2021
Report

Claims - Complaints - Appeals

Mental Health
&
Substance Use Disorder Benefits

and

Network Adequacy

For the Period January 1, 2020 - December 31, 2020

State Corporation Commission
Bureau of Insurance

Executive Summary

As required by § 38.2-3412.1 of the Code of Virginia 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. Further, § 38.2-3412.1 G of the Code of Virginia requires:

> The Bureau of Insurance (the Bureau), in consultation with health carriers providing coverage for mental health and substance use disorder benefits pursuant to this section, shall develop reporting requirements regarding denied claims, complaints, appeals, and network adequacy involving such coverage set forth in this section. By September 1 of each year, the Bureau shall (i) compile the information for the preceding year into a report that ensures the confidentiality of individuals whose information has been reported and is written in nontechnical, readily understandable language; (ii) make the report available to the public by, among such other means as the Bureau finds appropriate, posting the reports on the Bureau's website; and (iii) submit the report to the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor.

Managed Care Health Insurance Plans ("MCHIPs") licensed in Virginia currently submit annual reports on claims, complaints and appeals to the Virginia Department of Health and to the State Corporation Commission Bureau of Insurance (the "Bureau") pursuant to §§ 32.1-137.6 C and 38.2-5804 of the Code of Virginia. However, specific information related to claims, complaints and appeals for mental health and substance use services could not be gleaned from the reports. Therefore, a separate survey was developed by the Bureau in conjunction with the Virginia Association of Health Plans ("VAHP"), and with health carriers that provide the majority of fully-insured health insurance in Virginia that are not members of VAHP, along with major input from the Virginia Department of Behavioral Health and Developmental Services. Through this survey, the Bureau receives information to help it analyze whether claims, complaints and appeals related to mental health and substance use disorder benefits are being treated in parity with claims, complaints and appeals related to medical/surgical benefits.

The report's finding on parity within network adequacy is included as an addendum separate from the general reporting of parity comparisons of mental health and substance use

abuse benefits to medical and surgical benefits.

The results of the 2021 survey, which contains information related to calendar year 2020, are provided in this report. Overall, the survey results suggest that health insurance carriers generally treat claims, complaints and appeals related to mental health and substance use disorder benefits in parity with claims, complaints and appeals related to medical/surgical benefits.

The Bureau has provided initial results from its Network Adequacy parity analysis and will continue to monitor these results to identify any areas of concern.

Overview

The Bureau surveyed 16 health carriers, each identified as insuring greater than 5,000 lives in Virginia in the individual, small group, and large group health insurance markets during the 2020 calendar year. In total, these carriers reported more than 1.65 million covered lives. Carriers were requested to report information specific to three benefit categories: Medical/Surgical Benefits, Mental Health Benefits, and Substance Use Disorder Benefits. Further, the carriers were required to report data for the 2020 calendar year related to these specific three benefit categories for:

- Claims paid, denied and the reason for the denial;
- Complaints received and processed;
- Internal appeals processed; and
- External reviews processed.

Generally, and from year to year, the report serves to provide an overview of the surveyed data.

As required by § 38.2-3412.1 of the Code of Virginia 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 shall be in parity with the medical and surgical benefits coverage. The report provides an observation of claims, complaints and appeal denials as well as network adequacy for coverage of mental health benefits and substance use disorder benefits, compared to medical/surgical benefit coverage, based on the surveyed data.[1]

[1] To protect the confidentiality of the individual member and health carrier the report only provides data in the aggregate. None of the data in the report pertains to any one individual or health carrier; rather, it is a compilation of the total data reported by the health carriers in response to each surveyed question.

Section I. Claims

Overview

Carriers surveyed reported a total of 36,784,134 claims received with 4,041,253 (11.99%) of claims being denied. This is a lower denial rate from the previous report's denial rate of 12.8%.

Each carrier reported whether each denied claim related to medical/surgical, mental health, or substance use disorder benefits. The claims reported in each of these three benefit categories were broken into five separate claims categories: Office Visit Claims, All Other Outpatient Claims, Inpatient Claims, Emergency Care Claims, and Outpatient Prescription (Rx) Drug Transactions. Tables 1, 2, and 3 below provide the breakdown into the five claim categories of the total claims handled in each benefit category.

