Allan L. McVey
CPCU, ARM, AAI, AAM, AIS
Insurance Commissioner

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MENTAL HEALTH PARITY 2023

2022 Plan Year

I. Introduction.

This Mental Health Parity Report (Report) is in response to the West Virginia Legislature's requirement, pursuant to W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, 33-25A-8u, and W.Va. Rule 114-64-7.3 and 8, that the West Virginia Offices of the Insurance Commissioner (OIC) annually issue a mandatory data call and provide a detailed report to the Joint Committee on Government and Finance, on the status of mental health and substance use disorder (MH/SUD) parity in the State of West Virginia. As specified in West Virginia law, this Report addresses carrier compliance with the requirements of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) related to parity in the imposition of financial requirements (FRs) and treatment limitations, both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs).[1]

II. Applicable Mental Health Parity Laws.

In 2020, West Virginia passed a state "Mental Health Parity Law" (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, MH/SUD, and medical and surgical services. The Mental Health Parity Law mandates, in part, that health insurers comply with MHPAEA and its regulations, as amended, concerning FRs, QTLs, and NQTLs. The Mental Health Parity Law also requires that the OIC report annually and submit a written report to the Joint Committee on Government and Finance on certain data collection and analyses undertaken by the OIC regarding mental health parity.

MHPAEA is a federal law that imposes parity standards that generally prohibit group health plans, health insurance issuers, and individual health insurance plans from imposing certain FRs and treatment limitations on MH/SUD benefits that are less favorable than FRs and treatment limitations applied to medical/surgical benefits.[2] MHPAEA's regulations address the following types of requirements and treatment limitations: (1) FRs or aspects of plan design that outline cost sharing between the plan and the enrollee (including copayments, coinsurance, deductibles and out-of-pocket limits); (2) QTLs or treatment limitations that are expressed numerically, such as calendar year limits on the number of office visits or inpatient days, or lifetime limits on the coverage of benefits; and (3) NQTLs or limits on the scope or duration of treatment that are not expressed numerically. (e.g., medical management techniques like prior authorization, formulary design for prescription drugs, standards for provider admission to a network (including reimbursement rates paid to a provider or facility) or provider network adequacy).[3] Plans and

[1] See 42 USC 300gg-26. See also MHPAEA's Final Regulations can at 2013-27086.pdf (govinfo.gov).
[2] 42 USC 300gg-26(a)(3)(a) and 45 CFR 146.136(b)(1).
[3] See 45 CFR 146.136(a). The regulations provide the following illustrative list of NQTLs: medical management standards, formulary design prescription drugs, network tier design, standards for provider admission to participate in a network (including reimbursement rates paid to a provider or facility), plan methods for determining usual, customary and reasonable charges, refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective, exclusions based on failure to complete a course of treatment, and restrictions based on geographic location, facility type, provider specialty, and any other criteria that limits the scope or duration of a benefit. See 45 CFR 146.136(c)(4)(i). The Preamble to MHPAEA's Final Rules also states that the regulations' list of NQTLs is merely

issuers that impose FRs, QTLs, and NQTLs must meet specific tests to be in compliance with the law and its regulations. FRs, QTLs and NQTLs are analyzed on a classification-by-classification basis. MHPAEA's regulations establish six classifications of benefits as follows: (1) inpatient, in-network; (2) inpatient, out-of-network, (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) pharmacy. The rules permit the plans or issuers to subclassify their outpatient benefits into office visits and outpatient other items and services subclassifications.[4]

Once the benefits are separated into benefits classifications, the carrier must identify every FR, QTL or NQTL which is applied to M/SUD benefits. If there is no corresponding FR, QTL, or NQTL imposed on the medical/surgical benefit, it is a separate treatment limitation and it expressly violates MHPAEA.[5] However, if the FR, QTL, or NQTL applies to both MH/SUD and medical/surgical benefits, the plan must determine if the applicable FR, QTL, or NQTL meets the compliance tests required by the law and its regulations.

A. FR and QTL Tests.

For any FR or QTL that applies to both MH/SUD and medical/surgical benefits, it must be determined if the FR or QTL applies to "substantially all" of the medical/surgical benefits within the same benefits classification based on plan expected payments for covered medical/surgical benefits.[6] An FR or QTL is considered to apply to substantially all of the medical/surgical benefits in a benefits classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. If the FR or QTL type does not apply to substantially all of the medical/surgical benefits in that benefits classification, the type of FR or QTL cannot be applied to the MH/SUD benefits in the classification.

