Coverage for Mental Health and Substance Use Disorders: Summary of 2022 Insurance Carrier Data

Submitted to the Senate Committee on Commerce and Labor and the House of Delegates Committee on Commerce and Energy, pursuant to § 38.2-3412.1 G Code of Virginia

November 1, 2023

COMMONWEALTH OF VIRGINIA

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Transmitted via Email

The Honorable Richard L. Saslaw
Chair, Commerce and Labor Committee
Senate of Virginia

The Honorable Terry G. Kilgore
Vice Chair, Commerce and Energy Committee
Virginia House of Delegates

Members of the Senate Commerce and Labor Committee

Members of the House Commerce and Energy Committee

Dear Senator Saslaw and Delegate Kilgore:

Pursuant to the requirements of § 38.2-3412.1 G of the Code of Virginia, the Bureau of Insurance submits this report containing aggregate health carrier data concerning denied claims, complaints, appeals, and network adequacy for mental health and substance use disorder benefits for the reporting period January 1, 2022 through December 31, 2022. In addition, in accordance with the statutory amendments enacted by the General Assembly during its 2022 legislative session, this report also includes a summary of all comparative analyses of Non-Quantitative Treatment Limitations prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau during the reporting period.

Sincerely,

Scott A. White
Commissioner of Insurance

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Executive Summary

As required by § 38.2-3412.1 B of the Code of Virginia (Code) and in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, mental health and substance use disorder benefits provided by group and individual health insurance coverage must be in parity with medical and surgical benefits coverage.

The Bureau of Insurance (Bureau) has developed health carrier reporting requirements for mental health and substance use disorder benefits that includes denied claims, complaints, appeals, and network adequacy, and compiled the information into a report pursuant to § 38.2-3412.1 G of the Code. In addition, this report also includes a summary of all comparative analyses of Non-Quantitative Treatment Limitations (NQTL) prepared by health insurance carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau during the reporting period.

To gather the necessary information, the Bureau conducted a data call of 17 health carriers insuring more than 2.51 million lives in the individual, small group, and large group health insurance markets in Virginia during 2022. The Bureau also conducted a supplemental data call to assess network adequacy. Key takeaways include:

- In total, while the difference was small, carriers denied claims more often for mental health and substance use disorder benefits than for medical/surgical benefits. Carriers generally denied claims in fewer service categories (2 of 5) for mental health benefits and in more service categories (5 of 5) for substance use disorder benefits than claims for medical/surgical benefits.

- The largest share of complaints for both mental health and medical/surgical benefits concerned administrative/service (36.7 percent and 33.3 percent, respectively), while the largest share of complaints for substance use disorder benefits concerned utilization management (37.5 percent).

- Denied claims involving mental health benefits were upheld by carriers in 62 percent of closed internal appeals and upheld in 25 percent of closed external reviews.

- Based on information submitted by the health carriers and the differing standards for network adequacy, the Bureau could not reasonably determine parity in network adequacy or compare access to network providers for mental health, substance use disorder or medical/surgical benefits.

- The Bureau deemed all reported comparative analyses of NQTLs insufficient.

Introduction

As required by § 38.2-3412.1 B of the Code of Virginia (Code) and in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, mental health and substance use disorder benefits provided by group and individual health insurance coverage must be in parity with medical and surgical benefits coverage.

For purposes of the information presented in this report, if a particular analysis indicates a greater occurrence for a mental health or substance use disorder service than that for a medical/surgical service, then the carrier is considered to be in noncompliance with parity requirements.

In accordance with § 38.2-3412.1 G of the Code, the Bureau has developed health carrier reporting requirements for mental health and substance use disorder benefits that includes denied claims, complaints, appeals, and network adequacy, and compiled the information into this report. In addition, pursuant to the statutory amendments enacted by the General Assembly during its 2022 legislative session, this report also includes a summary of all comparative analyses of NQTLs prepared by health insurance carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau during the reporting period. The Bureau must submit the report to the designated legislative committees annually by November 1, and post it on the Commission's website.

To gather the necessary information, the Bureau conducted a data call of 17 health carriers insuring more than 2.51 million lives in the individual, small group, and large group health insurance markets in Virginia during 2022. The Bureau also conducted a supplemental data call to assess network adequacy.

The report provides only aggregate data to protect the confidentiality of individual members and health carriers.

Section I. Claims

Overview

Carriers surveyed reported a total of 46,264,175 claims received, with 9,122,332 (19.72 percent) claims denied. This was a significantly higher denial rate than reported in each of the two previous years: 13.63 percent in 2022 and 11.99 percent in 2021.

Each carrier reported the number of denied claims related to medical/surgical, mental health, and substance use disorder benefits. These claims were then separated into five service types: office visit claims, all other outpatient claims, inpatient claims, emergency care claims, and outpatient prescription (Rx) drug transactions. See Tables 1, 2, and 3.

Table 1. Claims Overview – Medical/Surgical Benefits (2022)

Claim Category: Medical/ Surgical Benefits	Total Claims Received	Claims Paid	Claims Denied	% Total Claims Denied
Office Visit Claims	9,884,144	9,256,778	627,366	6.3%
All Other Outpatient Claims	12,210,672	11,417,041	793,631	6.5%
Inpatient Claims	1,168,377	1,017,892	150,485	12.9%
Emergency Care Claims	1,062,328	971,445	90,883	8.6%
Outpatient Rx Transactions	16,935,736	10,547,490	6,388,246	37.7%
Totals:	41,261,257	33,210,646	8,050,611	19.5%

Table 2. Claims Overview – Mental Health Benefits (2022)

Claim Category: Mental Health Benefits	Total Claims Received	Claims Paid	Claims Denied	% Total Claims Denied
Office Visit Claims	1,154,342	1,080,906	73,436	6.4%
All Other Outpatient Claims	732,174	673,876	58,298	8.0%
Inpatient Claims	64,865	57,017	7,848	12.1%
Emergency Care Claims	27,466	25,267	2,199	8.0%
Outpatient Rx Transactions	2,634,553	1,789,107	845,446	32.1%
Totals:	4,613,400	3,626,173	987,227	21.4%

Table 3. Claims Overview – Substance Use Disorder Benefits (2022)

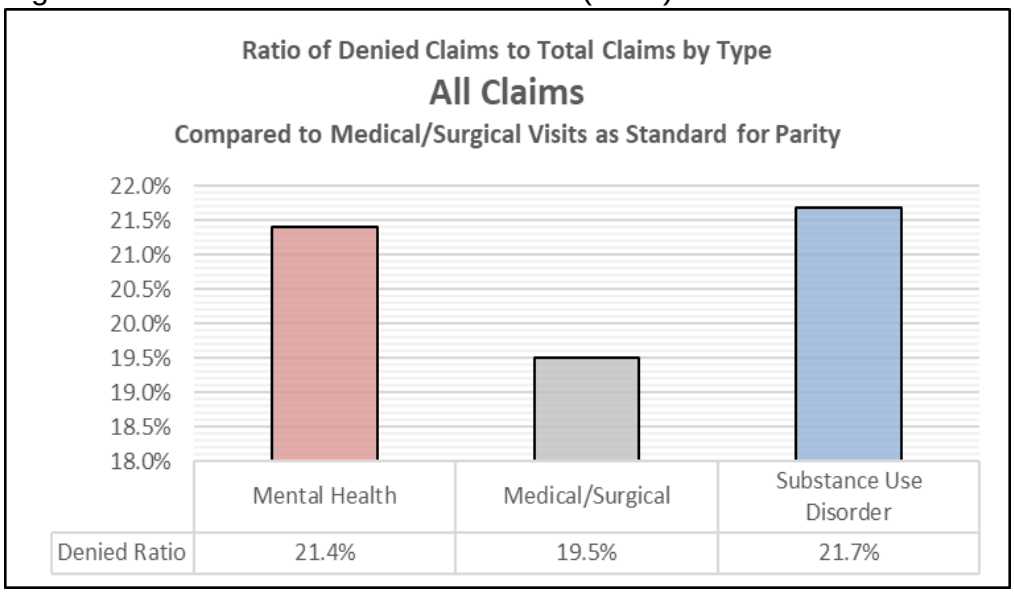
Claim Category: SUD Benefits	Total Claims Received	Claims Paid	Claims Denied	% Total Claims Denied
Office Visit Claims	87,029	69,449	17,580	20.2%
All Other Outpatient Claims	145,878	123,891	21,987	15.1%
Inpatient Claims	45,698	38,579	7,119	15.6%
Emergency Care Claims	31,055	27,717	3,338	10.7%
Outpatient Rx Transactions	79,858	45,388	34,470	43.2%
Totals:	389,518	305,024	84,494	21.7%