Table 1. Claims Overview – Medical/Surgical Benefits

Claim Category: Medical/ Surgical Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	8,860,296	8,371,296	489,000	5.5%
All Other Outpatient Claims	10,879,117	10,261,463	617,654	5.7%
Inpatient Claims	1,164,842	1,048,263	116,579	10.0%
Emergency Care Claims	937,820	885,112	52,708	5.6%
Outpatient Rx Drug Transactions	11,242,558	8,970,157	2,272,401	20.2%
Totals:	33,084,633	29,536,291	3,548,342	10.7%

Table 2. Claims Overview – Mental Health Benefits

Claim Category: Medical/ Surgical Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	733,518	687,993	45,525	6.2%
All Other Outpatient Claims	543,368	509,490	33,878	6.2%
Inpatient Claims	48,616	42,649	5,967	12.3%
Emergency Care Claims	42,859	40,096	2,763	6.4%
Outpatient Rx Drug Transactions	1,949,786	1,593,812	355,974	18.3%
Totals:	3,318,147	2,874,040	444,107	13.4%

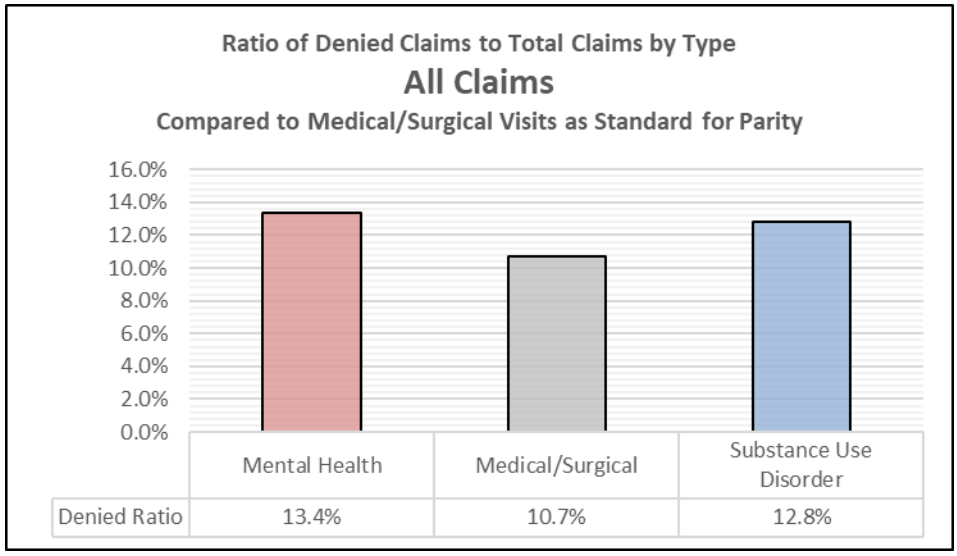
Table3. Claims Overview – Substance Use Disorder Benefits Health Benefits

Claim Category: Substance Use Disorder	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	170,310	159,138	11,172	6.6%
All Other Outpatient Claims	106,301	93,358	12,943	12.2%
Inpatient Claims	31,773	26,162	5,611	17.7%
Emergency Care Claims	16,335	14,453	1,882	11.5%
Outpatient Rx Drug Transactions	56,635	39,439	17,196	30.4%
Totals:	381,354	332,550	48,804	12.8%

Denied Claim Ratios

The following charts compare the ratios of denied claims to total claims for medical/surgical, mental health, and substance use disorder benefits. Figure 1 shows that the denial rate for claims related to mental health benefits and substance use disorder are respectively 2.7% and 2.1% greater than that for medical surgical benefits. This represents a decrease from the previous report where the mental health denial rate was 4.2% greater than the denial rate for medical surgical. The all-claims denial rate of 12.8% for substance use disorders was the same as that in the previous report.

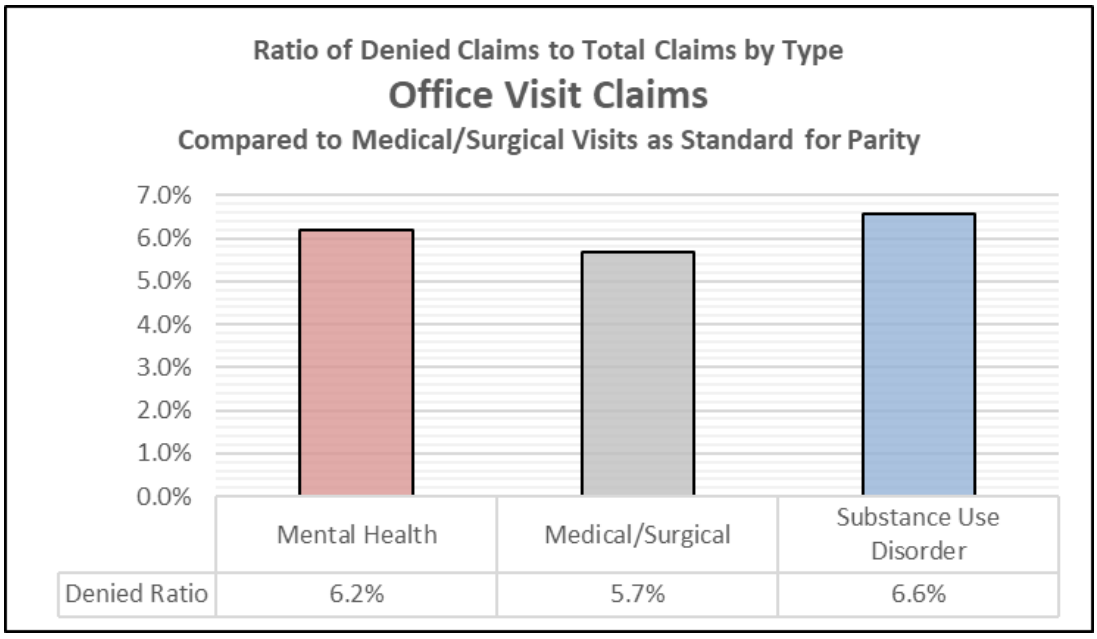
Figure 1. Denied Claims Ratio – All Claims



Claim denials were further broken down by the type of service and benefit category.