If the FR or QTL type does apply to substantially all of the medical/surgical benefits in the classification, then the health plan must apply the "predominant" test (i.e., the health plan must determine the level of the type of FR or QTL that is the predominant level in a benefits classification). The predominant level means that the FR or QTL applies to more than half of the medical/surgical benefits in that benefits classification based on plan costs. If a single level of a type of FR or QTL applies to more than one-half of the medical/surgical benefits subject to the FR or QTL within a benefits classification, it is the predominant level, and the health plan cannot apply that FR or QTL to the MH/SUD benefits at a level that is more restrictive. However, if there is no one level that applies to more than half of the medical/surgical benefits subject to the FR or QTL in a benefits classification, the health plan must combine levels until the combination of levels applies to more than one-half of the medical/surgical benefits subject to the FR or QTL in the classification.

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illustrative and not all of the NQTLs that may be imposed by a plan or issuer on MH/SUD benefits. The Final Rules offer additional illustrations of NQTLs (e.g., in- and out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy). See 78 FR 68246.

[4] MHPAEA's Final Rules permit three sub-classifications that were established to accommodate plan design features. These subclassifications are multi-tiered prescription drug benefits, multiple network tiers, and office visits, separated from other outpatient services. Once a subclassification is established by a plan or issuer, it must perform the appropriate parity analysis within the subclassification to determine its compliance with MHPAEA's tests (i.e., substantially all and predominant or comparability and no more stringency). See 45 CFR 146.136(c)(3)(iii).

[5] 42 USC 300gg-26(a)(3)(A) and 45 CFR 146.136(c)(3).

[6] 42 USC 300gg-26(a)(3)(A).

B. NQTL Tests.

For any NQTL that applies to both MH/SUD and medical/surgical benefits, the NQTL must comply with MHPAEA's comparability and stringency tests. Specifically, a plan or issuer may not impose an NQTL with respect to MH or SUD disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH or 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 with respect to medical/surgical benefits in the same benefit classification

The Consolidated Appropriations Act of 2021 (CAA), enacted on December 27, 2020, amended MHPAEA and established important requirements regarding comparative analyses for NQTLs. The CAA generally requires that group health plans perform and document comparative analyses of the design and application of all NQTLs and make this documentation available to the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (DHHS), and applicable state authorities upon request beginning February 10, 2021. The DOL, DHHS, and U.S. Department of the Treasury released Frequently Asked Questions (FAQ 45) on April 1, 2021, to provide important guidance to plans in conducting and documenting what comprises a sufficient comparative analysis.[7]

Specifically, the CAA provides that plans must "perform and document comparative analyses of the design and application of NQTLs." The *comparative analyses* must *demonstrate:*[8]

> …that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.[9]

The CAA also requires that group health plans and health insurance issuers perform the comparative analyses in a manner which demonstrates compliance with MHPAEA's NQTL rule by providing the following five required information elements (the "Required Steps"):

> **Required Step 1:** The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical/surgical benefits to which each such term applies in each benefits classification;[10]
>
> **Required Step 2:** The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical/surgical benefits;[11]

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[7] See FAQs-Part-45 (dol.gov).
[8] See 42 U.S.C. 300gg-26(a)(8)(A)(i) - (v).
[9] 42 U.S.C. 300gg-26(a)(8)(A)(iv)).
[10] 42 U.S.C. 300gg-26(a)(8)(A)(i).
[11] 42 U.S.C. 300gg-26(a)(8)(A)(ii).

Required Step 3: The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical/surgical benefits;[12]

Required Step 4: The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to med/surg benefits in the benefits classification;[13] and

Required Step 5: The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.[14]

The Required Steps are "Compliance Requirements," as reflected in the title of 42 U.S.C. section 300gg-26(a)(8), the section of the law which sets forth the Required Steps. Each step is a requirement that is necessary for establishing compliance. If a plan fails to meet any one of the Required Steps, it is a failure to provide the required information and conclusively demonstrate compliance through its comparative analysis.