Denied Claim Ratios

The following charts compare the ratios of denied claims to total claims for medical/surgical, mental health, and substance use disorder benefit categories.

Figure 1 shows that, for all claims, the denial ratios for mental health and substance abuse benefits were 1.9 and 2.2 percent higher, respectively, than the denial ratio for medical surgical benefits. This represents a decrease in denials for mental health benefits and an increase in denials for substance use disorder benefits from the previous report, where these all-claim denial ratios were 2.6 and 0.1 percent greater, respectively, than the denial ratios for medical/surgical benefits.

Fig. 1. Denied Claims Ratio – All Claims (2022)



Claim denials were further considered by service type and benefit category. Figure 2 shows that the denial ratios for office visit claims for mental health benefits were 0.1 percent less, and for substance use disorder benefits 13.7 percent greater, than the denial ratio for medical/surgical benefits. The previous report showed these respective denial ratios were 0.2 percent less and 2.6 percent greater than those for medical/surgical benefits.

Fig. 2. Denied Claims Ratio – Office Visit Claims (2022)

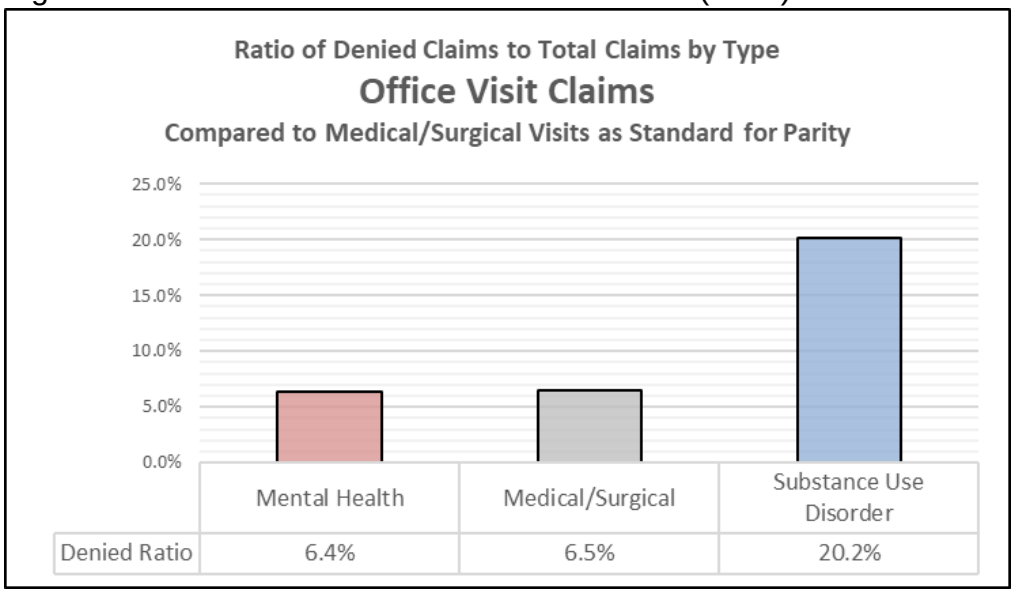


Figure 3 shows the denial ratios for all other outpatient claims were 1.5 and 8.6 percent greater for mental health benefits and substance use disorder benefits, respectively, than the denial ratio for medical/surgical outpatient benefits. The previous report showed these respective denial ratios were 0.4 and 5.7 percent greater than they were for medical/surgical benefits.

Fig. 3. Denied Claims Ratio – All Other Outpatient Claims (2022)

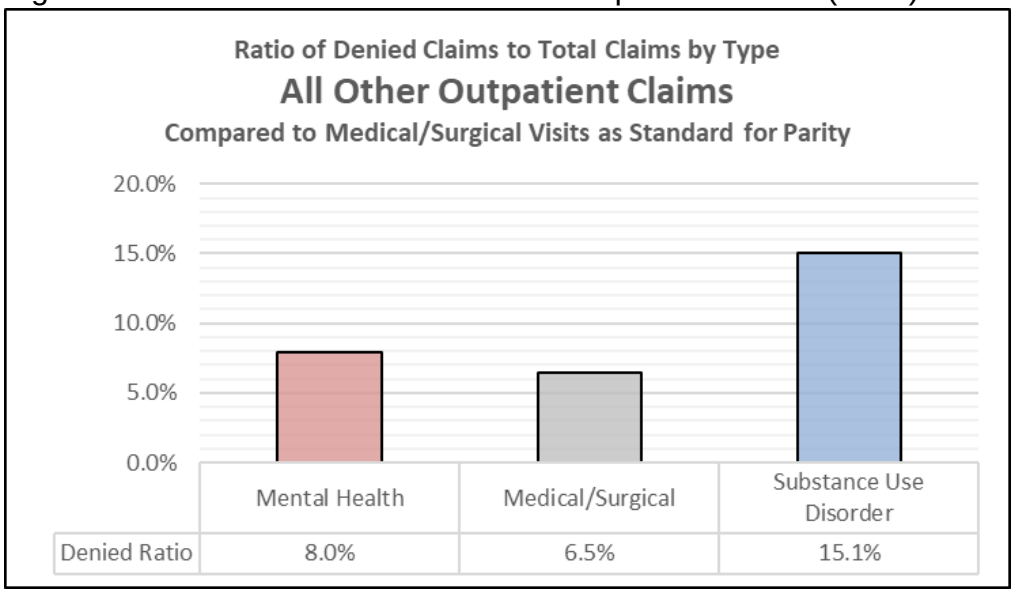


Figure 4 shows that the inpatient claims denial ratio was 0.8 percent lower for mental health benefits and 2.7 percent greater for substance use disorder benefits than the denial ratio for medical/surgical benefits. The previous report showed these respective denial ratios were 1.5 percent lower and 2.7 percent greater than they were for medical/surgical benefits.