Figure 2 shows the denial rate for Office Visit Claims (such as physician visits) related to mental health and substance use disorder is respectively 0.5% and 0.9% greater than the denial rate for medical/surgical office visits.

Figure 2. Denied Claims Ratio – Office Visit Claims



Figures 3, 4, 5 and 6 also show that the denial ratio for All Other Outpatient Claims (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items), Inpatient Claims, Emergency Care Claims, and Outpatient Prescription Drug Transactions related to substance use disorder benefits exceeds claims denied for mental health benefits and medical/surgical benefits in those categories. The denial rate for substance use disorders substantially exceeds the denial ratio for medical surgical benefits.

Figures 3a, 4a, 5a and 6a show these disparities were similar when compared to the previous year's report. While the data shown in the reports is aggregate and no individual company is identified, the Bureau will review the conduct of any carriers that have a three-year trend of potential bad behavior.

Figure 3. Denied Claims Ratio – All Other Outpatient Claims

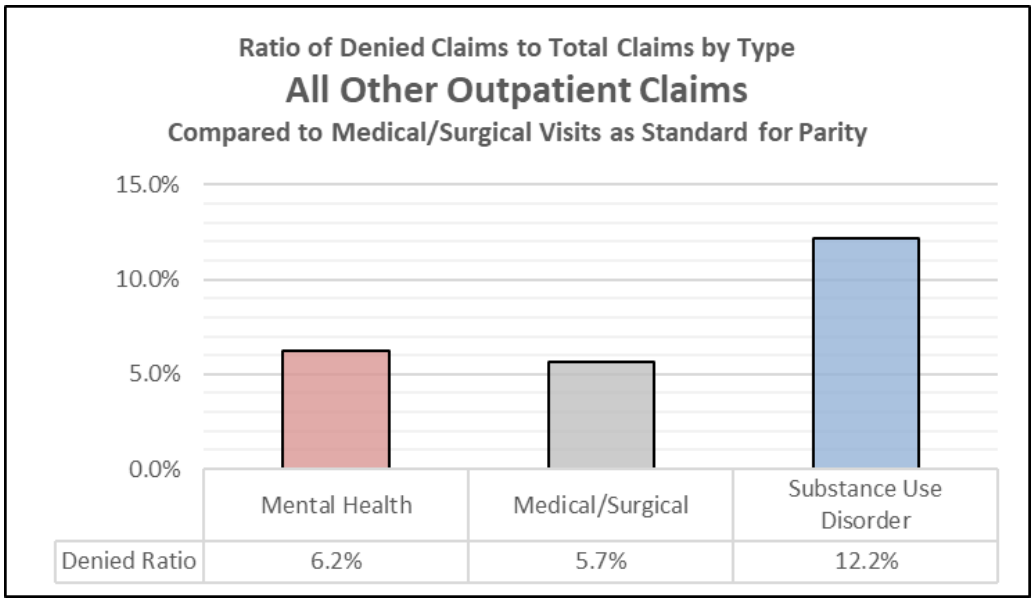


Figure 3a. All Other Outpatient Claims Denied Ratios 2020 to 2021

Year Ending 2019 **Year Ending 2020**

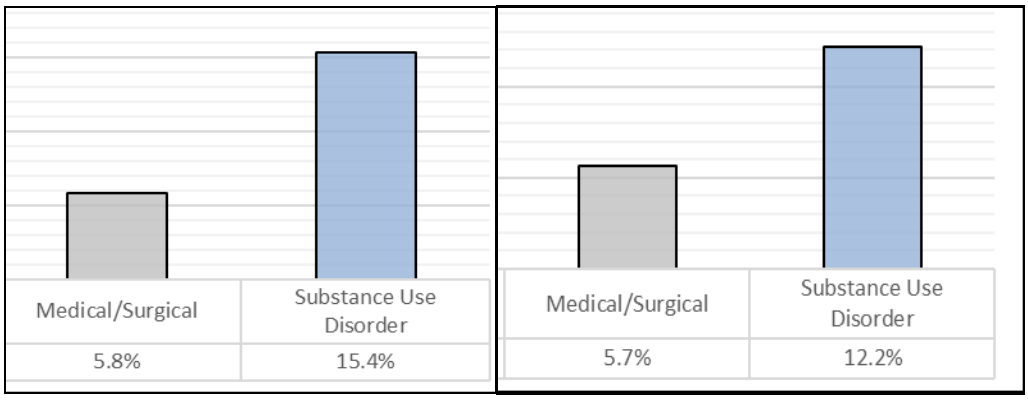