III. OIC Data Call.

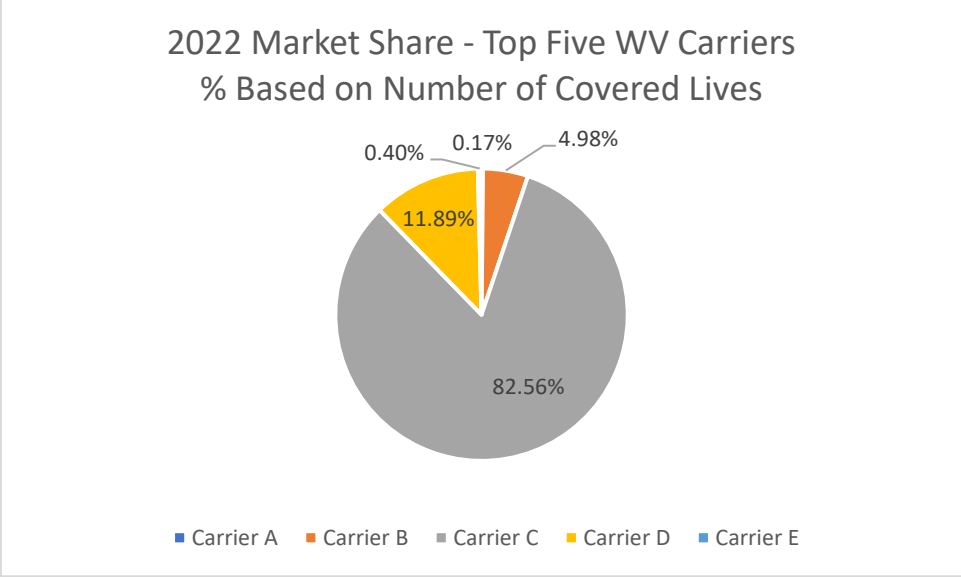
In order to fulfill its statutory obligations, the OIC issued a data call and information and reporting request (Data Call), designed to collect the information necessary to complete this Report, and to provide a basis to analyze the information regarding the state of compliance with the State West Virginia and federal mental health parity laws and regulations. The OIC issued the Data Call to the State regulated health plans and health insurance issuers (herein referred to as Carriers) in West Virginia on March 20, 2023, requesting information and data for the 2022 plan year.

The Data Call required the Carriers to complete a Carrier Information Worksheet, which requires the Carriers to report information regarding the plans operated in West Virginia, including claims expense data, vendor and delegate information, adverse determinations, all Carrier identified NQTLs, and medical necessity criteria used in making utilization management decisions. The Carriers must also provide the comparative analyses that they have developed for each NQTL identified by the Carrier, using a form provided by the State that comports with the Required Steps and complete a Workbook to report information regarding the Carrier's FRs and QTLs.

This Report will focus on the top 5 Carriers in West Virginia, providing coverage to 98% of the commercial market.[15] The top 5 Carriers, identified herein as Carriers A, B, C, D and E,

[12] 42 U.S.C. 300gg-26(a)(8)(A)(iii).
[13] 42 U.S.C. 300gg-26(a)(8)(A)(iv).
[14] 42 U.S.C. 300gg-26(a)(8)(A)(v).
[15] Three additional Carriers, who account for 2% of the market in West Virginia, have submitted responses for review. These responses are being reviewed by the OIC and all parity and reporting issues identified will be addressed with the applicable Carrier.

responded to the Data Call. The chart below reflects each of the top 5 Carrier's market share by percentage based on the number of covered lives.



IV. Review of Plan Submissions.

The OIC has conducted an initial review of the Carriers' responses to the Data Call, a summary of which is provided below based on the type of FR or treatment limitation imposed by the Carriers given the different tests for such FRs and treatment limitations required by MHPAEA and its regulations.

A. FRs and QTLs.

A preliminary review of the data per the required reporting format submitted by the Carriers to demonstrate compliance with the required predominant and substantially all tests indicates that there are some information gaps and/or missing information needed to verify compliance for the identified FRs and QTLs via the applicable summary plan descriptions and certificates of coverage. The documentation gaps we have identified are not necessarily an indication of noncompliance but reveal that further inquiry and review with the Carriers is required in order to render definitive conclusions respecting compliance. This inquiry and review, along with the data validation, will be conducted and a final determination of compliance will be made by the OIC and reported as appropriate.

