional reporting and audit requirements for health plans without consistent guidance from the U.S. Department of Labor (DOL) on compliance expectations will not address stakeholders' concerns with ensuring patient access to mental health and substance use disorder (MH/SUD) services.

Any guidance and/or reporting requirements should be in the best interest of the member. A template that is overly detailed and prescriptive can undermine plans' ability to design robust and evidence-based MH/SUD benefits. It is often not in the best interest of the patient for a plan to impose QTLs in the same manner for MH/SUD benefits as it is for medical/surgical benefits. Many of these services are provided differently based on the type of condition and needs of the patient. For example, treatment for MH/SUD conditions often focuses on less discrete services

(e.g., ongoing therapy rather than an MRI or surgical procedure) and it is rarely linear (e.g., many patients will have regressions and gaps in treatments that will require backtracking or adjustments to a treatment plan). As such, health plans must be able to account for the nuances that impact coverage and reimbursement in real-world scenarios, reflecting the flexibility that plans have under the parity standard.

Furthermore, an overly complex tool does not provide consumers or regulators with useful information while adding considerable administrative burden to health plans. Overly burdensome administrative requirements divert resources away from Plans' efforts to support members and impose costs on members, employers and government entities through their premium dollars. While regulators have the authority to request extensive data from health plans, BCBSA is unaware of any compliance issues with QTLs that would support the need for such a detailed template.

BCBSA appreciates the MHPAEA (B) Working Group's public comments that the QTL template is not mandatory for states to adopt. However, BCBSA is concerned that, in practice, certain states will automatically require use of the working group's final version of the QTL template. Furthermore, QTL compliance is relatively straightforward to determine as compared to NQTL compliance where more standardization and guidance may be appropriate.

Alternatively, BCBSA recommends that the Working Group rely upon the DOL's resources and tools related to QTL parity compliance. To support our shared desire to ensure compliance and consistent with the Working Group's 2020 charges, we would reiterate the need for greater clarity with the MHPAEA's NQTL requirements. We encourage NAIC to urge DOL to provide more clarity and examples of permissible differences in NQTLs across medical/surgical benefits and MH/SUD benefits, including examples where plans are in compliance with the requirements to demonstrate that not all plan limits amount to noncompliance. This would help establish clear and consistent expectations for plans to ensure a common understanding across stakeholders and support patient access.

However, if adopted, BCBSA recommends that the NAIC's Revised Draft QTL Template and Instructions:

- Not be adopted as a uniform resource and that NAIC conduct a cost-benefit analysis to understand net effects and to inform clarification of the purpose and utility before adopting any QTL template
- Not be required by states for form filing
- Be modified to provide more flexibility for carriers in completing the template
- Be enhanced to address security and functionality
- Be updated to clearly direct carriers to input allowed amounts per the MHPAEA

We provide more details on these recommendations and technical aspects of the tool in the comments below. We look forward to continued work with NAIC and appreciate your consideration of our comments. If you have any questions, please contact Anshu Choudhri at 202.626.8606 or Anshuman.Choudhri@bcbsa.com.

Sincerely,

A handwritten signature in black ink that reads "Clay S. McClure". The signature is written in a cursive, flowing style.

Clay S. McClure
Executive Director, State Relations

BCBSA DETAILED COMMENTS AND RECOMMENDATIONS REGARDING THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (B) WORKING GROUP QTL TEMPLATE AND INSTRUCTIONS

Issue: The potential use of the QTL template is overly broad and unclear in scope, leading to an administratively burdensome process for carriers, particularly in comparison to templates carriers have used effectively in certain states.

Recommendation # 1: The template should not be finalized as a uniform resource. If the Working Group wishes to proceed with a uniform template for QTLs, the MHPAEA (B) Working Group should conduct a cost-benefit analysis to understand the administrative costs and effectiveness of the QTL template. Further, the working group should provide clarity on the use of the template (e.g., market conduct tool, QTL data collection, market analysis tool).

Rationale: BCBSA seeks to support the MHPAEA Working Group's objective to monitor, facilitate and coordinate best practices and compliance and enforcement efforts with states, DOL and the U.S. Department of Health and Human Services (HHS). To that end, BCBSA considers the draft QTL template and instructions administratively burdensome for carriers for the following reasons:

- **Existing tools satisfy and ensure QTL compliance:** A key concern with the template and instructions is that insurers already have a process and set of tools in place to ensure plans are compliant for QTLs, based on DOL templates. If states chose to require this new template, it would demand substantial efforts to complete an essentially duplicative test or to switch internal processes over to this new format. These investments may inadvertently delay product offerings and/or discourage new entrants to market.
- **Carriers may be mandated to use this burdensome template despite NAIC's WG statement that this is optional for states to use.** Insurers believe that the proposed financial requirement/quantitative treatment limitation (FR/QTL) template is unnecessary and substantially burdensome to carriers. MHPAEA has been in force for more than 10 years. Some Departments of Insurance (DOIs) allowed carriers to develop their own FR/QTL testing formats to demonstrate MHPAEA compliance. Carriers have built automated processes to conduct this extensive testing and provide that information to DOIs where required or requested. Although the templates being considered are not required to be used, insurers are concerned that some DOIs will require the use of this template to submit FR/QTL testing during form filing.

