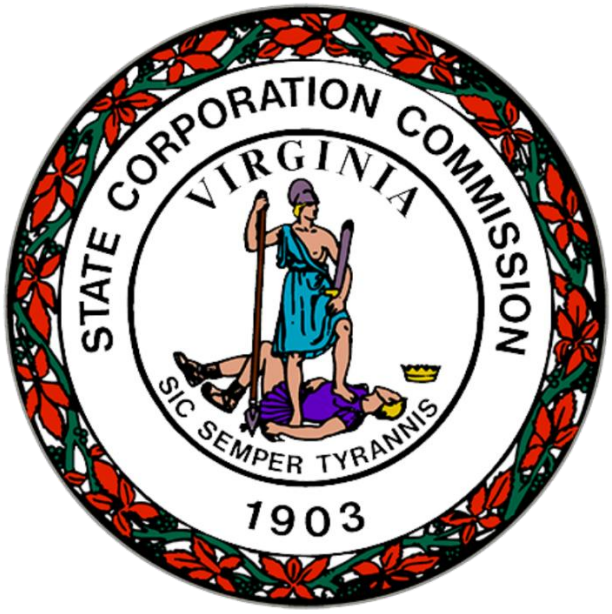
Claims - Complaints - Appeals
Mental Health, Substance Use Disorder
Benefits, Network Adequacy

Comparative Analyses

Summary of 2024 Insurance Carrier Data

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



State Corporation Commission
Bureau of Insurance

November 1, 2025

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
COMMISSIONERS
JEHMAL T. HUDSON • SAMUEL T. TOWELL • KELSEY A. BAGOT

November 1, 2025

Transmitted via Email

The Honorable R. Creigh Deeds
Chair, Commerce and Labor Committee
Senate of Virginia

The Honorable Jeion A. Ward
Chair, Labor and Commerce Committee
Virginia House of Delegates

Members of the Senate Commerce and Labor Committee

Members of the House Labor and Commerce Committee

Dear Senator Deeds, Delegate Ward, and Committee Members:

Pursuant to the requirements of subsection G of § 38.2-3412.1 of the Code of Virginia, the Bureau of Insurance submits this annual report containing a summary of findings from its review 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.

The report also includes aggregate outcomes data compiled from information received from health carriers related to denied claims, complaints, appeals, and network adequacy for mental health and substance use disorder benefits for the reporting period January 1, 2024, through December 31, 2024.

Sincerely,

Scott A. White
Commissioner of Insurance

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Executive Summary

Subsection B of § 38.2-3412.1 of the Code of Virginia (Code), in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),[1] requires mental health and substance use disorder benefits provided by individual and group health insurance plans to be in parity with medical and surgical benefits coverage.

Subsection G of that same section directs the Bureau of Insurance (Bureau) to prepare an annual report that includes a summary of findings from its review of all of Non-Quantitative Treatment Limitation (NQTL)[2] comparative analyses requested by the Bureau and prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8). It also requires the Bureau to include outcomes data compiled from information received from health carriers related to denied claims, complaints, appeals, and network adequacy for mental health and substance use disorder benefits for the reporting period January 1, 2024, through December 31, 2024. Key findings in this report include the following:

- The Bureau collected 552 comparative analyses for NQTL review during the current reporting period, which are all still under review.

- As an update to the prior reporting period, the Bureau received 320 comparative analyses, all of which were deemed insufficient. The Bureau has received 180 additional comparative analyses, with 140 still in process by the health carriers.

- Information provided to the Bureau by health carriers demonstrates that health carriers denied claims more often for substance use disorder benefits than for medical/surgical benefits and less often for mental health benefits. Carriers denied claims in fewer service categories (2 of 5) for mental health benefits and more service categories (4 of 5) for substance use disorder benefits than claims for medical/surgical benefits. The substance use disorder claim denial rates for office visits, all other outpatient services, emergency care, and inpatient services were substantially higher than those for medical/surgical claims.

- Health carriers upheld denied claims involving mental health benefits in 64% of closed internal appeals and 40% of closed external reviews, compared to 57%

[1] "Emergency Economic Stabilization Act of 2008," Pub. L. 110-343, 122 Stat. 3765. The Mental Health Parity and Addiction Equity Act of 2008 is included in division C.

[2] Treatment limitations include both Quantitative Treatment Limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and Non-Quantitative Treatment Limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. *See* 45 CFR 146.136(c)(4)(ii), which provides an illustrative list of examples of NQTLs, such as medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative.

and 50% for medical/surgical claims, and 75% and 80% for substance use disorder claims, respectively.

- The largest share of complaints differed across each benefit category. For medical/surgical benefits, claims processing accounted for 53% of complaints; for mental health, utilization management accounted for 38%; and for substance use disorders, administrative/service accounted for 77%.

1. Introduction

As required by subsection B of § 38.2-3412.1 of the Code and in accordance with the federal MHPAEA, 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 requirement for comparability between medical/surgical benefits and mental health or substance use disorder benefits with respect to NQTLs is a key element of MHPAEA. It states that a carrier may not impose a NQTL with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) both as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical/surgical benefits in the classification. This requirement is largely assessed via the Bureau's detailed reviews of comparative analyses through the market conduct examination process. In accordance with subsection G of § 38.2-3412.1 of the Code, this report includes a summary of the Bureau's findings from its review of all NQTL comparative analyses prepared by health carriers pursuant to 42 U.S.C. § 300gg-26(a)(8) and requested by the Bureau during the reporting period.

In addition, the report is required to include outcomes data compiled from information received from health carriers related to denied claims, complaints, appeals, and network adequacy for mental health and substance use disorder benefits for the reporting period January 1, 2024, through December 31, 2024. To collect this information, the Bureau conducted a data call of 15 health carriers insuring more than 2.38 million lives in the individual, small group, and large group health insurance markets in Virginia during 2024. While outcomes (e.g., claims denial rates) are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the carrier that a particular provision may warrant further investigation.

The Bureau must submit this report to the designated legislative committees annually by November 1, and post it on the State Corporation Commission's (Commission) website.