Figure 4. Denied Claims Ratio – Inpatient Claims

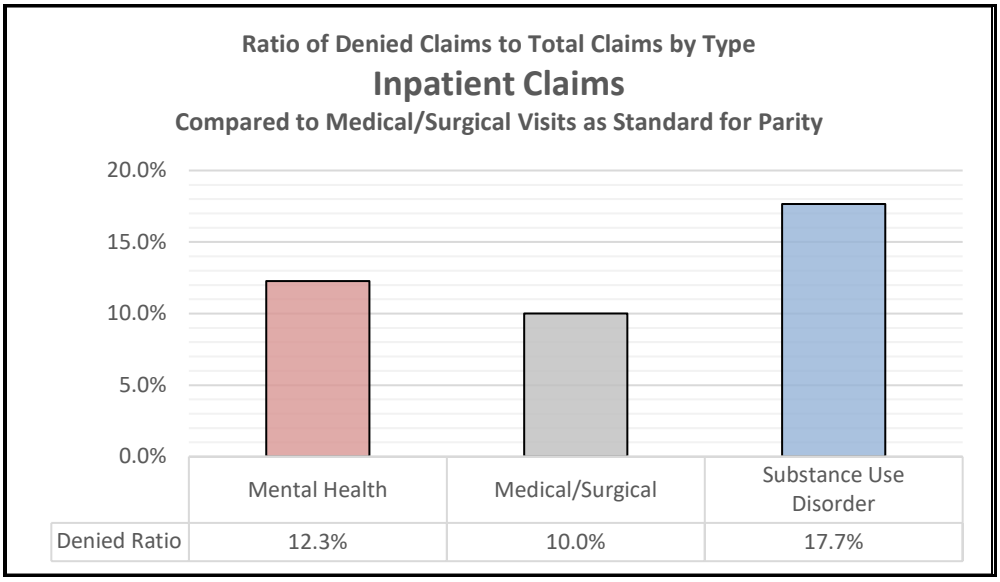


Figure 4a. Inpatient Claims Denied Ratios 2020 to 2021

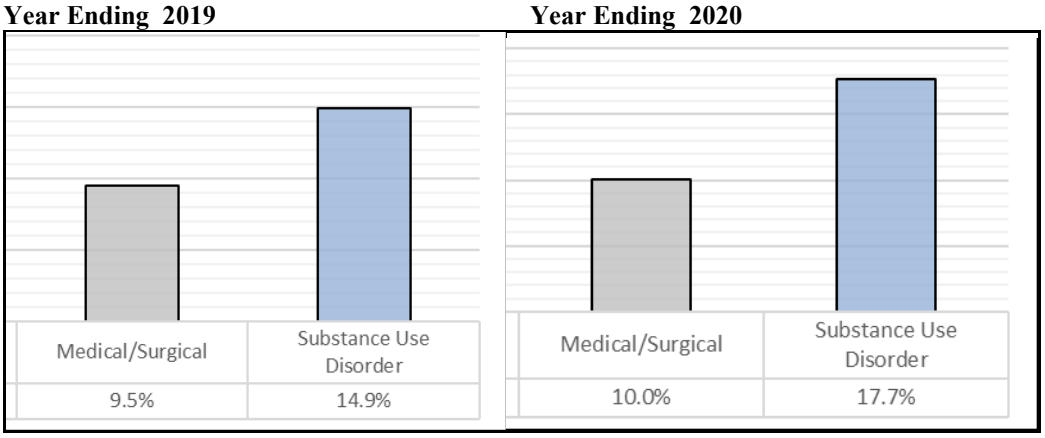


Figure 5. Denied Claims Ratio – Emergency Care Claims

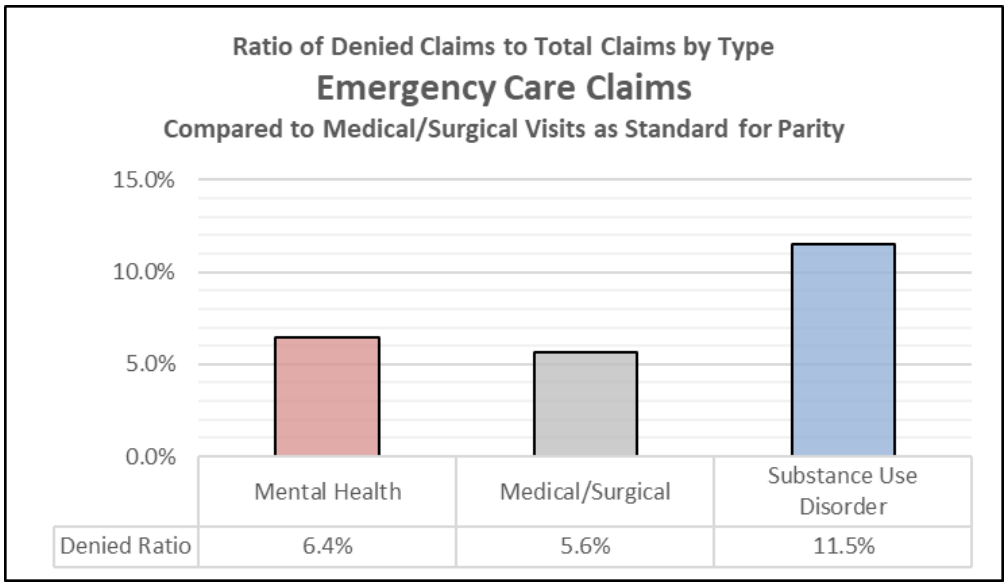
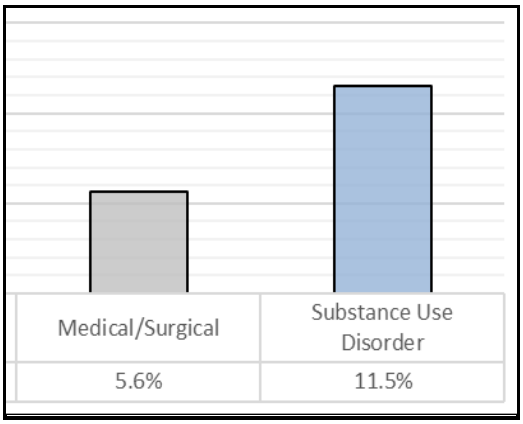


Figure 5a. Emergency Care Claims Denied Ratios 2020 to 2021

Year Ending 2019



Year Ending 2020

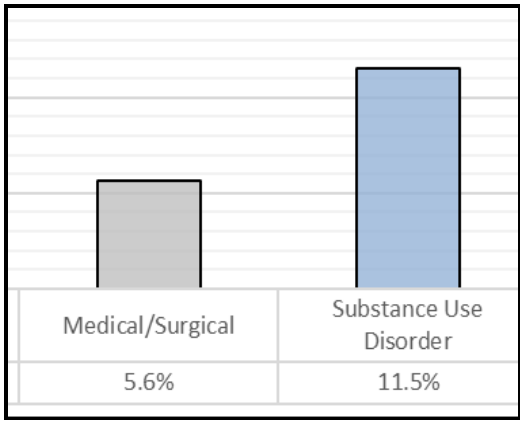


Figure 6. Denied Claims Ratio – Outpatient Prescription Drug Transactions

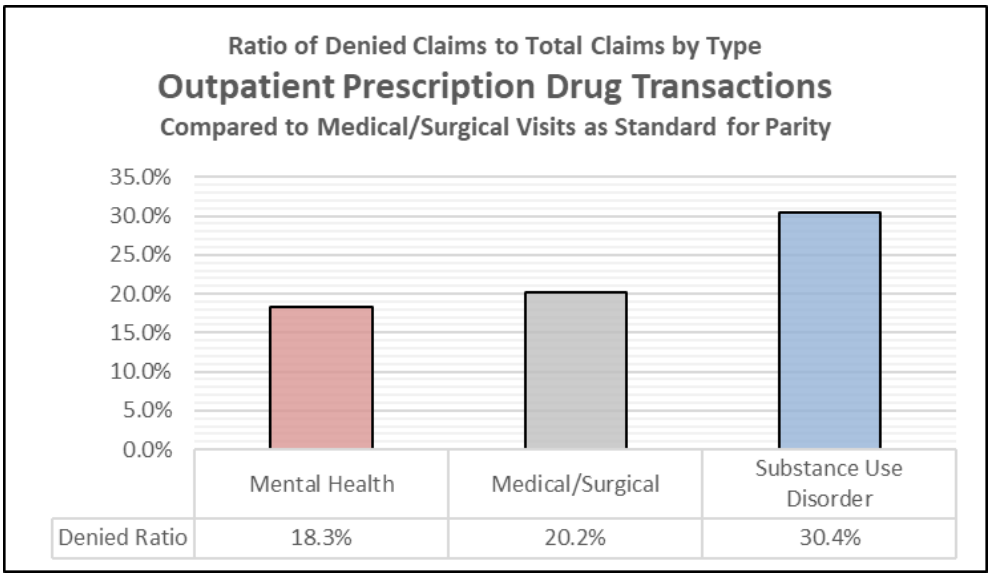
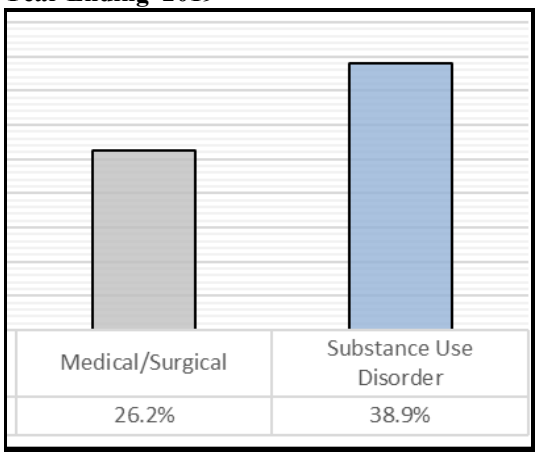
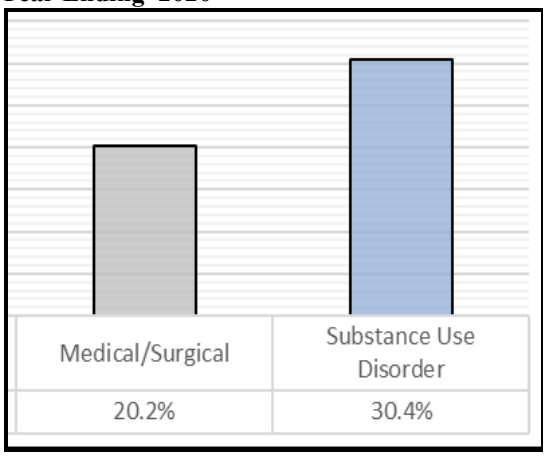