In addition, it is critically important that the working group undertake a substantive cost benefit analysis before adopting any template in order to make an informed decision about the use, cost and administrative burden of completing the template as opposed to its ultimate utility and other alternatives. This can only be done if there is a clear understanding of why the data is being collected and how the template will be used. As noted on the last working group conference call on June 5, this template is being proposed for adoption for any use that states may decide. During working group calls it has been suggested that the proposed template could be used as a means of FR/QTL data collection; it could be a market conduct tool; it could be used as a market analysis tool; and it could also be used to review and approve forms. But it

cannot, nor should it be, used for all four. Each of these potential purposes will generate a different analysis of the template, different filing requirements upon carriers and different legal and practical results from the template's review. It is critical that there be a generally accepted understanding between states, and between regulators and the industry, about how this template will be used and why it is being proposed.

Recommendation # 2: If the template is adopted, the template should not be required by states for form filing. If states wish to check compliance on form filings and don't have an existing process, we recommend a process where carriers can submit an attestation in the form filing that states the insurer has conducted the required parity analysis and documentation in the form filing.

Rationale:

- **The draft template requires unnecessary and proprietary information that should not be publicly disclosed:** BCBSA is also concerned that this template requires more information than is necessary for the QTL substantially all/predominant test. Requiring page references to Certificates of Coverage (COC) or Schedules of Benefits (SOB), for example, serves a different purpose than the QTL test and would be burdensome to track as changes are made over time. Given the additional level of detail, BCBSA considers this form would only be appropriate or useful in the case of responding to a filing objection or, potentially, during a market scan. Other situations would involve publicly disclosing information plans ordinarily would not need to disclose.
- **Requirement for entering cost-sharing information at the plan level may not be possible for certain insurers:** Some insurers test each product configuration (i.e., how different cost-sharing types apply) and because of how the benefits are set up, can generally test for substantially all types with no need to test for predominant level as they often only have one level. Therefore, some insurers do not test every single cost-sharing combination, but rather broader product configurations. This template requires cost-sharing amount as an entry. Some insurers would not be able to do this testing on every fully insured plan offered as they have thousands. Insurers might be able to do the testing on all small group and individual plans, but even then, many plans have the same cost-sharing application structure, so testing all of them individually would be redundant.

Recommendation # 3: Regulators should allow flexibility for insurers to group-covered services together on the template if the services are in the same classification and have the same cost-sharing parameters and limits rather than breaking out allowed amounts by each service line.

Rationale: The onerous level of detail required with regard to covered services does not materially improve the accuracy of the "predominant" and "substantially all" calculation that the template is intended to implement. For example, the instructions under Step 3 indicate that: "All services included in Certificates of Coverage (COC) and Schedules of Benefits (SOB) should be identifiable in the list of covered services." Since the template depends on having claims by service, for every service included, plans and issuers would need to be able to identify and report on all associated claims. Health plan policies include hundreds of services, but issuers typically group services in conducting QTL testing.

Listing out each covered service and the associated cost-share in each classification is unduly burdensome because cost-sharing does not vary across benefits in this manner. For example, numerous services rendered during an inpatient stay apply the same cost-share across the board. The only relevant distinction in these circumstances is whether the service is designated as medical/surgical (M/S) or mental health/substance abuse (MH/SUD). Conversely, in an outpatient setting, lab or pathology, imaging or x-ray might be different and, therefore, cost-share for those services should rightfully be delineated.

In another example from the Instructions, speech therapy and occupational therapy are enumerated based on place of service and diagnosis; however, from a cost-share perspective, insurers may group all such claims into the larger category of “Short Term Therapies,” all with the same cost-share. It would not make sense, therefore, to break these services out separately and then further cite to the COC and SOB for each.

In addition, there is no meaningful purpose in including covered MH/SUD benefits in the template, and certainly not by each and every diagnosis for which an MH/SUD treatment may be rendered. The type and level of FR/QTLs applied to the MH/SUD classifications of benefits is dictated by the type and level of QTLs applied to at least two-thirds of the M/S benefits. Overall, the approach taken with regard to classification is very prescriptive and does not allow for other approaches to parity calculation in this area.