2. Comparative Analyses

A. Overview

Pursuant to subsection G of § 38.2-3412.1 of the Code the Bureau is required to include a summary of findings from its review of all NQTL comparative analyses requested of health carriers during the reporting period for the design and application of NQTLs pursuant to 42 U.S.C. § 300gg-26(a)(8). The summary must include the Bureau's explanation of whether the analyses were accepted as compliant, rejected as noncompliant, or under review. The report must also include the corrective actions health carriers were required to take to bring noncompliant analyses into compliance.

A comparative analysis is a narrative with supporting documentation prepared by a health carrier that must demonstrate that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorder benefits 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. The comparative analyses should be sufficiently specific, detailed, and reasoned.

For illustrative purposes, the National Association of Insurance Commissioners' 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 Bureau conducts this review as part of the market conduct examination process. 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 are made public upon the conclusion of the examinations.[3]

B. Summary for Prior Reporting Period (2023)

As indicated in the previous report, the Bureau initiated reviews of 320 comparative analyses under 10 insurance products from two health carriers as part of the market conduct examination process. These included the following NQTLs: medical necessity, prior authorization, concurrent review, retrospective review, post-payment retrospective review, experimental/investigational/unproven, and provider reimbursement.

The status of these reviews is as follows:

[3] https://www.scc.virginia.gov/regulated-industries/companies/for-insurance-companies/market-conduct-examination-reports/

- All comparative analyses requested from the two health carriers were initially deemed insufficient by the Bureau.
- The Bureau provided correspondence to the health carriers specifying the missing information required to make the comparative analyses sufficient, and health carriers were given an adequate amount of time to provide additional comparative analyses to include this information.
- The Bureau has received 180 additional comparative analyses, representing 4 NQTLs from two health carriers, and the remaining 140 additional analyses are in process by the health carriers. The Bureau continues to review the additional comparative analyses that it has received.

Since the requested comparative analyses continue to be under review as part of the market conduct examination process, no compliance determinations have yet been made.

C. Summary for Current Reporting Period (2024)

During the current reporting period, the Bureau requested and received comparative analyses of NQTLs associated with a sampling of 12 insurance products from two health carriers. These included the same NQTLs from the prior reporting period.

While the selected products account for 25,145 covered lives, it is also important to note that comparative analyses generally represent a health carrier's entire fully insured book of business in Virginia rather than just the selected products. 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 552 comparative analyses during the reporting period. The comparative analyses are being reviewed for compliance with the federal MHPAEA and subsection B of § 38.2-3412.1 of the Code.

Since the requested comparative analyses are currently under review as part of the market conduct examination process, no compliance determination has yet been made.

D. Completed Examinations and Corrective Actions

The Bureau finalized the following market conduct examinations regarding the review of comparative analyses requested during previous reporting periods:

- Cigna Health and Life Insurance Company was found in violation of subsection B of § 38.2-3412.1 of the Code of Virginia for noncompliant comparative analyses, as well as other issues regarding the federal MHPAEA and the Code. As part of the corrective action plan, the health carrier was required to provide sufficient comparative analyses demonstrating compliance or to remove the NQTLs in question from mental health or substance use disorder benefits in the classifications under review. The examination report, with details of the NQTLs reviewed, is available here. The health carrier submitted updated comparative

analyses in accordance with the corrective action plan, and this confidential documentation is currently under review by the Bureau.

- UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc., and Optimum Choice, Inc. were found in violation of subsection B of § 38.2-3412.1 of the Code of Virginia for noncompliant comparative analyses, as well as other issues regarding the federal MHPAEA and the Code. As part of the corrective action plan, the health carriers were required to provide sufficient comparative analyses demonstrating compliance or remove the NQTLs in question from mental health or substance use disorder benefits in the classifications under review. The examination report, with details of the NQTLs reviewed, is available here. The health carriers submitted updated comparative analyses in accordance with the corrective action plan, and this confidential documentation is currently under review by the Bureau.

The Bureau continues to strongly caution health carriers that insufficient comparative analyses are noncompliant with the requirements of the federal MHPAEA and subsection B of § 38.2-3412.1 B of the Code and will be cited by the Bureau.

3. Outcomes Data

A. Claims

Health carriers surveyed for this report received a total of 44,482,942 claims in 2024, with 7,953,579 denied, for a 17.9% denial rate. This denial rate was significantly lower than the 22.3% denial rate for 2023 (16,233,560 denied out of 72,730,407 claims received).

Each health carrier reported the total 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.

Based on this data, denial rates were calculated for each category of mental health and substance use disorder benefits for comparison to the denial rates medical/surgical benefits.

Denial Rate Comparisons

All Claims

Of the 7,953,579 total claims denied, 6,986,834 were medical/surgical, 830,635 were mental health, and 136,110 were substance use disorder. Of these, the denial rates were 17.9% for medical/surgical, 17.0% for mental health, and 25.6% for substance use disorder.

Table 1. Denial Rate Comparison – All Claims (2024)

Claim Benefit Category:	Claims Received	Claims Denied	% Claims Denied
Medical/ Surgical Benefits	39,077,043	6,986,834	17.9%
Mental Health Benefits	4,874,086	830,635	17.0%
Substance Use Disorders	531,813	136,110	25.6%
Totals:	44,482,942	7,953,579	17.9%

Figure 1. Denied Claims- All Claims (2024)

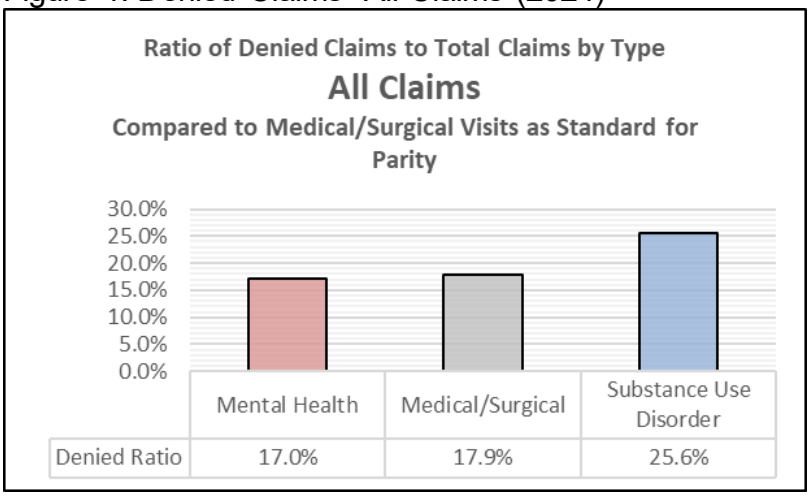


Figure 1 shows the overall claims denial rate of 25.6% for substance use disorder claims is 7.7 percentage points higher and the 17.0% rate for mental health is nine-tenths of a percentage point lower than the 17.9% denial rate for medical/surgical claims.