Fig. 4. Denied Claims Ratio – Inpatient Claims (2022)

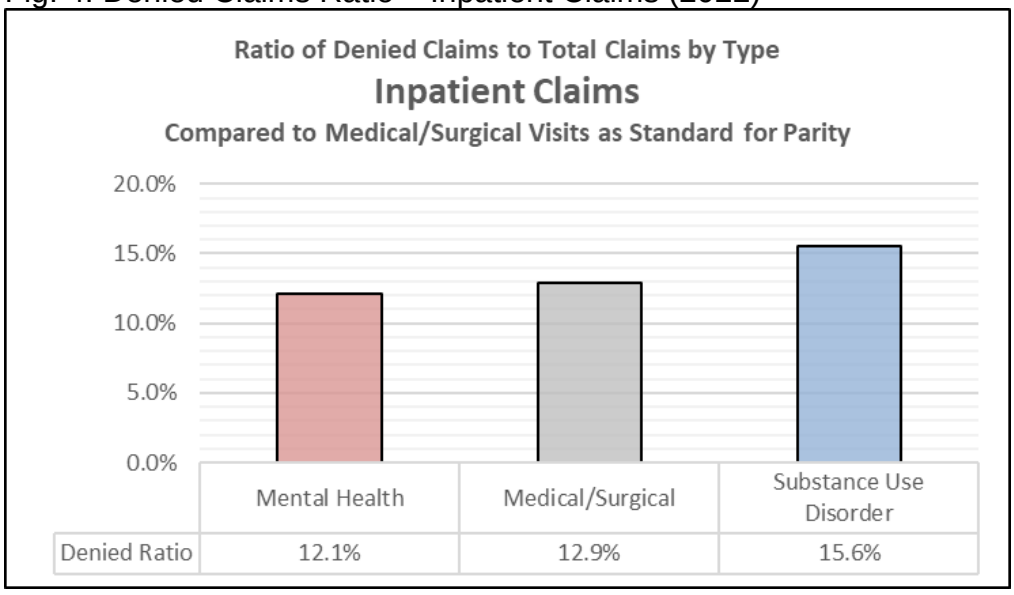


Figure 5 shows that the emergency care claims denial ratio was 0.6 percent lower for mental health benefits and 2.1 percent greater for substance use disorder benefits than the denial ratio for medical/surgical benefits. The previous report showed the respective denial ratios to be 1.3 percent lower and 8.6 percent greater than that for medical/surgical benefits.

Fig. 5. Denied Claims Ratio – Emergency Care Claims (2022)

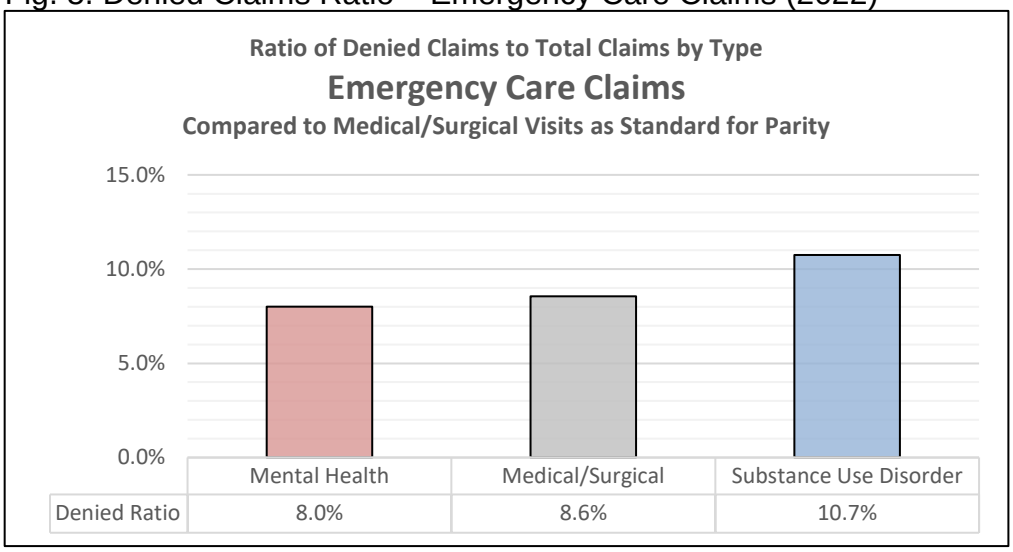
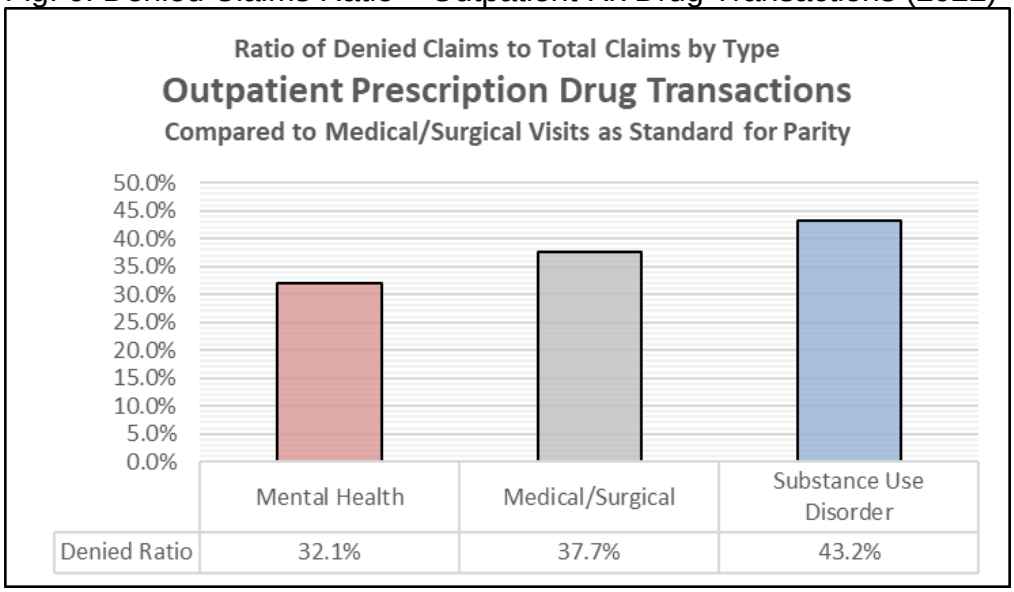


Figure 6 shows that the Outpatient Prescription Drug Transactions denial ratio was 5.6 percent lower for mental health benefits and 5.5 percent greater for substance use disorder benefits than it was for medical/surgical benefits. The previous report showed these respective denial ratios were 3.8 percent lower and 7.4 percent greater than they were for medical/surgical benefits.

Fig. 6. Denied Claims Ratio – Outpatient Rx Drug Transactions (2022)



Reasons for Claim Denial

Carriers were asked to report the total number of claims denied for which the denial would leave the member responsible for payment and identify the top three reasons for claim denial in each of the three benefit categories.

Carriers reported that out of 9,122,660 total claims, nearly 62 percent could be attributed to each carrier's top three reasons for claim denial. This means that 38 percent or 3,482,347 reported claim denials were for other reasons.

Table 4 shows the top three reasons responding carriers denied claims. These reasons remained unchanged from the previous report.

Table 4. Top Three Reasons for Claim Denials (2022)

Reason for Claim Denial by Benefit Category	Number of Denials	Rank	Percent of Total
Medical/Surgical			
Prescription refill too soon	1,550,515	1	19.3%
Not a covered benefit/service contractually excluded	1,368,132	2	17.0%
Exceeds benefit limits (contractual)	1,030,021	3	12.8%
Mental Health			
Prescription refill too soon	334,463	1	33.9%
Exceeds benefit limits (contractual)	152,768	2	15.5%
Individual ineligible/not insured when services provided	88,260	3	8.9%
Substance Use Disorders			
Individual ineligible/not insured when services provided	6,997	1	8.3%
Not a covered benefit/service contractually excluded	5,608	2	6.6%
Provider not participating with individual's plan*	5,361	3	6.3%

*In approximately 42 percent of the 5,361 denials, the third-ranked reason for substance use disorder claims shown in Table 4 was reported by a single carrier.