Recommendation # 4: BCBSA requests the requirement to cite COC and SOB page numbers and sections be removed.

Rationale: Step 7 requires citations to the contract and the SOB where the benefit is mentioned. Each plan contract and SOB is different, and there are often amendments that change these citations. Step 7 would be a purely manual step and would be extremely burdensome to the carrier, especially if required for each plan the carrier files. BCBSA cautions against adopting a template that creates a substantial burden for the carriers where there are not identified compliance issues.

If required as part of the form filing process – which BCBSA does not encourage – this will significantly hamper the form filing process for many states and carriers. This is particularly concerning in the small group and individual markets with their form filing deadlines, as it will be nearly impossible to create these cross references for an entire slate of products in a manner that will allow carriers to meet those deadlines. State form reviewers already complete their own internal checklists and read the forms thoroughly as part of the approval process. Rather than force carriers to list each and every M/S benefit on the SOB at a granular level, BCBSA suggests the tool ought to afford flexibility consistent with the “any reasonable method” language of the rule. BCBSA urges the working group to drop the cross-reference requirements, which, ultimately, are unnecessary for a quantitative parity analysis of the M/S FR/QTLs.

Recommendation # 5: BCBSA recommends the following main flexibilities for plans to properly input data:

- **Allow multiple plans to be input at once:** If multiple plans have the same benefit classifications and just different copay and coinsurance values, it may be possible for the tool to intake multiple plan designs.
- **Use per-member per-month (PMPM) figures or percentages of total rather than total allowed dollar amounts by service type:** When prospectively testing plan designs, total allowed dollars are not available. The classification tabs note that if using PMPM data, annual membership totals and methodology for calculating PMPM data is to be provided, but it is not clear that the PMPMs can be entered on the covered services column, and this option is not mentioned in the instructions.
- **Allow entry of any plan designs handled by the Actuarial Value (AV) calculator into template:** Template should provide flexibility to enter any plan design that is handled by the AV calculator.
- **Implement limit on the number of evaluations necessary in large group plan market:** Some kind of reasonable approach should be taken to limit the number of evaluations required in the large group plan market. Also, credibility standards used in the testing process likely vary among insurers.
- **Incorporate an indicator for emergency services:** Add an indicator for plans where emergency services are classified as such without regard to a diagnosis, and such services share the same cost-sharing irrespective of an underlying diagnosis. The emergency services tab is not necessary in these situations.
- **Remove pharmacy benefits from QTL template:** Pharmacy benefits should not be included in the template. Pharmacy co-pays may vary by tier, generic/brand etc., but within generic and within brand, there is not any difference in co-pay based on what the drug is used to treat. Having to complete tabs for these categories would be administratively burdensome. There is an exception from the predominant/substantial testing under MHPAEA for pharmacy benefits that are sorted into tiers based on reasonable factors. 45 CFR § 146.136(c)(3)(iii); 29 CFR § 2590.712(c)(3)(iii). The test for pharmacy benefits sorted into tiers (generic/brand) as presented in this rational is the NQTL test, not the actuarial test that this template conducts.
- **Remove NQTL Requirement from the draft QTL template:** Column H of the proposed FR/QTL template requires carriers to identify all NQTLs to which each covered benefit is subject. There are many different types of NQTLs, such as prior authorization requirements, development and application of medical necessity criteria, methodology for determining in-network and out-of-network provider reimbursements, etc. Moreover, there are different parity rules governing NQTLs and FR/QTLs. State regulators generally review them separately, with different templates and information for each. BCBSA agrees with this approach and urges the working group to remove the NQTL requirement in the proposed QTL template.
- **Create in-network and out-of-network columns in draft QTL template:** Eliminate redundancy by creating in-network and out-of-network columns as opposed to having a

different row for each time a service is in-or out-of-network. Another way to streamline the spreadsheet is to consider pre-populating standard categories (e.g., under covered services) and then allow for plan customization where necessary.

- **Provide insurers with sufficient time to implement systems and process changes.** If a QTL template is adopted, NAIC should allow industry reasonable accommodations to ensure that there is enough time to implement systems and process changes to conform to the imposed requirements. If changes to regulations or the market conduct examination handbook are required, NAIC should establish new requirements through appropriate notice and comments processes, including the promulgation of any model laws or regulations that may be necessary to facilitate such changes. Requirements should be applied prospectively in accordance with established precedent.

Rationale: Implementing the recommended changes will provide significant flexibilities to appropriately capture plan benefit design parameters. Additionally, these changes will simplify the QTL template, satisfy QTL testing requirements and reduce administrative burden.