Denial By Type of Claim Service

The overall denial rates for total claims received and denied were generally distinguished by one of five claim service types: office visits, all other outpatient claims, inpatient claims, emergency care claims and outpatient prescription (Rx) transactions. For parity purposes, the denial rates in each claim service type for mental health and substance use benefits were compared to those for medical/surgical health benefits.

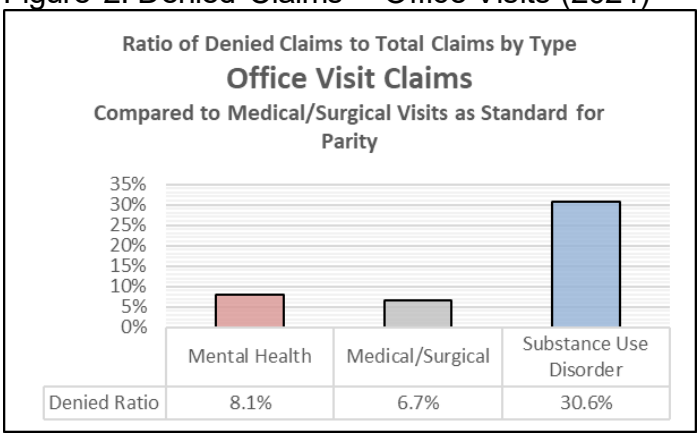
Office Visit Claims

There were a total of 12,065,798 claims received for office-visits, with 10,678,111 for medical/surgical, 1,242,645 for mental health, and 145,042 for substance use disorders. Of these, the denial rates were 6.7% for medical/surgical, 8.1% for mental health, and 30.6% for substance use disorders.

Table 2. Denied Claims Rate – Office Visits (2024)

Service Claim Category: Office Visit	Claims Received	Claims Denied	% Claims Denied
Medical/Surgical Benefits	10,678,111	715,690	6.7%
Mental Health Benefits	1,242,645	100,532	8.1%
Substance Use Disorders	145,042	44,357	30.6%
Totals:	12,065,798	860,579	7.1%

Figure 2. Denied Claims – Office Visits (2024)



The denial rates for both mental health and substance use disorder claims are higher than the 6.7% denial rate of medical/surgical office visits. The mental health, 8.1%, is 1.4 percentage points and the substance use disorder rate, 30.6% is 23.9 percentage points greater than medical/surgical.

All Other Outpatient Claims

There were a total of 11,710,200 claims received for all other outpatient claims, with 10,439,429 for medical/surgical, 1,065,932 for mental health, and 204,839 for substance use disorders. Of these, the denial rates were 7.1% for medical/surgical, 9.4% for mental health, and 21.2% for substance use disorders.

Table 3. Denied Claims Rate – All Other Outpatient Claims (2024)

Service Claim Category: All Other Outpatient Claims	Claims Received	Claims Denied	% Claims Denied
Medical/Surgical Benefits	10,439,429	738,562	7.1%
Mental Health Benefits	1,065,932	99,943	9.4%
Substance Use Disorders	204,839	43,345	21.2%
Totals:	11,710,200	881,850	7.5%

Figure 3. Denied Claims – All Other Outpatient Claims (2024)

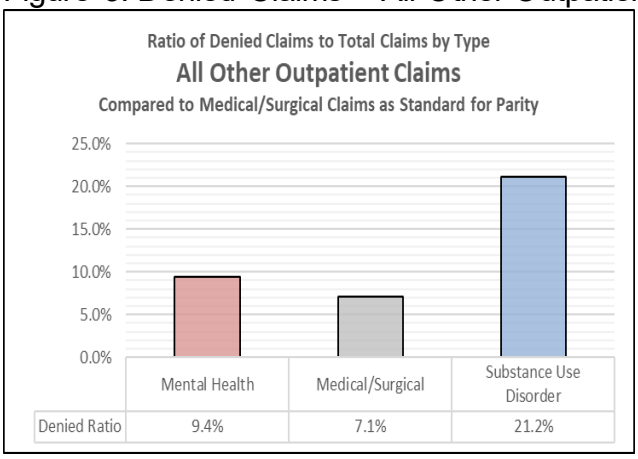


Figure 3 shows the denial rates for both mental health and substance use disorder claims are higher than the 7.1% denial rate for medical/surgical. In particular, the denial rate of substance abuse disorder claims of 21.2% is 14.1 percentage points higher than medical/surgical denials.

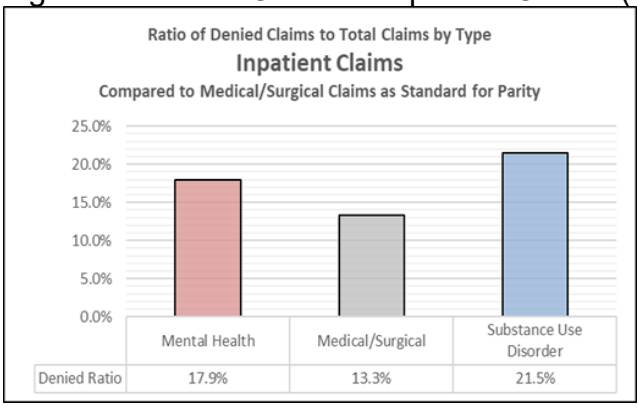
Inpatient Claims

There were 1,359,258 inpatient claims received, with 1,235,702 for medical/surgical; 70,922 for mental health; and 52,634 for substance use disorders. Of these, the denial rates were 13.3% for medical/surgical, 17.9% for mental health, and 21.5% for substance use disorders.