Across all benefit categories, the Bureau consolidated the top three reasons carriers denied claims into six general subcategories. Table 5 shows the number of all denied claims attributable to each subcategory by benefit category.

Table 5. Number of Claims Denied by General Subcategories (2022)

General Subcategories	Medical/ Surgical	Mental Health	Substance Use Disorder	All Claims Denied
	4,912,684	696,008	31,621	5,640,313
Non-covered benefits or services	2,648,489	237,187	13,180	2,898,856
Prescription drug services	1,652,957	422,723	1,689	2,077,369
Non-participating providers/ out-of-network or service area	253,189	13,574	5,988	272,751
Preauthorization or precertification	183,359	8,979	5,361	197,699
Provider or administrative billing	136,108	7,908	4,464	148,480
Medical necessity/inappropriate service	38,582	5,637	939	45,158

Section II. Complaints

Overview

For 2022, carriers reported receiving 8,705 complaints from either covered persons or the Bureau, with 97 percent being closed. This was down from 10,182 complaints reported for 2021, but significantly more than the 3,278 complaints reported for 2020. Complaints were assigned to one of five complaint areas for each of the three benefit categories: access to health care services, utilization management, practitioners/ providers, administrative/service, and claims processing. Table 6 shows the number of complaints for each complaint area and whether the complaint was related to a medical/surgical benefit, mental health benefit, or substance use disorder benefit.

Table 6. Complaints Submitted (S) and Closed (C) (2022)

Complaint Area	Medical/ Surgical		Mental Health		Substance Use Disorder		All Complaints	
	S	C	S	C	S	C	S	C
Access to Health Care Services	787	753	148	147	1	1	936	901
Utilization Management	1,636	1,613	82	81	24	24	1,742	1,718
Practitioners/Providers	84	77	1	1	0	0	85	78
Administrative/ Service	2,720	2,572	169	162	23	23	2,912	2,757
Claims Processing	2,953	2,867	61	60	16	16	3,030	2,943
Totals	**8,180**	**7,882**	**461**	**451**	**64**	**64**	**8,705**	**8,397**

Table 7 shows the ratio of complaints in each complaint area by benefit category, to the total of all complaints in each complaint area and in total by benefit category.

Table 7. Ratio of Complaints by Area Relative to their Respective Totals (2022)

Complaint Area	Medical/ Surgical		Mental Health		Substance Use Disorder		All Complaints	
	S	C	S	C	S	C	S	C
Access to Health Care Services	9.6%	9.6%	32.1%	32.6%	1.6%	1.6%	10.8%	10.7%
Utilization Management	20.0%	20.5%	17.8%	18.0%	37.5%	37.5%	18.5%	20.5%
Practitioners/ Providers	1.0%	1.0%	0.2%	0.2%	0.0%	0.0%	1.1%	0.9%
Administrative/ Service	33.3%	32.6%	36.7%	35.9%	35.9%	35.9%	41.3%	32.8%
Claims Processing	36.1%	36.4%	13.2%	13.3%	25.0%	25.0%	28.4%	35.0%
Totals	**8,180**	**7,882**	**461**	**451**	**64**	**64**	**6,955**	**8,397**
Ratio to All Complaints	**94.0%**	**93.9%**	**5.3%**	**5.4%**	**0.7%**	**0.8%**	**100.0%**	**100.0%**

Complaint Ratios

Figures 7 through 11 show differences in the ratio of submitted complaints by complaint area for each benefit category. Medical/surgical services comprised 94.0 percent of all complaints. For example, of the total complaints received by carriers for medical/surgical benefits, 9.6 percent pertained to access to health care services, whereas of the total complaints carriers received for mental health benefits, 32.1 percent pertained to access to health care services. By comparison, 1.6percent of complaints were related to access to care for substance use disorder benefits. Utilization management generated the largest percentage of complaints in this category at 37.5 percent.

Fig. 7. Access to Health Care Services (2022)

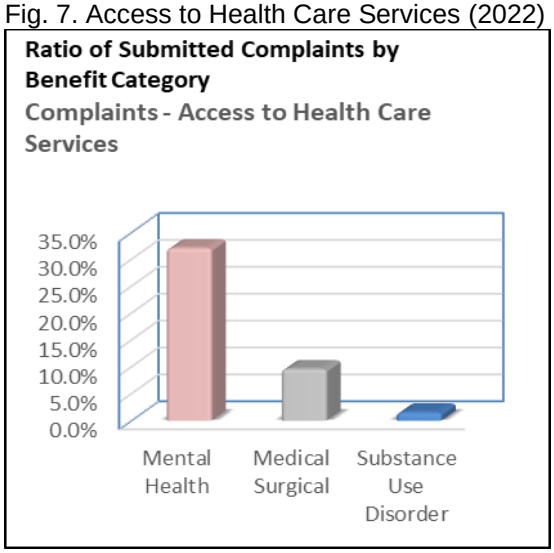


Fig. 8. Utilization of Management (2022)

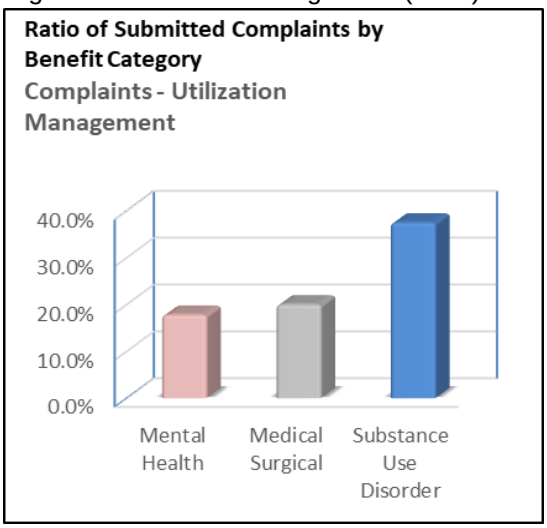


Fig. 9. Practitioners/Providers (2022)

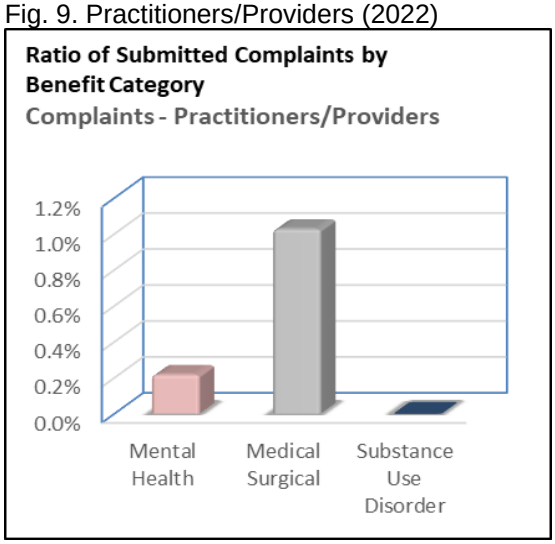


Fig. 10. Administrative/Service (2022)