Figure 6a. Outpatient Prescription Drug Transaction Denied Ratios 2020 to 2021

Year Ending 2019



Year Ending 2020



Attachment A of the report provides an explanation of the reasons for a denial, the top three reasons for claim denials, and the number of denied claims under six general denial categories.

Section II. Complaints

Overview

Carriers were requested to provide the number of complaints submitted to the carrier by either covered persons or the Bureau during 2020 as well as the number of complaints the carrier closed during 2020. A total of 3,278 submitted complaints were reported by the 16 carriers completing the survey. This is significantly less than the 10,812 complaints reported in the previous report which may be due to the decrease in medical visits during Covid-19 restrictions.

The information was broken down into five complaint areas for each of the three benefit categories: Access to Health Care Services, Utilization Management, Practitioners/Providers, Administrative/Service, and Claims Processing. These five areas are further explained in Attachment B, Complaint Areas.

Table 4 shows the number of complaints for the respective complaint area and whether the complaint was related to a medical/surgical benefit, mental health benefit, or substance use disorder benefit. Table 5 shows the ratio of the number of complaints in each complaint area, broken down by benefit category to the total of all complaints in each complaint area and in total by benefit category.

Table 4. Total Complaints

Number of Complaints Related to:	Medical/ Surgical Benefits		Mental Health Benefits		Substance Use Disorder Benefits		All Complaints	
	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year
Access to Health Care Services	371	371	21	21	0	0	392	392
Utilization Management	556	556	39	39	24	24	619	619
Practitioners/ Providers	22	19	2	2	0	0	24	23
Administrative/ Service	984	983	17	17	3	3	1,004	1,003
Claims Processing	1,253	1,251	33	33	0	0	1,243	1,288
Totals	**3,186**	**3,180**	**112**	**112**	**56**	**56**	**3,278**	**3,325**

Table 5. Ratio of Complaints to Their Respective Total

Number of Complaints Related to:	Medical/ Surgical Benefits		Mental Health Benefits		Substance Use Disorder Benefits		All Complaints	
	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year
Access to Health Care Services	11.6%	11.7%	18.8%	18.8%	0.0%	0.0%	11.9%	11.9%
Utilization Management	17.5%	17.5%	34.8%	34.8%	88.9%	88.9%	18.9%	18.9%
Practitioners/ Providers	0.7%	0.6%	1.8%	1.8%	0.0%	0.0%	0.7%	0.7%
Administrative/ Service	30.9%	30.9%	15.2%	15.2%	11.1%	11.1%	30.5%	30.5%
Claims Processing	39.3%	39.3%	29.5%	29.5%	0.0%	0.0%	37.9%	38.7%
Totals	**3,186**	**3,180**	**112**	**112**	**27**	**27**	**3,728**	**3,325**
Ratio to All Complaints	**97.2%**	**95.6%**	**3.4%**	**3.4%**	**0.8%**	**0.8%**	**100.0%**	**100.0%**

Complaint Ratios

The following charts demonstrate how the different areas of complaints reported for the year ending for 2020 related to mental health or substance use disorder benefits compare to those complaint areas for medical/surgical services, which comprised 97.2% of all complaints. For example, of the total complaints carriers received for medical/surgical benefits, 11.9% pertain to complaints regarding access to health care services, whereas 18.8% of the total complaints carriers received for mental health benefits were due to access to health care services. At the same time there were no complaints reported for 2020 regarding access to care for substance use disorder benefits; utilization management produced the greatest percentage of complaints in this benefit category 88.9%.