B. NQTLs.

With respect to NQTLs, after an examination of the NQTL comparative analyses and other information provided by the top 5 Carriers, the OIC has generally determined that the Carriers have not sufficiently demonstrated that each NQTL imposed complies with the Required Steps, and

therefore, they have not demonstrated compliance as stipulated by 42 U.S.C. section 300gg-26(a)(8)(A)(i) - (v) or the Mental Health Parity Law.

1) <u>Reasons for a Failure to Demonstrate Compliance.</u>

There are a number of reasons that each Carrier's NQTL comparative analyses may fail to demonstrate compliance. The reasons that a Carrier may fail to demonstrate compliance include, but are not limited to, one or more of the following:

i. The Carrier did not provide a comparative analysis for each NQTL imposed on medical/surgical and MH/SUD benefits and/or did not provide a comparative analysis for each NQTL in each benefits classification.

ii. The Carrier's comparative analyses do not correlate with the reporting format provided by the OIC as part of the Data Call.

iii. The Carrier did not sufficiently identify what benefits or plan terms the NQTLs apply to, as required by 42 U.S.C. 300gg-26(a)(8)(A)(i).

iv. The comparative analyses did not adequately describe how the NQTLs were designed or how they are applied in practice, as required by 42 U.S.C. 300gg-26(a)(8)(A)(i).

v. There is either inadequate supporting documentation or information included with the submissions or supporting documentation that was not properly integrated with the analysis provided or adequately identified in the analysis or its relevance as to demonstrating compliance explained.

vi. The Carrier did not sufficiently define the factors identified or did not sufficiently delineate or explain the sources or evidentiary standards for each factor used to determine that the NQTLs will apply, as required by 42 U.S.C. 300gg-26(a)(8)(A)(ii) and (iii).

vii. The Carrier did not demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH or SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in each benefits classification, as required by 42 U.S.C. 300gg-26(a)(8)(A)(iv).

viii. The Carrier included data with no explanation as to how the data was collected or how the data supported a finding of comparability and equitable stringency application and some of the data was not plan specific to West Virginia but reported on a Carrier's larger book of business basis.

ix. The Carrier did not provide the specific findings and conclusions reached, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with MHPAEA, as required by 42 U.S.C. 300gg-26(a)(8)(A)(v).

x. The Carrier made incorrect assertions regarding applicable law which fundamentally impact the conclusions set forth in the comparative analyses submitted and the validity of the analysis itself.

xi. The Carrier did not appropriately define or explain its relationships with vendors or delegates that may have design or management responsibilities for the NQTLs and how MHPAEA compliance is assured/coordinated, or specifically provide the policies, procedures and processes used by the vendor or delegate with respect to MH/SUD benefits.

xii. The Carrier provided conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

2) <u>Other Issues Identified.</u>

The OIC identified the following areas that warrant additional investigation and review post this report:

i. Identification of NQTLs.

The Mental Health Parity Law requires that the OIC identify all of the NQTLs that the Carriers apply to MH/SUD and medical/surgical benefits within each classification of benefits. The top 5 Carriers provided comparative analyses for the NQTLs listed in the chart below. While the Carriers provided comparative analyses for the NQTLs listed, there may well be other NQTLs that a Carriers did not report on (e.g., fraud, waste, and abuse programs; network adequacy; coding edits; treatment plan requirements; etc.). The Carriers did not specify the methodology they use to identify NQTLs for this reporting or whether there are other plan design features that may warrant comparative analysis. Also, while some Carriers provided comparative analyses by benefits classification, other Carriers did not and still others combined analyses of NQTLs which may or may not be appropriate. These deficiencies create gaps in the information required to properly assess all applicable Carrier NQTLs. Going forward, these issues will be reviewed by the OIC with Carriers and any compliance questions and information deficiencies will be resolved prior to rendering conclusive compliance determinations.