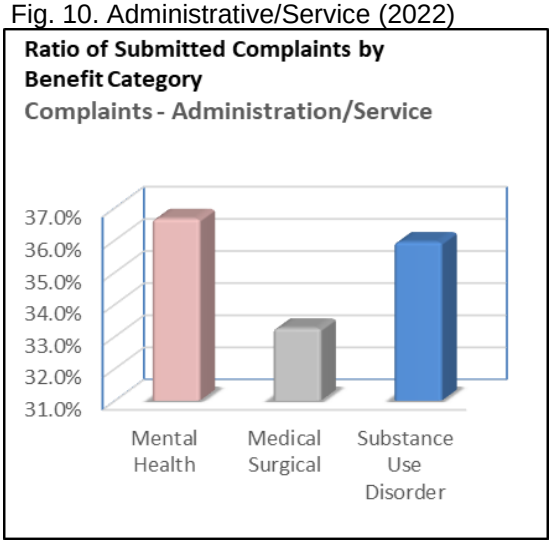
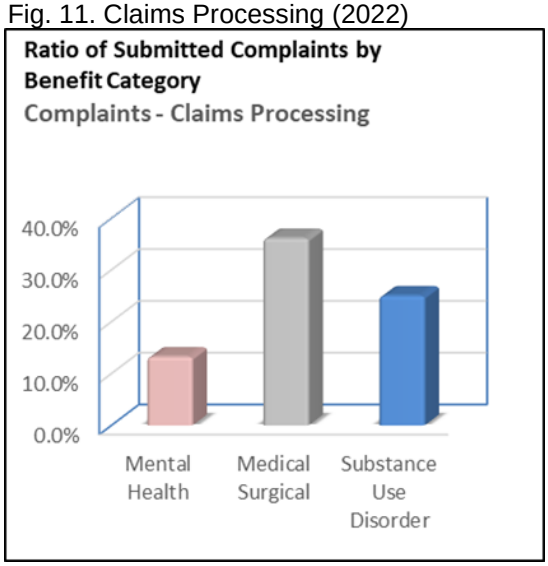


Fig. 11. Claims Processing (2022)



Section III. Appeals

Overview

An internal appeal is filed to obtain approval for services denied by a managed care health insurance plan as the result of utilization review or an administrative denial. The defining characteristic of the internal appeal process is that the health carrier makes the determination. The consumer may have one or two levels of internal appeal.

When a consumer with a fully insured Virginia policy receives a denial after completing the health carrier's internal appeals process, an external review facilitated by the Bureau may be available. If it approves the request, the Bureau will assign the external review to an approved Independent Review Organization, which will either uphold the health carrier's denial or overturn it.

Internal Appeals

As shown in Table 8, survey respondents processed and closed a total of 6,571 internal appeals across the three benefit categories in 2022, a decrease from 9,557 closed in 2021.

Table 8. Outcomes of Closed Internal Appeals (2022)

Outcomes of Closed Internal Appeals	Number Related to Medical/ Surgical	Number Related to Mental Health	Number Related to Substance Use
Denial Upheld	3,804	146	48
Denial Partially Upheld	81	5	8
Denial Overturned	2,363	83	33
Total	6,248	234	89

Figures 12 through 14 compares the outcome of internal appeals for each of the three benefit categories.

Fig. 12. Closed Internal Appeals – Denial Upheld (2022)

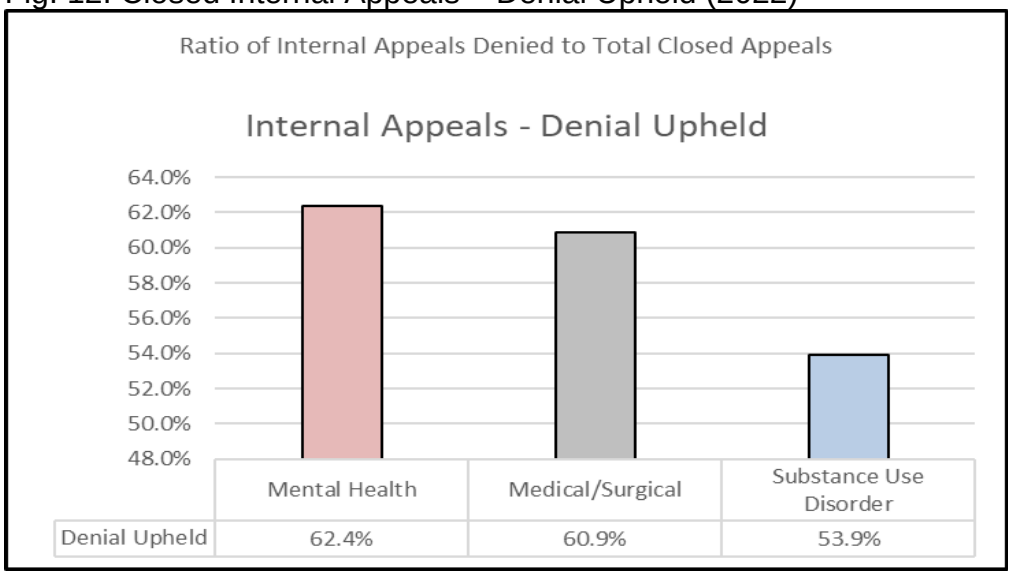


Fig. 13. Closed Internal Appeals – Denial Partially Upheld (2022)

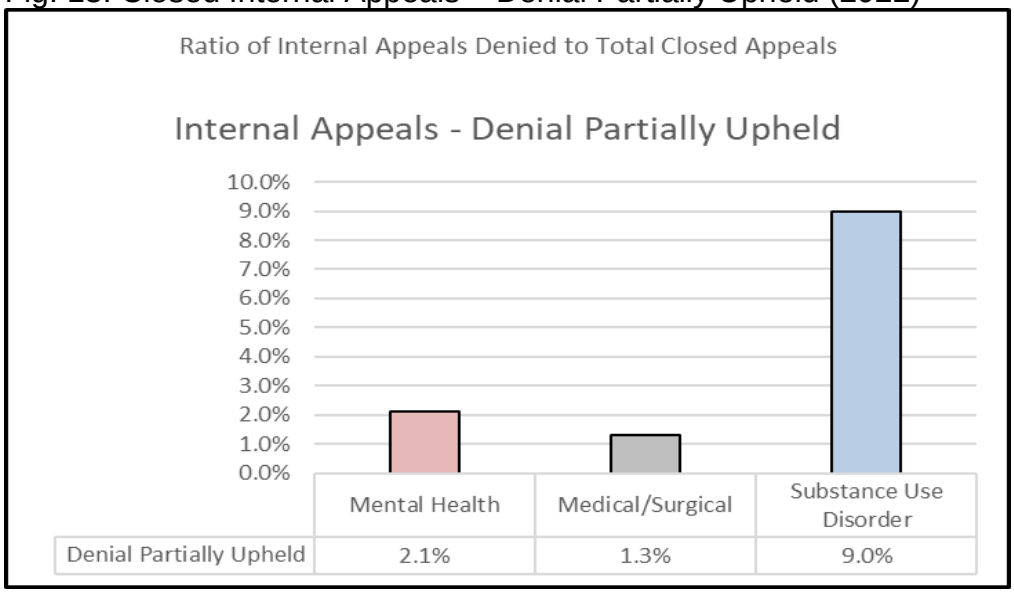
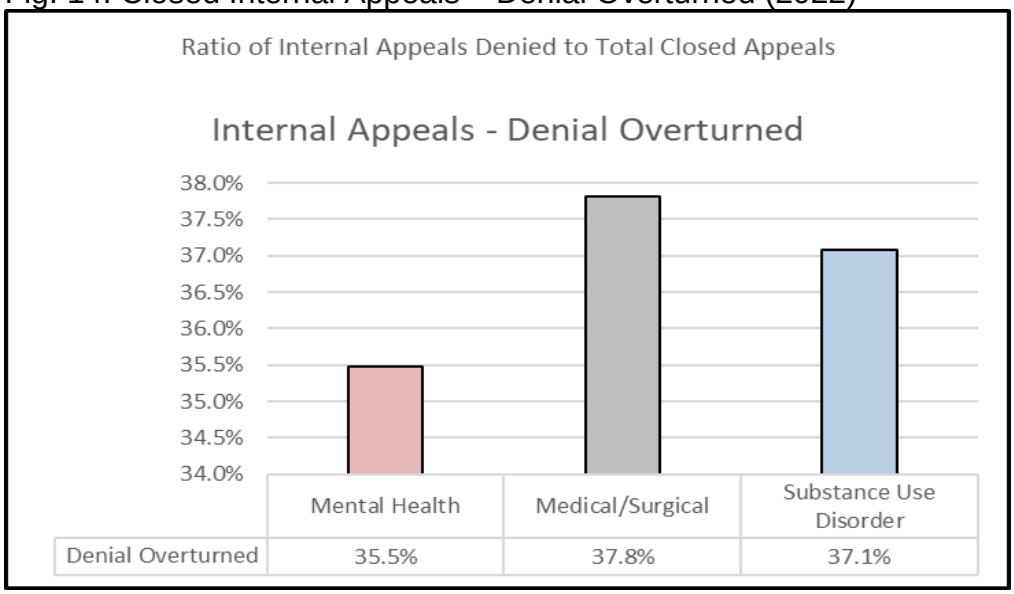