The charts below are an illustration of the respective ratios for the year ending 2020 .

Attachment B of the report provides examples of the complaints that fall into the five areas of complaints.

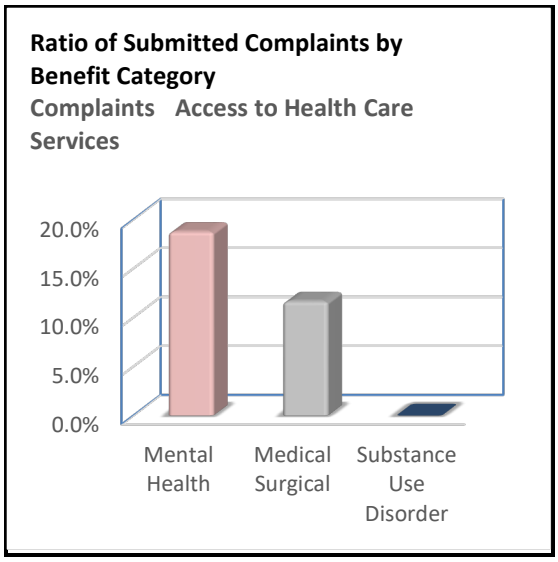


Figure 7. Access to Health Care Services Complaints

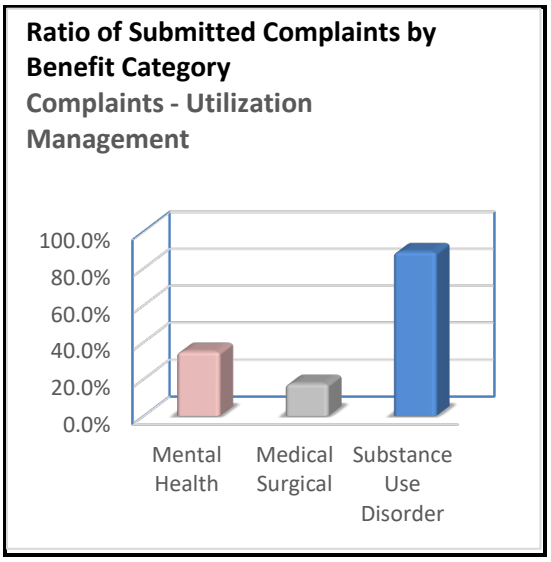


Figure 8. Utilization of Management Complaints

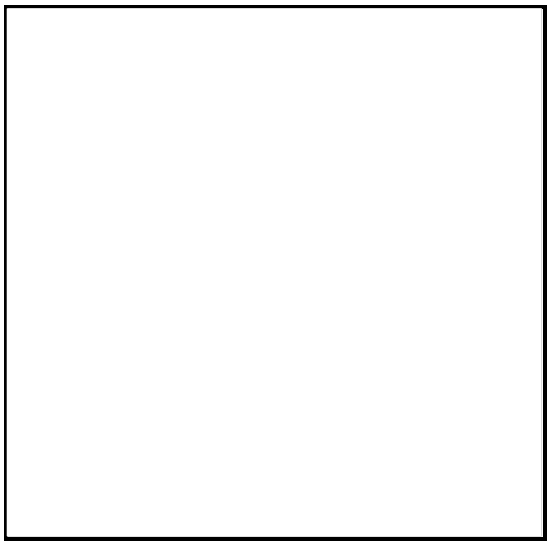


Figure 9. Complaints regarding Practitioners/Providers

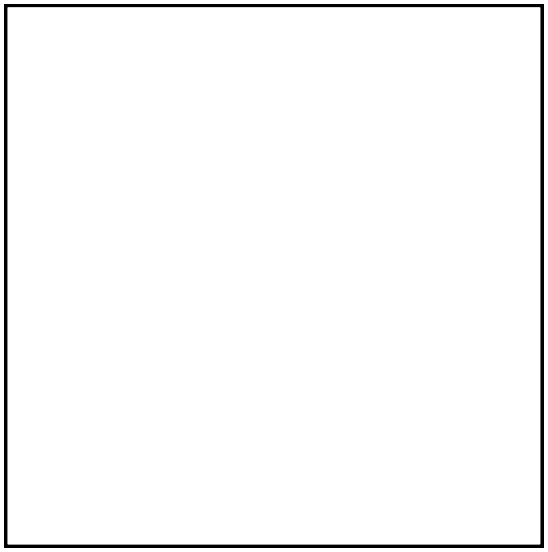


Figure 10. Administrative/Services Complaints

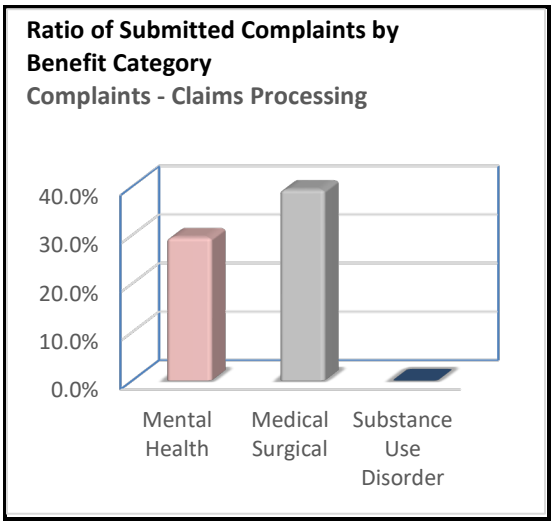


Figure 11. Claims Processing Complaints

Section III. Appeals

Internal Appeals

An internal appeal is filed by a healthcare provider or consumer to obtain approval for services an MCHIP has denied as the result of utilization review or an administrative denial. The appeal could concern a denied request for pre-authorization, which is a pre-service appeal, or the appeal could concern services that have already been provided or that do not require pre-authorization, which is a post-service appeal. The defining characteristic of the internal appeal process is that the MCHIP makes the determination. Depending upon the particular MCHIP and an individual's health plan, the person may have one or two levels of internal