Table 4. Denied Claims Rate – Inpatient Claims (2024)

Service Claim Category: Inpatient Claims	Claims Received	Claims Denied	% Claims Denied
Medical/Surgical Benefits	1,235,702	164,426	13.3%
Mental Health Benefits	70,922	12,707	17.9%
Substance Use Disorders	52,634	11,324	21.5%
Totals:	1,359,258	188,457	13.9%

Figure 4. Denied Claims – Inpatient Claims (2024)



As indicated in Figure 4, both the 17.9% denial rate for mental health inpatient claims and the 21.5% denial rate for substance use disorder are 4.6 and 8.2 percentage points greater than the 13.3% denial rate for medical/surgical inpatient claims.

Emergency Care Claims

There were 1,399,438 claims received for emergency care, with 1,348,858 for medical/surgical, 26,395 for mental health, and 24,185 for substance use disorder services. Of these, the denial rates were 9.9% for medical/surgical, 13.5% for mental health, and 20.1% for substance use disorder services.

Table 5. Denied Claim Rates – Emergency Care Claims (2024)

Service Claim Category: Emergency Care Claims	Claims Received	Claims Denied	% Claims Denied
Medical/Surgical Benefits	1,348,858	133,452	9.9%
Mental Health Benefits	26,395	3,576	13.5%
Substance Use Disorders	24,185	4,852	20.1%
Totals:	1,399,438	141,880	10.1%

Figure 5. Denied Claims – Emergency Care Claims (2024)

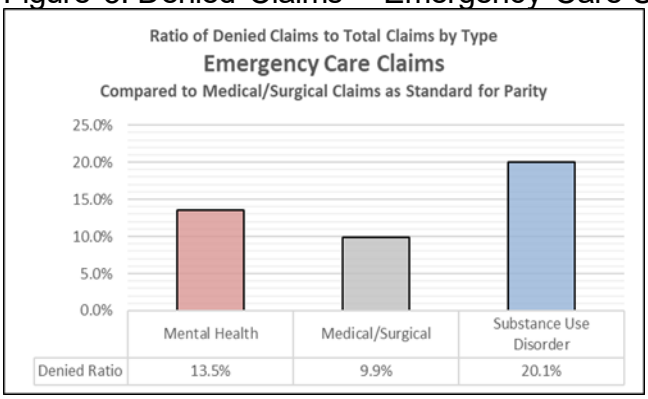


Figure 5 shows that the 13.5% denial rate for mental health emergency claims are higher than the 9.9% denial rate for medical/surgical. The 20.1% denial rate for substance use disorder emergency claims is more than double that of medical/surgical.

Outpatient Prescription (Rx) Transactions (2024)

There were 17,948,248 prescription transactions received for outpatient services, with 15,374,943 for medical/surgical, 2,468,192 for mental health, and 105,113 for substance use disorder services. Of these, the denial rates were 34.0% for medical/surgical, 24.9% for mental health, and 30.7% for substance use disorders.

Table 6. Denied Outpatient Prescription (Rx) Transactions (2024)

Service Claim Category: Outpatient Rx Transactions	Claims Received	Claims Denied	% Claims Denied
Medical/Surgical Benefits	15,374,943	5,234,704	34.0%
Mental Health Benefits	2,468,192	613,877	24.9%
Substance Use Disorders	105,113	32,232	30.7%
Totals:	17,948,248	5,880,813	32.8%

Figure 6. Outpatient Prescription (Rx) Transactions (2024)

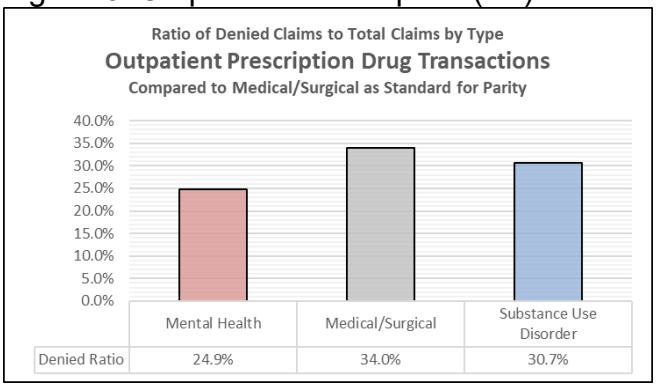


Figure 6 shows that claims for outpatient prescription drug transactions were denied at rates of between 25 and 35 percent. The denial rates for prescription drug transactions for mental health and substance use disorders are lower than that for medical/surgical.

Reasons for Claim Denial

Within or each benefit category, health carriers identified the top three reasons the 7,953,579 claims were denied in 2024. These were unchanged from the prior year and accounted for 83% (6,586,993) of denied claims. The remaining 17% (1,366,586) were denied for some other reason. For medical/surgical and mental health, health carriers cited "prescription refill too soon" or "exceeds contractual benefit limits" among the top three reasons. Health carriers also cited "not a covered benefit/service contractually excluded" only for medical/surgical, and "rejected under a drug utilization review" only for mental health benefits. The top three reasons claims were denied for substance use disorders were different than those of the other two benefit categories. They included "services were not preauthorized," "provider was incorrectly billed," or "the provider was out-of-network, a non-participating provider (NPP/OON)."

The Bureau consolidated the top three reasons health carriers denied the 6,586,993 claims into six subcategories across all benefit categories:

Non-covered benefits or services……..3,140,523 denials (47.1%)

Prescription drugs…..……..…….2,355,517 denials (35.6%)

Provider or administrative billing……..465,309 denials (7.0%)

Preauthorization or precertification ……..356,270 denials (5.4%)

NPP/OON or service area…….. ……...247,849 denials (3.8%)

Medical necessity/inappropriate service... ……21,525 denials (<1%)

See Appendix A for the complete list of reasons claims were denied, by general category.

B. Complaints

For 2024, health carriers reported receiving 9,929 complaints from either covered persons or the Bureau and closing 98.9% (9,824). The number of complaints received increased from 9,417 in 2023.

Closing and Submission Comparisons

For each of the three benefit categories, complaints were assigned to one of five areas: access to health care services, utilization management, practitioners/providers, administrative/service, and claims processing. See Appendix B for a complete list of reasons by complaint area.

Access to Health Care Services

The closing ratios, or the number of complaints closed to the number of claims submitted, did not indicate any concerns under access to health care services warranting further investigation since 100% of mental health and substance use disorder complaints submitted were closed, and just under 100% of medical/surgical complaints were closed.

