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May 31, 2022

MENTAL HEALTH PARITY 2022

2021 Plan Year

I. Introduction and Background

Mental Health Parity, as described by the National Alliance on Mental Illness, is the basic idea that health insurance benefits for mental health and addiction care, or substance use disorder, must be covered at the same benefit levels as care for other medical or surgical conditions. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. MHPAEA originally applied to group health plans and group health insurance coverage, but was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Affordable Care Act") to also apply to individual health insurance coverage.[1]

In addition to federal law, West Virginia most recently passed a state Mental Health Parity law in 2020 (S.B. 291). The law, which is codified at W.Va. Code §§ 33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r and 33-25A-8u, as well as W.Va. Code. R. §114-64-1, et seq., generally provides that, for all health insurance policies issued or renewed after January 1, 2021, health insurance companies must provide parity regarding coverage for behavioral health, mental health and substance use disorder and medical and surgical procedures. The state law mandates that health insurers comply with federal regulations concerning financial requirements and quantitative treatment limitations, and may not apply any nonquantitative treatment limitations to benefits for behavioral health, mental health, and substance use disorders that are not applied to medical and surgical benefits within the same classification of benefits. Applicable insurers must have procedures to authorize treatment with a nonparticipating provider if a covered service related to behavioral health, mental health, and substance use disorders is not available within established time and distance standards and within a reasonable period after service is requested, and the same coinsurance, deductible, or copayment requirements apply as if the service was provided at a participating provider, and at no greater cost to the covered person than if the services were obtained from a participating provider. The state mental health parity law, as set forth in S.B. 291 (2020), also requires the West Virginia Offices of the Insurance Commissioner (WVOIC) to report annually to the Joint Committee on Government and Finance on certain data collection and analysis undertaken by the WVOIC regarding mental health parity.

To fulfill its obligations, the WVOIC issued a data call to the top 5 major medical carriers in West Virginia in April 2022, requesting data for the 2021 plan year. The top 5 major medical insurance carriers in West Virginia provide coverage to 98% of the commercial market. [2] The Mental Health Parity data collection and analyses undertaken by the WVOIC focused on six categories of benefits: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, prescription drugs and emergency services. In addition, health

[1] MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly in connection with the Affordable Care Act's essential health benefit (EHB) requirements.
[2] PEIA data is not included in the WVOIC report. PEIA was asked to report separately in S.B. 291 (2020).

insurance plans have the option to subdivide the outpatient category to office visits versus other outpatient services.

II. Quantitative and Non-quantitative Treatment Limitations

Quantitative Treatment Limitations (QTLs) are numerically based, or quantifiable, differences between medical/surgical benefits and mental health/substance use disorder benefits. Quantitative treatment limitations could include placing a numerical limitation on the number of visits covered for mental health counseling versus an unlimited number of primary care medical visits, or limiting the number of days an inpatient stay is covered for mental health or substance use disorder treatment versus placing no inpatient stay limit for any other medical illness.

Non-quantitative treatment limitations (NQTLs) include a wide variety of other benefit limitations that are sometimes harder to identify. NQTLs include, but are not limited to, placing stricter medical management, prior authorization, or utilization review standards on mental health/substance use disorder benefits than what is placed upon medical/surgical benefits. Even though NQTLs are not always written in benefit books or insurance contracts, the NQTL limitations may be customarily applied more stringently by an insurer to mental health/substance use disorder diagnoses than medical/surgical diagnoses.

In April 2022, the WVOIC issued a data collection call to the top five (5) major medical health insurance carriers in West Virginia primarily focused on QTLs and NQTLs in each of the identified categories. The health insurance carriers, identified herein as Carriers A, B, C, D and E, responded to the data collection call in mid-May. Analyses from this data collection is reported herein. One health insurance carrier has, thus far, refused to submit state-specific data. This carrier provided only national data and asserted that state-specific data is not valid in West Virginia due to the small number of claims. However, data provided by the other health insurance carriers was state specific.