Issue: The QTL template is Excel-based and includes formulas that could result in incorrect submissions if the user is not highly skilled in Excel. In addition, the template could be expanded to introduce additional functionality.

Recommendation: BCBSA requests that NAIC determine whether the template can be protected in such a way that carriers can complete the template and DOIs can review the template, but accidental manipulation is not possible or at least improbable. Specifically, BCBSA recommends the following changes to bolster the security and usability of the QTL template:

- **Lock the formulas in the final template:** Formula references from the “Covered Services” tab to the “Classification” tabs can be broken if cutting and pasting rows on the “Covered Services” tab. If a user is not adept at Excel, they may not know how to fix the formula references in hidden columns J:M on the “Classification” tabs to remove the reference errors, and the “Classification” tabs may not populate correctly.
- **Clearly identify where carriers should input data:** Use formatting to clearly indicate the fields where data input is required.
- **Consolidate all classifications in separate tab:** Add a “summary” worksheet tab where the analysis for all classifications is summarized and consolidated.
- **Address the inability of the tool to handle multiple network tiers:** The instructions state that the template does not support multiple network tiers, and the analysis has to be performed manually. This note should also be included in the Excel template. It may be helpful if the tool would populate additional classification tabs to support the number of tiers entered by the user, and a tab could be populated by the user specifying tier level on the “Covered Services” tab. The template should allow for the flexibility to test either by tier or across tiers. At a minimum, additional guidance is needed on how to complete the analysis manually. The draft QTL template includes very complex formulas in an Excel spreadsheet that don’t translate easily to manual calculations. The draft QTL

template seems to put plans with multiple networks at a disadvantage since they are unable to use it to determine compliance with QTLs.

- **Hide extraneous cost-sharing types or clarify instructions:** The “Substantially All” Test is first conducted to determine the type of cost-sharing to use in the “Predominant” Test. Then, the “Predominant” Test only needs to be conducted on that one cost-sharing type. However, the template displays the “Predominant” Test for all the types of cost-sharing, rather than just the one that meets the “Substantially All” Test. We recommend that the template hide the extraneous cost-sharing types or the instructions can provide greater clarity.

Rationale: On the June 6 NAIC Working Group call, the Chair acknowledged that the template (which was developed by her team at the Pennsylvania DOI) is susceptible to manipulation, and she has accidentally “broken” it multiple times. She cautioned that significant Excel expertise is required to fix the template in those situations. BCBSA is concerned about the Excel template’s susceptibility to accidental manipulation. If a DOI requires carriers to fill this template out for each plan it files, and the template is accidentally manipulated by either the DOI or the carrier, the result could be:

- (1) Duplicating already burdensome and expensive work
- (2) Improper denials and delays
- (3) Fines for MHPAEA violations

To limit these issues, BCBSA recommends the above key precautionary steps.

Issue: Instructions for the “expected claim dollar amount” are unclear if allowed payment amounts can be used in QTL template.

Recommendation: Update instructions to clearly allow carriers to input allowed amounts per the MHPAEA. BCBSA recommends the Step 5 instructions be modified as follows:

*“All covered medical/surgical services, including those services with zero-dollar cost sharing for members, must have an associated expected plan claim dollar amount listed. Also, expected claim dollar amounts must be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year; ~~expected claim dollar amounts are not cost sharing amounts paid by members~~ **the dollar amount of plan payments is based on the amount the plan allows (before enrollee cost-sharing) rather than the amount the plan pays (after enrollee cost-sharing) because payment based on the allowed amount covers the full scope of the benefits being provided.**”*

Rationale: Instructions for “expected claim dollar amount” state that the expected claim dollar amount is the “expected plan claim dollar amount listed. Also, expected claim dollar amounts must be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year; expected claim dollar amounts are not cost sharing amounts paid by members.” The [MHPAEA rules](#) require the testing to be based on the allowed amount, which represents both the plan payment and the enrollee cost-sharing amount. The preamble to the Final Rule states, “The dollar amount of plan

payments is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided.” The instructions should be modified to clearly indicate that allowed amounts may be used.

We also note that while the federal parity regulations prohibit a plan from applying a type or level of cost share to MH/SUD benefits within a classification that is more restrictive than the predominant type and level of cost share applied to substantially all (at least two-thirds) of the M/S benefits within the corresponding classifications of benefits [45 CFR 146.136(c)(2)(i)], that applicable federal regulations provide that carriers may use any reasonable method to determine the dollar amount expected to be paid under a plan for M/S benefits subject to a QTL. [45 CFR 146.136(c)(3)(i)(E)]. Rather than force carriers into a specific analysis, a template should request an explanation of each plan’s methodology.