Table 7. Complaint Ratios - Access to Health Care Services (2024)

Access to Health Care Serices	Medical/Surgical		Mental Health		SUD		All	
	Submitted	Closed	Submitted	Closed	Submitted	Closed	Submitted	Closed
Number of Complaints	1064	1045	66	66	3	3	1133	1114
Closed Ratio	-	98.2%	-	100.0%	-	100.0%	-	98.3%
Ratio to All Area Totals	11.0%	11.0%	22.4%	23.0%	13.6%	14.3%	11.4%	11.3%
Total Complaints-All Areas	**9,643**	**9,516**	**294**	**287**	**22**	**21**	**9,929**	**9,824**

Figure 7. Complaints Submitted - Access to Health Care Services (2024)

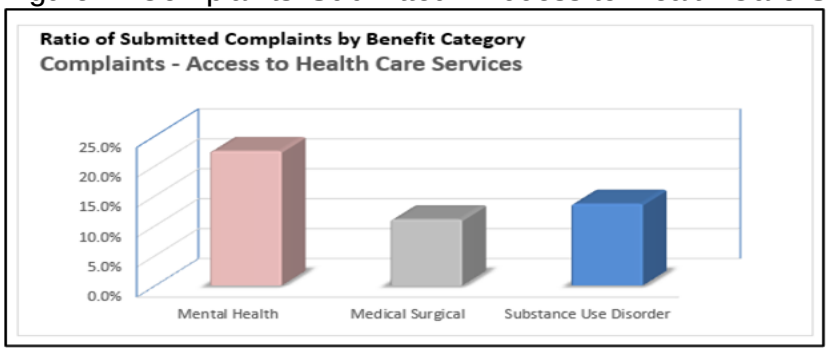


Figure 7 shows that mental health (22.4%) and substance use disorder (13.6%) received a greater percentage of complaints associated with access to health care services than did medical/surgical (11.0%).

Utilization Management

The mental health closed complaint ratio of 99.1% was similar to that of medical/surgical at 98.3% – a difference of less than one percent. Although the closed complaint ratio for substance use disorders was 100%, this was based on just one complaint received in 2024.

Table 8. Complaint Ratios – Utilization Management (2024)

Utilization Management	Medical/Surgical		Mental Health		SUD		All	
	Submitted	Closed	Submitted	Closed	Submitted	Closed	Submitted	Closed
Number of Complaints	1,403	1,379	111	110	1	1	1,515	1,490
Closed Ratio	-	98.3%	-	99.1%	-	100.0%	-	98.3%
Ratio to All Area Totals	14.5%	14.5%	37.8%	38.3%	4.5%	4.8%	15.3%	15.2%
Total Complaints-All Areas	**9,643**	**9,516**	**294**	**287**	**22**	**21**	**9,929**	**9,824**

Figure 8. Complaints Submitted – Utilization Management (2024)

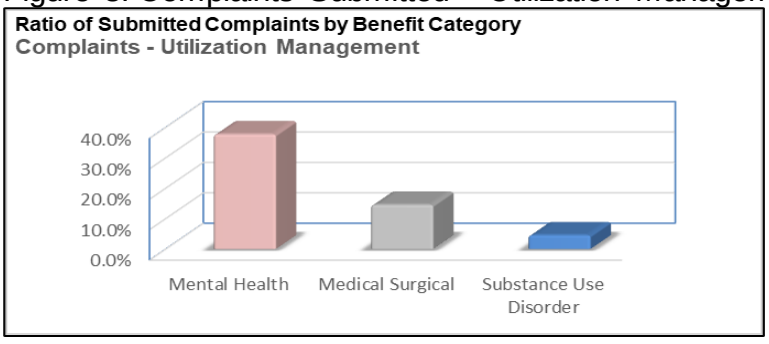


Figure 8 shows that mental health (37.8%) had a greater percentage of submitted

complaints associated with utilization management than did medical/surgical (14.5%). Substance use disorder complaints have a much lower ratio (4.5%).

Practitioners/Providers

Complaints under practitioner/provider did not indicate a problem with processing. The closing ratio shows that 99.4% of the 171 complaints submitted were closed. Closing rates for mental health were not considered because there was just one complaint submitted in 2024, and one complaint carried forward from the previous year, with both closed out in 2024. There were no substance use disorder complaints regarding providers or practitioners.

Table 9. Complaint Ratios – Practitioners/Providers (2024)

Practitioners/Providers	Medical/Surgical		Mental Health		SUD		All	
	Submitted	Closed	Submitted	Closed	Submitted	Closed	Submitted	Closed
Number of Complaints	171	170	1	2	0	0	172	172
Closed Ratio	-	99.4%	-	200.0%	-	n/a	-	100.0%
Ratio to All Area Totals	1.8%	1.8%	0.3%	0.7%	0.0%	0.0%	1.7%	1.8%
Total Complaints-All Areas	**9,643**	**9,516**	**294**	**287**	**22**	**21**	**9,929**	**9,824**

Figure 9. Complaints Submitted – Practitioners/Providers (2024)

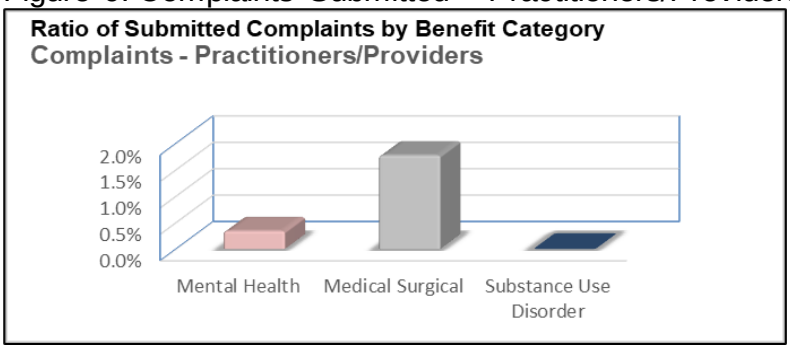


Figure 9 reflects the very low submission ratios of 0.3% for one mental health provider complaint compared to all 294 mental health complaints, 1.8% of 9,643 medical/surgical complaints, and no calculated ratio for substance use disorders since there were no provider/practitioner complaints received.