The initial question in the data collection call focused on protocols used to make utilization decisions for mental health/substance use disorder and medical/surgical benefits. All health insurance carriers surveyed use the American Society of Addiction Medicine (ASAM) and the InterQual guidelines, in addition to insurance carrier specific protocols. ASAM and InterQual are evidence based and continually reviewed by panels of specialty-specific physicians.

After determining the standard for which decisions are made, the WVOIC then looked at perceived limitations in the health insurance plans. Each carrier applied basic QTLs in all health insurance plans, including QTLs in medical/surgical and mental health/substance use disorder benefits. Mental health parity violations were not detected in the QTLs. However, the NQTL review appears to show some limitations or imparity regarding mental health/substance use disorder benefits. The top NQTLs across all commercial health insurance plans are listed in Table 1.

Table 1: Top NQTL's as Reported by Insurers
Inpatient Prior Authorization
Concurrent Review
Retrospective Review
Medical Necessity
Network Standards
Pharmacy Prior Authorization
Pharmacy Step Therapy
Pharmacy Formulary Tiering

Findings from the NQTL responses include, but are not limited to, concerns with carriers failing to deviate between concurrent review and prior authorization, which does not allow for separation to verify mental health parity compliance. Additional findings show that "case management workers" are assigned to all mental health/substance use disorder claims, while "case management workers" are only assigned to the highest risk medical/surgical members.

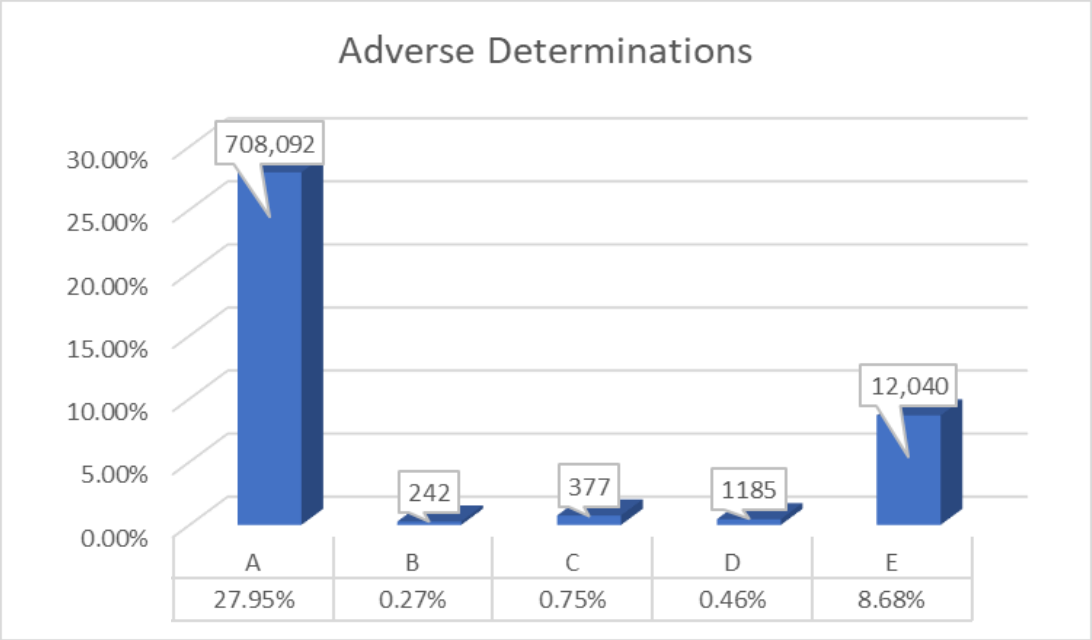
A variety of concerns were detected in prior authorization comparison including forms by which prior authorization is requested by providers and requiring all mental health/substance use disorder stays to be subject to prior authorization.

One health insurance carrier submitted data that identified credentialling differences by requiring a mental health/substance use disorder providers to have differing amounts of malpractice insurance from other types of medical/surgical providers.