Fig. 14. Closed Internal Appeals – Denial Overturned (2022)



External Review

Survey respondents reported that 200 external reviews were performed in 2022. Table 9 shows the number and results of closed external reviews related to medical/surgical, mental health, and substance use disorder benefits. Figures 15 through 16 demonstrate the frequency with which denials were upheld or overturned for each of these three benefit categories.

Table 9. Outcomes of Closed External Reviews (2022)

Outcomes of Closed External Reviews	Number Related to Medical/ Surgical	Number Related to Mental Health	Number Related to Substance Use Disorder
Denial Upheld	106	1	0
Denial Partially Upheld	0	0	0
Denial Overturned	90	3	0
Total	196	4	0

Fig. 15. Closed External Reviews – Denial Upheld (2022)

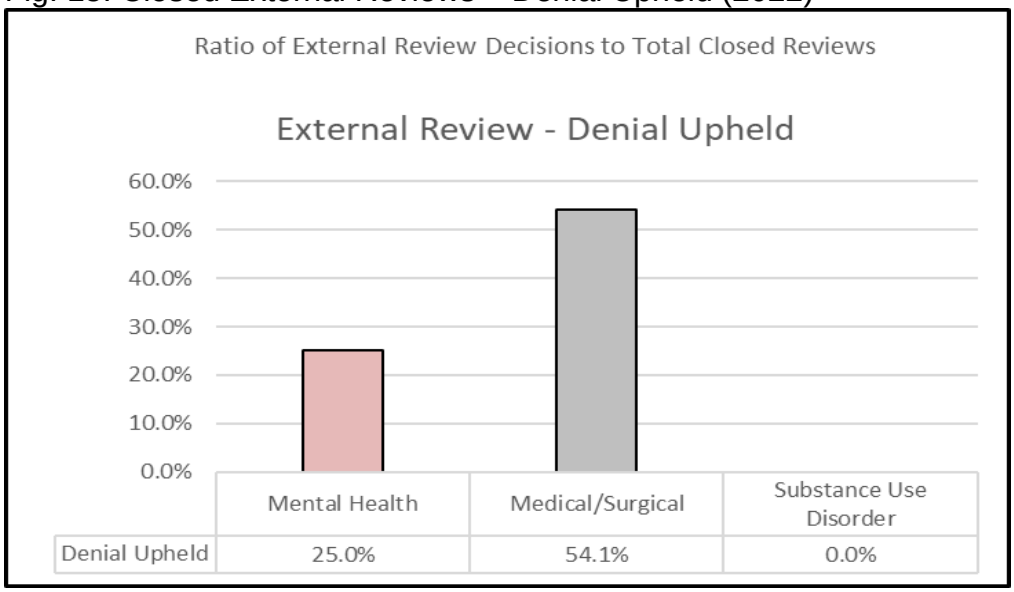
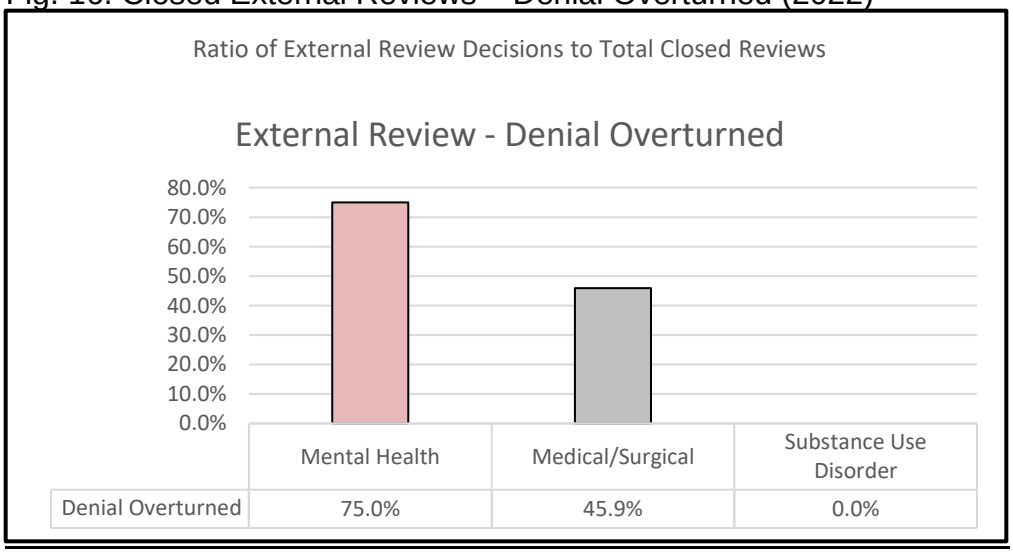


Fig. 16. Closed External Reviews – Denial Overturned (2022)



Section IV. Network Adequacy

Overview

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all other health care services included under the terms of the contract. Determining the adequacy of networks has can be challenging for several reasons, including:

- There is no national standard for network adequacy and those that do exist vary significantly across states and types of coverage.

- Evaluation of health plan networks relies on plan provider directory data which may be inaccurate or out of date.

- No national standard for the accuracy of information in health plan provider network directories exists.

- There is neither a standard measure of network size or breadth, nor any way for consumers or regulators to easily discern differences in network size.

Section 32.1-137.2 G of the Code requires the Virginia Department of Health (VDH) to determine standards for access to provider networks and VDH regulation 12 VAC-408-260 requires carriers to establish network adequacy regarding access to providers. Federal regulation 45 CFR § 156.230 provides network adequacy standards to include requirements for access to mental health and substance use disorder services. Other states have various rules and laws concerning network adequacy and the federal Centers for Medicare and Medical Services (CMS) has been conducting meetings to establish a standard for enforcement of network adequacy.

Because of the differing standards, determining network adequacy can be challenging, assessing parity between medical/surgical, mental health, and substance use disorder network services provisions has yet to be resolved.

Network Adequacy Parity Analysis

In the past, the Bureau has compared complaint ratios to analyze parity of network adequacy between these three benefit categories. This approach could suggest possible disparities in network adequacy for mental health or substance use disorder benefits if the complaint ratio is higher for these categories than it is for medical**/**surgical benefits and there are enough complaints for results to be credible.

Table 10 shows that medical/surgical claimants submit more complaints than mental health or substance use disorder claimants, based on the ratio of complaints to total claims. The numbers for this factor do not suggest the presence of different treatment, although the number of complaints for mental health and substance use disorders remains very low.