NQTLs Reported by the Top 5 Carriers:[16]

NQTL	Carrier A	Carrier B	Carrier C	Carrier D	Carrier E[17]
Prior Authorization	x	x	x	x	x
Concurrent Review	x	x	x	x	x
Retrospective Review	x	x	x	x	x
Medical Necessity	x	x	x	x	x
Credentialing Standards	x	x	x	x	x
Fraud and Abuse Programs			x		
Reimbursement Rates[18]	x	x	x	x	x
Network Adequacy	x			x	x
Experimental/Investigational[19]	x	x	x	x	x
Formulary Development	x	x	x	x	x
Step Therapy/Fail First	x	X	x	x	
Quantity Limits	x	x	x	x	
Network Tiering				x	
Geographic Restrictions					x
Facility Restrictions				x	
Exclusions	x	x		x	
Treatment Plan Requirements	x			x	
Scope Limits				x	
Expedited Claims				x	
Coding Edits					x
Sequenced Treatment	x				

ii. Medical Necessity Criteria.

Each Carrier provided a comparative analysis related to the medical necessity NQTL that it uses to make utilization management decisions. However, the comparative analyses provided do not demonstrate compliance with the Required Steps per 42 USC 300gg-26(a)(8)(A) and do not provide for a demonstration of compliance with the federal and state laws and regulations. Three of the five Carriers provided a definition of medical necessity and two of the Carriers provided no definition at all. Two of the Carriers do not state whether they use nationally recognized, evidence-based clinical criteria (e.g., ASAM, InterQual, LOCUS, CALOCUS, MCG, etc.) or internally developed criteria. Two other Carriers state that they use internally developed criteria that is based on nationally recognized, evidence-based criteria but do not provide the internally developed

[16] The "x" in the chart indicates that the Carrier provided a response for the applicable NQTL. A gray space indicates that the Carrier did not provide a comparative analysis for the NQTL.
[17] Carrier E submitted one pharmacy comparative analysis for formulary development. The Carrier mentions step therapy and quantity limits in the response provided for prior authorization but did not provide a separate response.
[18] Carrier A submitted comparative analyses for in-network and non-participating providers and facilities. Carrier B submitted one comparative analysis that is not specific to in- or out-of-network providers. Carrier C submitted one response for out-of-network reimbursement only. Carrier D submitted comparative analyses for network reimbursement standards and out-of-network reimbursement. Carrier E provided comparative analyses for in-network facility and professional reimbursement and out of network reimbursement.
[19] Carrier A and Carrier C provided comparative analyses for Exclusions which included Experimental/Investigational but did not provide separate comparative analyses.

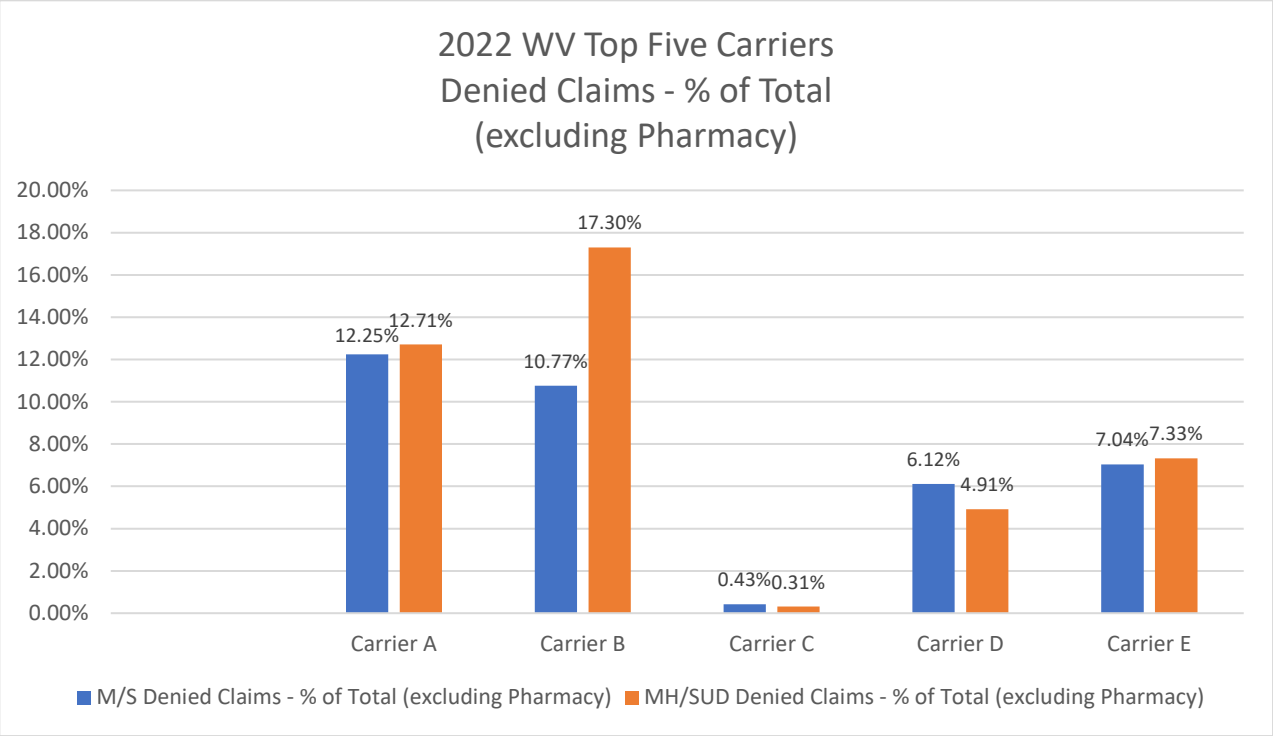
criteria or explain how they develop the criteria and how the criteria is different than the nationally recognized criteria. One Carrier states that it uses externally developed clinical criteria but does not state whether it modifies the external criteria for situations where no external criteria exists and how it modifies the criteria. Without an appropriate disclosure of the definitions used for medical necessity and the criteria used to make utilization management decisions, the OIC is unable to determine compliance with the law and regulations. The OIC has noted these deficiencies in the comparative analyses and will reach out to Carriers to obtain clarifications to enable appropriate assessment of Carrier compliance.