Of note, pharmacy claims also show a higher number of overturns on appeal for mental health/substance use disorder drugs than for other types of medical/surgical drugs.

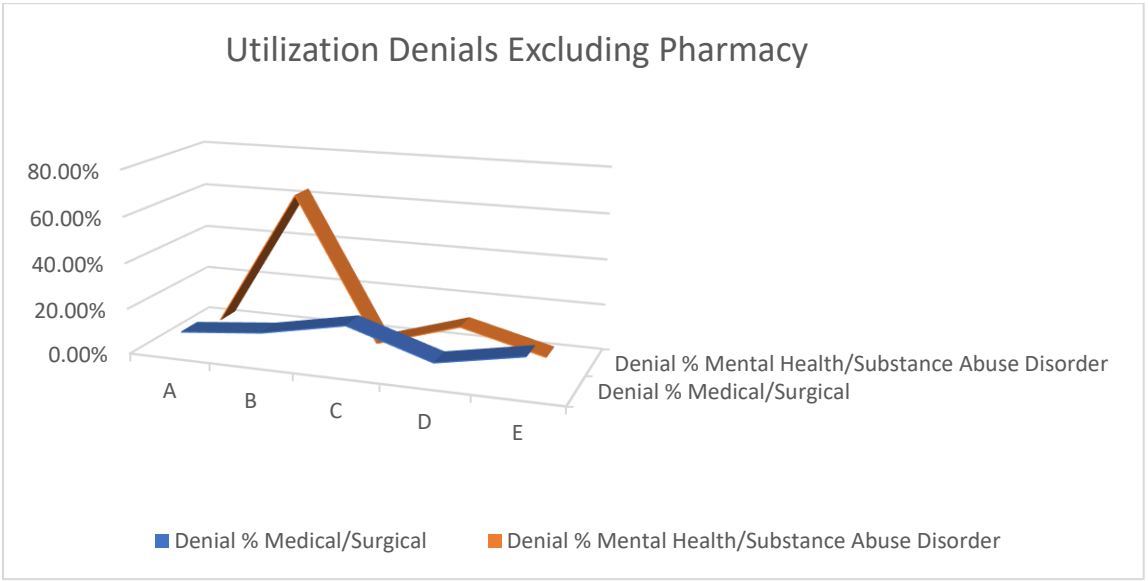
A. NQTL Adverse Determinations

Adverse determination, as defined in W.Va. Code §33-16H-1, means "a decision by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed does not meet the health carrier's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore, denied, reduced or terminated." One health insurance carrier reported a statistically significant number of adverse determinations in the reporting year.