Table 10. Comparison of Total Complaints to Total Claims (2022)

Benefit Category	**Claims Presented**	**Percent of Claims Presented**	**Complaints**	**Complaints to Claims Ratio**
Medical/Surgical	41,261,257	89.2%	8,180	1 in 5,044
Mental Health	4,613,400	10.0%	461	1 in 10,007
Substance Use Disorder	389,518	0.8%	64	1 in 6,086
Total	**46,264,175**	**100%**	**8,705**	**1 in 5,315**

Table 11 shows the percentage and number of complaints involving access to health care services for each benefit category. This complaint subcategory includes out-of-network service provision, availability and timeliness of appointments, and availability of providers, all of which can provide insight into network utilization and adequacy.

Table 11. Complaint Ratios – Access to Health Care Services by Benefit Category (2022)

Complaint Type	Mental Health	Medical/Surgical	Substance Use Disorder
Access to Health Care Services	32.1% (148 of 461)	9.6% (787 of 8,180)	1.6% (1 of 64)

The mental health complaint ratio for the access to health care services subcategory is 3.3 times that of the medical/surgical ratio (down from 5.0 times in the 2022 report and up from 1.6 times reported in the 2021 report).

Supplemental Data Call

Research into network adequacy determinations for any service points to in-network versus out-of-network provider availability as a significant part of any discussion of network adequacy and, ultimately, parity for mental health and substance use disorder benefits.

Recognizing this, the Bureau, with input from health carriers, developed a supplemental data call to the initial survey of health carriers. This supplemental data call was intended to provide information to determine whether the Bureau could identify significant differentials between medical/surgical provider networks and those of mental health and substance use disorder networks.

Carriers were asked to identify for each benefit category, the number of unique individual or group providers or facilities

- In network;
- In network and receiving any payment in 2022;
- Out-of-network and receiving payment in 2022; and
- Out-of-network and denied payment for being out of network in 2022.

The initial data call was based on the logic that potential disparities could be identified if provider networks did not include enough providers for patients to easily access care for each of the three benefit categories. This is important because the previously collected information only dealt with complaints, which did not provide sufficient information to conclude that networks were inadequate in different ways to the point of denying access to care.

Carriers were also asked to indicate whether their provider networks had received accreditation from any of the nationally recognized accreditation organizations. Carrier responses were mixed, with approximately three quarters of them indicating that their

provider networks had received accreditation from the National Committee for Quality Assurance.

The Bureau sent the supplemental data call to the same 17 health carriers responding to the initial survey. While COVID-19 continues to impact the information technology resources of many businesses, including health insurance carriers, the Bureau expects this to have only a negligible impact on future reports.

One of the primary problems in identifying the adequacy of each carrier's networks is that many mental health professionals also provide substance use disorder services, which could result in double counting of providers.

Network adequacy measurements can be skewed if only a fraction of providers listed as in-network providers are treating patients. Table 12 shows how this factor may be measured. The Bureau compared information on the total number of in-network providers, along with the number of in-network providers actually paid for services in 2022.

Table 12. Network Adequacy Measurements (2022)

A.		B.	C.	D.	E.
Percent of in-network providers receiving payment (active participants)		***Percent of out-of-network providers paid***	***Percent of providers denied payment because out-of-network***	***Number of members per month to number of in-network providers***	***Percent of total claims***
Medical/Surgical	62.8%	12.5%	2.2%	51	89.2%
Mental Health	50.4%	9.2%	2.1%	234	10.0%
Substance Use Disorder	94.1%	6.9%	3.3%	1574	0.8%

This information is shown in Column A as a percentage of the total network. The highest active provider participation is for substance use disorders, 94.1 percent up 41.1 percent as compared to 53.0 percent in the previous report with medical/surgical showing an increase of 1.8 percent and mental health showing a decrease of 9.4 percent respectively, of network providers with active participation. From this information, the Bureau does not see anything that would point to network disparity issues, but rather more in-network providers are used for services related to substance use disorders.

The Bureau also analyzed information identifying, when compared to in-network provider payments, the extent to which members go to out-of-network providers to obtain services.

Column B shows that substance use disorder benefits have the lowest level of providers paid out-of-network, with the percentage for medical/surgical, and mental health being, respectively, 5.6 percent and 2.4 percent higher. This suggests that it is less difficult for a consumer to find their desired substance use disorder provider in-network than for either of the other two categories.

Column C shows the percentage of out-of-network providers denied payment due to not participating in a network. Substance use disorder benefits have the highest number, with medical surgical and mental health benefits trailing behind by just more that 1ne percent correspondingly.

Column D shows that the number of members to each mental health and substance use disorder provider in-network is greater than that of members to each medical/surgical provider. This is not unfavorable when compared to the fact that, as shown in column E of Table 12, medical/surgical benefit claims are filed at a much higher rate: there is one substance use disorder claim for every ten mental health claims and every 89 medical/surgical claims. It makes sense that any network would need more medical/surgical providers for adequate provision of services to its members. Because of this, the Bureau does not find any indication of disparity from these numbers.

Section V. Comparative Analyses

Overview

This report is also required to include a summary of all comparative analyses prepared by health carriers for the design and application of NQTLs pursuant to 42 U.S.C. § 300gg-26(a)(8) that the Bureau requested during the reporting period. A comparative analysis is a narrative with supporting documentation prepared by a health carrier that is required to demonstrate that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD 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 to medical/surgical benefits in the same classification.[1] For illustrative purposes, the National Association of Insurance Commissioners' (NAIC) Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group provided an example of a comparative analysis qualifying as sufficient for the NQTL Concurrent Review.

The summary must include the Bureau's explanation of whether the analyses were accepted as compliant, rejected as noncompliant, or are in process of review. For analyses that were noncompliant, the report shall include the corrective actions that the Bureau required the health carrier to take to come into compliance. Issuers should ensure that comparative analyses are sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying an NQTL are comparable and applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits

During the reporting period, the Bureau requested and reviewed NQTL comparative analyses from four carriers. In the aggregate, the following NQTLs were reviewed:

[1] U.S. Department of Labor, FAQs-Part-45 (dol.gov), April 2, 2021.

- Medical Necessity
- Prior Authorization
- Concurrent Review
- Retrospective Review
- Post-Payment Retrospective Review
- Experimental/Investigational/Unproven
- Blanket Policy Exclusions

The Bureau reviewed NQTLs associated with a sampling of 12 insurance products in total among the four carriers. When accounting for the number of applicable classifications (such as “Inpatient, In-Network,” “Outpatient, Out-of-Network, All Other”), the Bureau’s review accounts for 416 comparative analyses during the reporting period. The comparative analyses were reviewed for compliance with the federal Mental Health Parity and Addiction Equity Act, 42 U.S.C. § 300gg-26(a)(8), and § 38.2-3412.1 B of the Code of Virginia.

Findings

As the comparative analyses were requested and reviewed as part of ongoing market conduct examinations, the information provided in this report regarding findings is preliminary. These analyses remain under current market conduct review. The working papers and other specific details are required to be kept confidential under § 38.2-1320.5 of the Code. However, the market conduct reports including more specific information will be made public upon the conclusion of the examinations. The preliminary findings are as follows:

- All comparative analyses requested from the four carriers were initially deemed insufficient by the Bureau.
- The Bureau informed the carriers of the missing information required to make the comparative analyses sufficient. Carriers were given an adequate amount of time to provide additional comparative analyses to include this information.
- Upon receipt and review of the carriers’ additional comparative analyses, the Bureau completed its review of five NQTLs from the four carriers, representing 160 comparative analyses. It found that the comparative analyses continued to be insufficient and were in noncompliance with the federal Mental Health Parity and Addiction Equity Act, 42 U.S.C. § 300gg-26(a)(8), and § 38.2-3412.1 B of the Code However, the four carriers will have an opportunity to respond to the draft report issued at the end of the examination. The Bureau continues to review the remaining additional analyses.