iii. Adverse Determinations.

The OIC has reviewed the adverse determination of the top 5 Carriers. According to W.Va. Code §33-16H-1, an adverse determination is:

> …a determination 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 and, based upon the information provided, does not meet the health carrier's requirements 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.

Claims denied by Carriers are adverse determinations. A review of the top 5 Carriers claims denials as a percentage of total claims is set forth in the chart below denied claims represent adverse determinations. It is important to note that the outcomes, whether similar or different, do not per se prove that the Carrier is or is not in compliance with MHPAEA or its regulations. outcomes as part of their respective comparative analyses. However, the outcomes may indicate that there may be a compliance question that needs further investigation. As a result, the OIC will follow up with the Carriers to review the data and ensure that compliance is demonstrated. It should also be noted that the data contemplated by the statutory definition for adverse determinations is complex. For example, the reported data may lack definitional precision as to what is reported as a claim denial versus an MCO review and whether negotiation with the requesting provider results in a modification of the actual coverage approved which is different than the original request but not counted as a denial which complicates a valid conclusion. It may also be unclear as to how a carrier defines and counts denials which are based on a medical necessity determination as opposed to denied for administrative reasons. The revised Carrier reporting format for adverse determinations included more granular data requests to enable better assessment of what this data represents. Some of the data received is incomplete or requires further discussion with Carriers. The OIC will be further exploring refinements and definitions for the adverse determination data to enable a more comprehensive assessment as to what it actually represents in a manner which is consistent with what the OIC thinks is the legislature's intent for this reporting requirement.



V. Conclusion

After reviewing the Carrier responses with respect to FRs and QTLs, the OIC has determined that additional data validation and review is necessary to determine whether the Carriers are in compliance with MHPAEA's substantially all and predominant tests. With respect to NQTLs, the OIC has determined that the Carriers' comparative analysis submissions were generally not able to demonstrate that the Carriers are in compliance with MHPAEA's comparability and stringency tests. This is not a conclusion that any of the Carriers is not in compliance with MHPAEA or the Mental Health Parity Law but a finding that further review and analysis is necessary in order to determine the sufficiency of the top 5 Carriers' comparative analyses and any potential compliance concerns related to NQTLs imposed on MH/SUD benefits.

The OIC will be working extensively with the Carriers over the next several months to better determine whether or not there are actual parity compliance issues. Should these endeavors yield identification of parity issues, the OIC will determine what regulatory enforcement may be appropriate and whether other functions such as audits/examinations, monetary penalty/fines, and licensure actions should be initiated. The OIC looks forward to engaging with the Legislature on this issue and appreciates the opportunity to be of service to West Virginians.