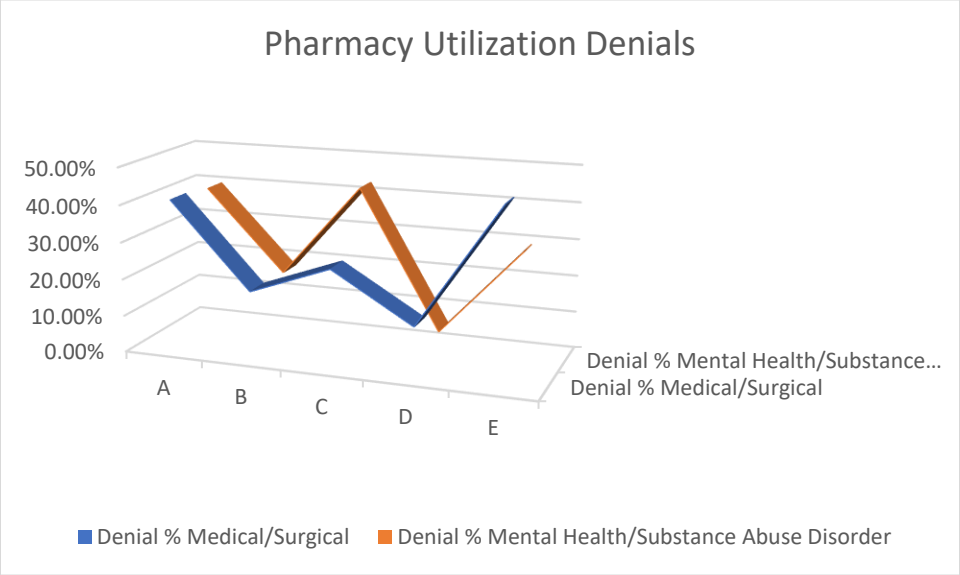


B. NQTL Utilization Denials

An average of all health benefit plans offered by an insurance carrier showed that denials on utilization review requests are in parity with the exception of utilization review denials for Carrier B. However, individual plans within insurance carriers have shown higher denial percentages for mental health/substance use disorder benefits versus medical/surgical benefits.

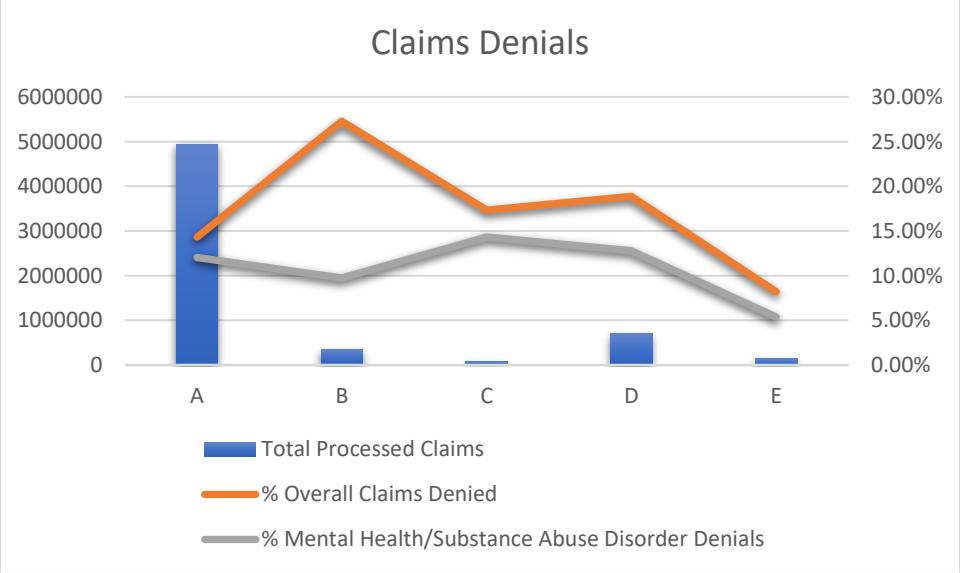


Pharmacy utilization shows higher levels of denials for both mental health/substance use disorder care than for medical/surgical care. However, with the increases in expensive drugs, pharmacy claims are often the highest scrutinized claims overall.



C. NQTL Claims Denials

In addition to adverse determinations and utilization requests, the WVOIC reviewed claims denials post procedure. For all carriers, the percentage of denied claims for mental health/substance abuse disorders falls under the percentage of claims denied for medical/surgical procedures.



III. Conclusion

After reviewing the collected data and other health insurance carrier responses, the WVOIC believes that further review and analysis of potential disparity about NQTLs for mental health/substance use disorder treatment is necessary. Health insurance carrier plans show parity of benefits available for mental health/substance use disorder and medical surgical benefits. However, the collected data may indicate disparity in the actual application of those benefits. The WVOIC has already sought to engage with each health insurance carrier surveyed as part of an "exit interview" to improve compliance with Mental Health Parity law in West Virginia. Further, the WVOIC will consistently work with the insurers over the next several months to improve access to and claims payments for mental health and substance use disorder treatment and services. Should those efforts not be deemed sufficient, the WVOIC has other regulatory enforcement authority as well such as audits/examinations, monetary penalty/fines, and licensure actions. The WVOIC looks forward to engaging with the Legislature on this issue and appreciates the opportunity to be of service to West Virginians.