Corrective Actions

For the five NQTLs from the four carriers found to be in noncompliance, the Bureau informed the carriers that the required corrective actions issued at the end of the examination will be that the carriers must develop a sufficient comparative analysis demonstrating compliance, or the Bureau will require the carriers to remove the NQTL in question from mental health or substance use disorder benefits in the classifications reviewed. Carriers are strongly cautioned that insufficient comparative analyses are noncompliant with the requirements of the Mental Health Parity and Addiction Equity Act, 42 U.S.C. § 300gg-26(a)(8), and § 38.2-3412.1 B of the Code of Virginia and will be cited by the Bureau.

Conclusion

This is the fourth data collection effort[2] by the Bureau and health carriers to assist in determining if parity in network adequacy exists between medical/surgical, and mental health, and substance use disorder benefits. The Bureau continues to participate in CMS discussions of enforcement of network adequacy standards and is monitoring ways to incorporate network adequacy measurements for use in future determinations of mental health and substance use disorder parity. The Bureau continues the review of NQTL comparative analyses as required of health insurance carriers by 42 U.S.C. § 300gg-26(a)(8).

The Bureau continues to examine the parity practices of individual carrier mental health and substance use disorder through its Health Market Conduct Section.

[2] Beginning with the data collection for this report, carriers were required to identify mental health benefits, substance use disorder benefits, and medical/surgical benefits based on the condition or disorder being treated, as required under the federal Mental Health Parity and Addition Equity Act of 2008, P.L. 110-343 and the Bureau's MHPAEA QTL/Financial Requirement Guidance.

Attachment A. Reasons for Denial of Claims by General Category

Denials related to non-covered benefits or services:
Exceeds benefit limits (contractual)
Not a covered benefit/service contractually excluded
Individual ineligible/not insured when the services were provided
Other (Explain): Workers Compensation
Denials related to prescription drug claims:
Prescription refill too soon
Rejected - Drug Utilization Review
Filled after coverage terminated
Does not meet step therapy protocol
Denials related to preauthorization or precertification:
Services not preauthorized/Referral not obtained
Claim submitted does not match prior authorization
Denials related to provider or administrative billing:
Provider billed incorrectly
Exceeds deadline for timely filing - member responsible
Incomplete information filed
Amount exceeds UCR/Allowable Charge
COB - plan is secondary
PCP not selected
The quantity of units billed exceeds the medically unlikely edit limit.
Other (Explain): The # of units reported exceeds the typical frequency per day.
Other (Explain): Submitted procedure disallowed because it is incidental to code billed on same date of service.
Other (Explain): ITS No Hold Harmless Allowable Override
Other (Explain): This service is not allowed because it is part of a CMS NCCI Column 1/ Column 2 edit that includes a procedure or service on a prior claim.
Other (Explain): The member's plan provides coverage for charges that are reasonable and appropriate as determined by [insurance company]. This procedure exceeds the maximum number of services allowed under [insurance company] guidelines for a single date of service.
Other (Explain): The member's plan provides coverage for charges that are reasonable and appropriate. The charge for this service does not meet this requirement of the member's plan of benefits because this service is considered mutually exclusive to another procedure performed on the same date of service.
Other (Explain): The procedure is disallowed because this service or a component of this service was previously billed by another health care professional.
Other (Explain): Submitted procedure code is disallowed because the primary related service was not reported on the claim or was denied for other reason.
Other (Explain): Claim Paid at 0 for 60 Day Grace Period
Other (Explain): No charges are eligible for payment due to Medicare provider's obligation or Medicare has paid full charges.
Other (Explain): Claim line denied by external bundling/fraud detection system
Other (Explain): Not covered overutilizes services
Other (Explain): Duplicate charges
Other (Explain): Facility's daily rate includes charges.
Other (Explain): Benefits for this service are included in the payment.
Denials related to no-participating provider, out-of-network, out of service area or other such denial reason:
Provider not participating with the individual's plan
Provider/Facility not a covered provider/facility type for this service
Rendering Clinician has not been individually credentialed
Other (Explain): Claim is not payable under our service area; must be filed to the Payer/Plan in the service area received.
Denials related to not medically necessary or inappropriate service:
Not Medically Necessary
Inappropriate level of care/inappropriate place of service/inappropriate treatment for condition or circumstance
Provider/Facility not a covered provider/facility type for this service
Experimental/Investigational

Attachment B. Complaint Areas

A. Access to Health Care Services	
1	Geographic access limitations to providers and practitioners
2	Availability of Primary Care Providers/Specialists/Behavioral and Mental Health Providers
3	Primary Care Provider after-hour access
4	Access to urgent care and emergency care
5	Out of network access
6	Availability and timeliness of provider appointments and provision of services
7	Availability of outpatient services with the network (to include home health agencies, hospice, labs, physical therapy, and radiation therapy)
8	Enrollee provisions to allow transfers to another Primary Care Provider
9	Patient abandonment by Primary Care Provider
10	Pharmaceuticals (based upon patient's condition, the use of generic drugs versus brand name drugs)
11	Access to preventative care (immunizations, prenatal exams, sexually transmitted diseases, alcohol, cancer screening, coronary, smoking)
B. Utilization Management	
1	Denial of medically appropriate services covered within the enrollee contract
2	Limitations on hospital length of stays for stays covered within the enrollee contract
3	Timeliness of preauthorization reviews based on urgency
4	Inappropriate setting for care, i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
5	Criteria for experimental care
6	Unnecessary tests or lack of appropriate diagnostic tests
7	Denial of specialist referrals allowed within the contract
8	Denial of emergency room care allowed within the contract
9	Failure to adequately document and make available to the members reasons for denial
10	Unexplained death
11	Denial of care for serious injuries or illnesses, the natural history of which, if untreated are likely to result in death or to progress to a more severe form
12	Organ transplant criteria questioned
C. Practitioners/Providers	
1	Appropriateness of diagnosis and/or care
2	Appropriateness of credentials to treat
3	Failure to observe professional standards of care, state and/or federal regulations governing health care quality
4	Unsanitary physical environment
5	Failure to observe sterile techniques or universal precautions
6	Medical records - failure to keep accurate and legible records, to keep them confidential and to allow patient access
7	Failure to coordinate care (example - appropriate discharge planning)
D. Administrative/Health Carrier Service	
1	Inadequate, incomplete, or untimely response to concerns by health carrier staff
2	Conflict of application of health carrier policies and procedures with evidence of coverage or policy
3	Breach of confidentiality
4	Lack of access/explanation of to health carrier complaint and grievance procedures
5	Incomplete or absent health carrier enrollee notification
6	Plan documents (evidence of coverage, enrollment information, insurance card) not received
7	Enrollee did not understand available benefits
8	Enrollee claimed plan staff members were not responsive to request for assistance, or phone calls or letters were not answered
9	Marketing or other plan materials was not clear
10	Complaints and appeals, formal or informal, were not responded to within required time frames, or were not adequately answered
E. Claim Processing, unrelated to utilization review	
1	Claim not paid in full, unrelated to utilization review decision
2	Claim not paid in a timely manner
3	Claim processed incorrectly, or an incorrect copayment or deductible was assessed
4	Claim was denied because of pre-existing condition
5	Enrollee held responsible contrary to “hold harmless” contractual agreement between the health plan and provider
6	Usual, Customary and Reasonable determination unreasonable