Administrative/Service

Complaints under administrative/service had closing ratios of 97.3% for medical/surgical based on 1,941 complaints submitted, 97.4% for mental health of 76 complaints submitted, and 94.1% for substance use disorders of 12 complaints submitted.

Table 10. Complaint Ratios – Administrative/Service (2024)

Administrative/Services	Medical/Surgical		Mental Health		SUD		All	
	Submitted	Closed	Submitted	Closed	Submitted	Closed	Submitted	Closed
Number of Complaints	1,941	1,889	76	74	17	16	2,015	1,979
Closed Ratio	-	97.3%	-	97.4%	-	94.1%	-	98.2%
Ratio to All Area Totals	20.1%	19.9%	25.9%	25.8%	77.3%	76.2%	20.3%	20.1%
Total Complaints-All Areas	**9,643**	**9,516**	**294**	**287**	**22**	**21**	**9,929**	**9,824**

Figure 10. Complaints Submitted – Administrative/Service (2024)

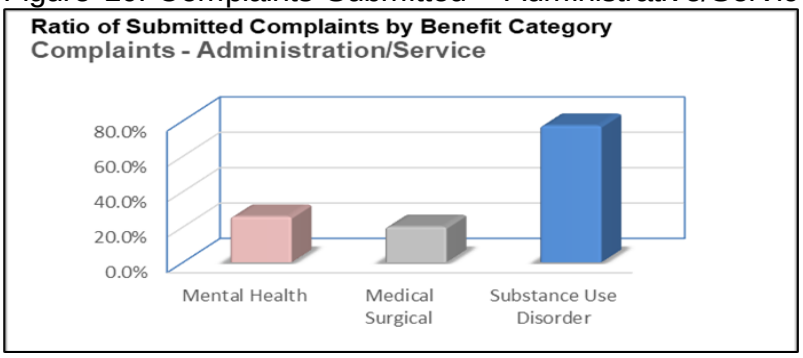


Figure 10 shows that the complaint ratio for substance use disorders under administrative/service was 77.3% of total substance use disorders complaints received. This was significantly greater in this service area than it was for mental health at 25.9% and medical/surgical at 20.1%.

Claims Processing

The closing ratio is 99.4% for medical/surgical, 100% for substance use disorders, and 87.5% for mental health complaints.

Table 11. Complaint Ratios – Claims Processing (2024)

Claims Processing	Medical/Surgical		Mental Health		SUD		All	
	Submitted	Closed	Submitted	Closed	Submitted	Closed	Submitted	Closed
Number of Complaints	5064	5033	40	35	1	1	5094	5069
Closed Ratio	-	99.4%	-	87.5%	-	100.0%	-	99.5%
Ratio to All Area Totals	52.5%	52.9%	13.6%	12.2%	4.5%	4.8%	51.3%	51.6%
Total Complaints-All Areas	**9,643**	**9,516**	**294**	**287**	**22**	**21**	**9,929**	**9,824**

Figure 11. Complaints Submitted – Claims Processing (2024)

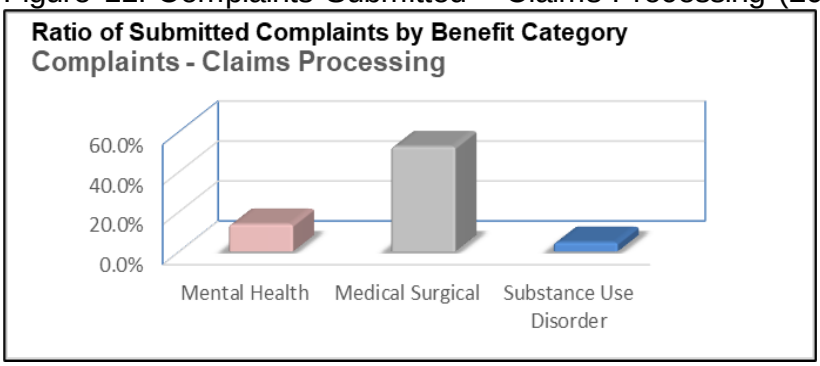


Figure 11 shows that complaints under medical/surgical benefits experienced a greater percentage of claims processing complaints at 52.5%, than did mental health at 13.6% or substance use disorders at 4.5%.

Top Complaint Area by Benefit Category

The top complaint area by benefit category were as follows:

- For medical/surgical: claims processing at 52.5% -- 5,064 complaints of 9,643 total medical/surgical complaints received.
- For mental health: utilization management at 37.8% -- 111 complaints of 294 total mental health complaints received.
- For substance use disorders: administrative/service at 77.3% --- 17 complaints of 22 total substance use disorders complaints received.

C. Appeals

Overview

An internal appeal is filed by the consumer 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 or exhausting the health carrier's internal appeals process, an external review facilitated by the Bureau may be available. If the request is eligible, the Bureau assigns the review to an approved independent review organization to either uphold the health carrier's denial, partially uphold it, or overturn it.

Comparisons by Appeal Type

Internal Appeals

As shown in Table 12, survey respondents processed and closed a total of 8,894 internal appeals across the three benefit categories in 2024, a decrease from 9,429 in 2023.

Table 12. Outcomes of Closed Internal Appeals (2024)

Outcomes of Closed Internal Appeals	Number Related to Medical/ Surgical	Number Related to Mental Health	Number Related to Substance Use Disorder
Denial Upheld	4,835	269	36
Denial Partially Upheld	124	6	2
Denial Overturned	3,465	147	10
Total	8,424	422	48

Figures 12 through 14 compare the outcome of internal appeals for each of the three benefit categories using the values in Table 12.

Figure 12. Closed Internal Appeals - Denial Upheld (2024)

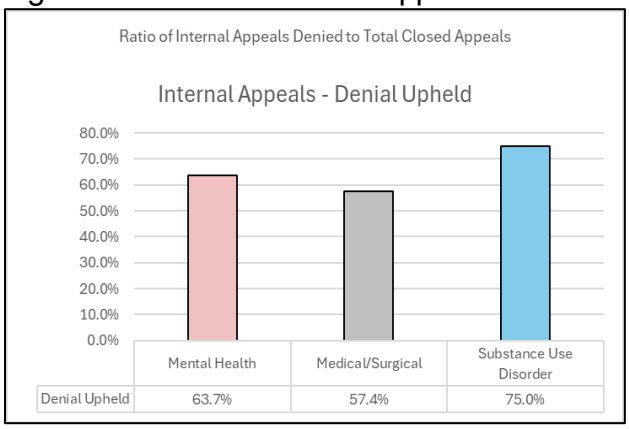


Figure 12 shows that denials of internal appeals were upheld more often for mental health (63.7%) and substance use disorder (75%) than medical/surgical (57.4%).

Figure 13. Closed Internal Appeals – Denial Partially Upheld (2024)

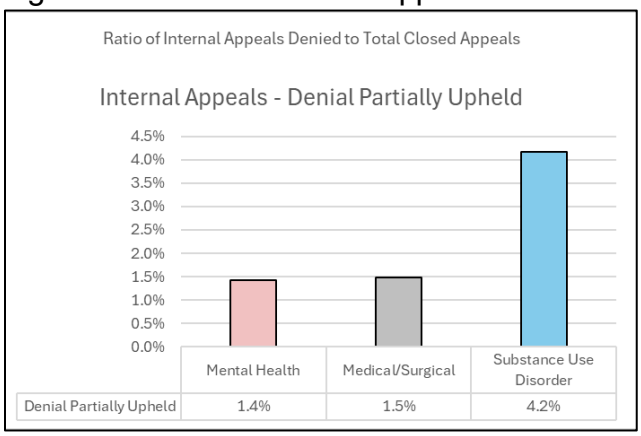


Figure 13 shows that carriers partially upheld denials at approximately the same rate for mental health (1.4%) and medical/surgical (1.5%), with substance use disorders at a higher rate (4.2%).

Figure 14. Closed Internal Appeals – Denials Overturned (2024)

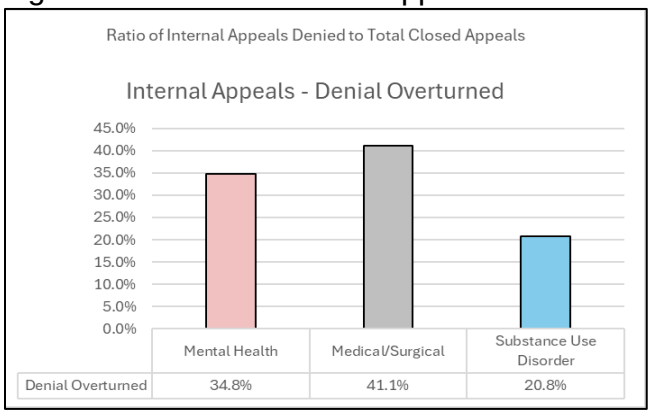


Figure 14 demonstrates that denials are more likely to be overturned for medical/surgical (41.1%), than for mental health (34.8%) or substance use disorders (20.8%). This makes it nearly half as likely that a substance use disorder denial is overturned compared to a denial of medical/surgical.

External Review

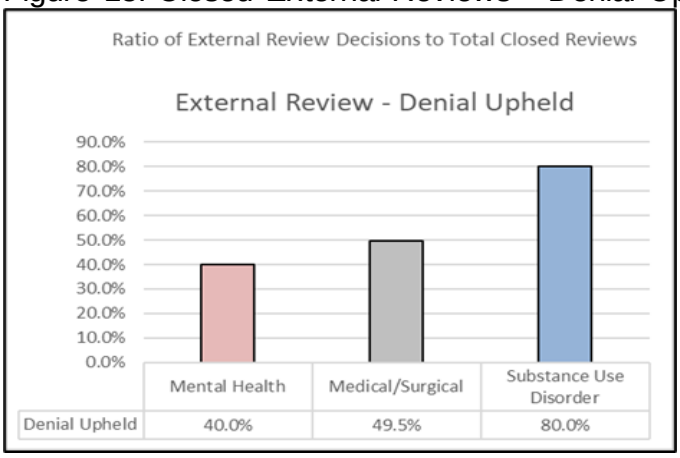
According to survey respondents, 216 external reviews were performed in 2024. Table 13 shows the number and results of closed external reviews for each benefit category.

Table 13. Outcomes of Closed External Reviews (2024)

Outcomes of Closed External Reviews	Number Related to Medical/ Surgical	Number Related to Mental Health	Number Related to Substance Use Disorder
Denial Upheld	102	2	4
Denial Partially Upheld	3	0	0
Denial Overturned	101	3	1
Total	206	5	5

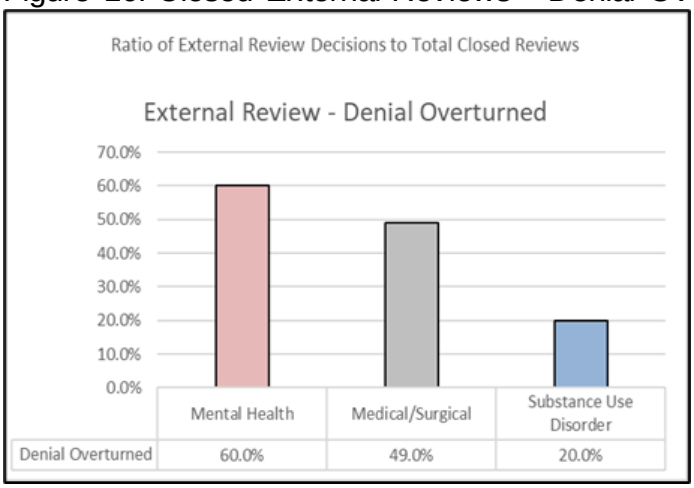
Figures 15 and 16 demonstrate the frequency using the values in Table 13 with which denials were upheld or overturned for each benefit category.

Figure 15. Closed External Reviews – Denial Upheld (2024)



In both Figures 15 and 16, the ratios for mental health and substance use disorders were based on five reviews, while medical/surgical was based on 206. In Figure 15, upheld denials were 40% for mental health and 80% for substance use disorder, compared to 49.5% for medical/surgical. In Figure 16, overturned denials were 60% for mental health, 49% for medical/surgical, and 20% for substance use disorders.

Figure 16. Closed External Reviews – Denial Overturned (2024)



D. 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 network adequacy can be challenging for several reasons, including:

- The absence of a national standard and the significant variation in standards that do exist across states and types of coverage;
- Reliance on plan provider directory data which may be inaccurate or out of date in evaluating health plan networks;
- The absence of a national standard for ensuring the accuracy of information in health plan provider network directories; and
- The absence of a standard measure of network size or breadth, or other methodologies for consumers or regulators to discern differences in network size easily.

Under 45 CFR § 156.230, federal regulations provide network adequacy standards, including those for accessing mental health and substance use disorder services. In Virginia, the Department of Health is required to determine standards for accessing provider networks pursuant to subsection G of § 32.1-137.2 of the Code. Pursuant to 12VAC5-408-260, the department requires health carriers to establish network adequacy regarding access to providers. For plan years beginning on or after January

1, 2026, new federal rules[4] will require state exchanges such as Virginia's Health Benefit Exchange to establish and hold health carriers to time and distance network adequacy standards for plans sold through the individual marketplace. The standards set must be at least as strict as federal requirements. The Health Benefit Exchange Division within the Commission establishes these standards and conducts the reviews.

Network Adequacy Parity Analysis

Despite challenges, the Bureau previously analyzed the parity of network adequacy among the three benefit categories by comparing complaint rates. Assuming enough complaints for results to be credible, this approach could suggest possible disparities in network adequacy for mental health or substance use disorder benefits if the complaint rate was significantly higher for these categories than for medical/surgical benefits.

Table 14 shows that medical/surgical claimants submit far more complaints than mental health or substance use disorder claimants, based on the ratio of complaints to total claims. While the numbers do not suggest differences in treatment, the number of complaints for mental health and substance use disorder remain very low.

Table 14. Comparison of Total Complaints to Total Claims (2024)

Benefit Category	Claims Presented	Percent of Claims Presented	Complaints	Complaints to Claims Ratio
Medical/Surgical	39,077,043	87.8%	9,643	1 in 4,052
Mental Health	4,874,086	11.0%	294	1 in 16,579
Substance Use Disorder	531,813	1.2%	22	1 in 24,173
Totals:	44,482,942	100%	9,959	1 in 4,467

Table 15 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 insights into network utilization and adequacy. The mental health complaint ratio for access to health care services is more than twice the medical/surgical ratio which is the same as the 2024 report. The compliant ratio for substance use disorders is 2.6 percentage points greater than medical/surgical while in the previous report it was 3.8 percentage points less than the medical/surgical ratio.

[4] 45 CFR. § 155.1050; 45 CFR Parts 153, 155, 156; and Virginia HBE Administrative Letter **2025-01**

Table 15. Complaint Ratios – Access to Health Care Services by Benefit Category (2024)

Complaint Type	Mental Health	Medical/Surgical	Substance Use Disorder
Access to Health Care Services	22.4% (66 of 294)	11.0% (1,064 of 9,643)	13.6% (3 of 22)

The percentage of complaints involving access to health care services in the mental health category was twice that of those in the medical/surgical category. However, one of the primary challenges in assessing the adequacy of health carrier networks is that many mental health professionals also provide substance use disorder services. Doing so could result in double counting of mental health or substance use providers.

Network adequacy measurements also can be skewed if only a fraction of providers listed as in-network providers are treating patients. Table 16 shows how this factor may be measured. The Bureau compared the total number of in-network providers and out-of-network providers actually paid for services in 2024 to 2023 end-of-year data.

Table 16. Network Adequacy Measurements (2024)

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	45.9%	11.8%	3.70%	71	87.8%
Mental Health	37.7%	30.5%	3.75%	282	11.0%
Substance Use Disorder	60.4%	4.75%	2.91%	973	1.2%

Since the previous year's report, the data in Table 16 shows:

- (Column A) Active in-network provider participation decreased across all categories, with substance use disorder seeing the largest drop. Medical/surgical decreased by 3.3 percentage points, to 45.9%; mental health decreased by 2.9 percentage points to 37.7%; and, substance use disorders decreased by 7.9 percentage points, to 60.4%.
- (Column B) The frequency of out-of-network provider payments remained the same for medical/surgical and mental health at 11.8% and 30.5%, respectively. However, the frequency for substance use disorders decreased significantly by 7.2 percentage points to 4.8%.
- (Column C) Payment denials for out-of-network providers decreased for medical/surgical and substance use disorder, respectively, by 2.9 and 6.9 percentage points, to 3.7% and 2.9%. While mental health showed a three-tenths

percentage point increase to 3.8%, that is not a significant change from the prior year.

- (Column D) The number of members per in-network provider (NMPNP) increased across all three benefit categories. While medical/surgical and mental health showed modest increases, substance use disorders showed a significant increase from 609 in 2023 to 973 in 2024. This measure could suggest an increase in potential access issues in the form of longer wait times or more difficulty getting appointments. However, it can be difficult to compare availability across these categories when one needs to consider provider availability for various specialties
- (Column E) The distribution of claims remained relatively stable, with a slight decrease in mental health claims.

4. Conclusion

The Bureau will continue to review NQTL comparative analyses required of health carriers under federal and state law and is in various stages in the process of determining compliance with and the need for or response to any required corrective actions. The Bureau will continue to enforce MHPAEA requirements with respect to NQTLs related to network adequacy and access to care as part of NQTL examinations and inquiries.

In addition, the Bureau will continue to collect and compile information received from health carriers and monitor outcomes data that could warrant further investigation from a parity perspective. Evaluating parity in network adequacy among the three benefit categories is particularly challenging, in part, because of varying standards and inaccurate network provider directories.

Attachment A. Reasons for Claims Denial by General Category

A. 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.
B. Denials related to prescription drug claims:
Prescription refill too soon.
Rejected - drug utilization review.
Filled after coverage terminated.
Does not meet step therapy protocol.
C. Denials related to preauthorization or precertification:
Services not preauthorized/referral not obtained.
Claim submitted does not match prior authorization.
D. 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 number 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.
E. 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.
F. 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.
12	Organ transport 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.
4	governing health care quality.
5	Unsanitary physical environment.
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.