appeal. Pre-service appeals must be decided within 30 days, and post-service appeals must be decided within 60 days. For situations involving a serious medical condition where a quicker response is required, a person or the healthcare provider can request an urgent care appeal. In such a case, the MCHIP has 72 hours to make a decision.

The health carriers responding to the survey reported that a total of 5,523 internal appeals were processed and closed in 2020, down from 8,478 closed in 2019. Table 6 shows the number of appeals related to the denial of benefits for medical/surgical, mental health, and substance use disorder services and the results of those appeals. Figures 12-14 demonstrate the appeal outcome for the three benefit categories.

Table 6. Closed Internal Appeals

Closed Internal Appeals	Number Related to Medical/ Surgical Benefits	Number Related to Mental Health Benefits	Number Related to Substance Use Disorder Benefits
Internal Appeals – Denial Upheld	**3,517**	**101**	**44**
Internal Appeals – Denial Partially Upheld	**91**	**8**	**4**
Internal Appeals – Denial Overturned	**1,664**	**78**	**16**
Total Closed Internal Appeals	**5,272**	**187**	**64**

Figure 12. Closed Internal Appeals – Denial Upheld

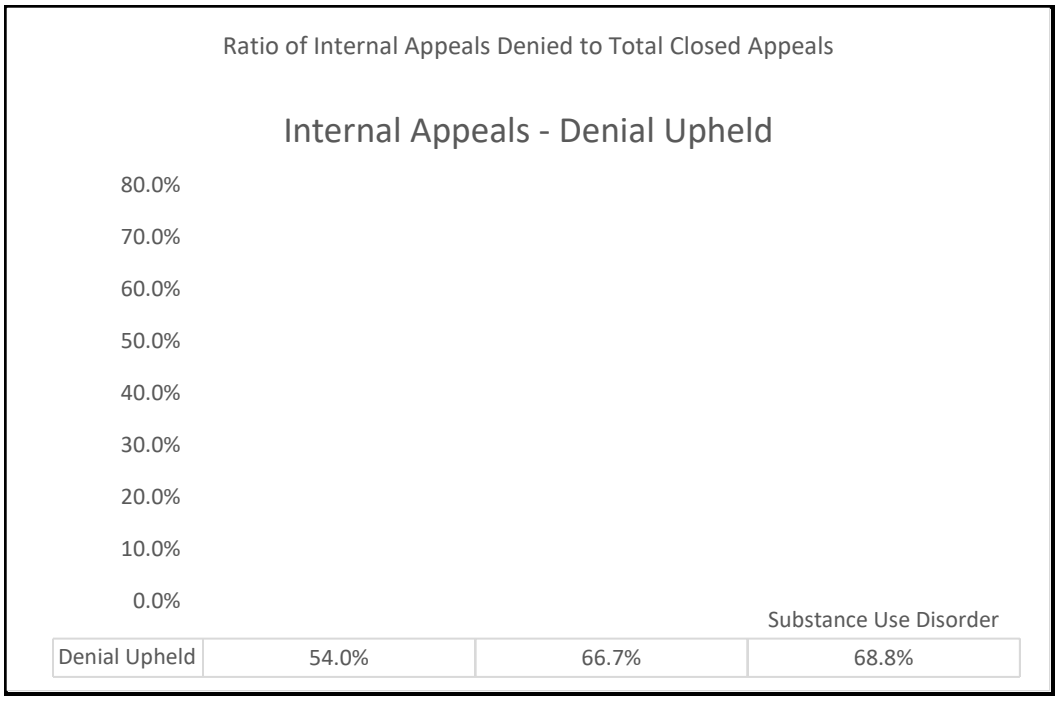


Figure 13. Closed Internal Appeals – Denial Partially Upheld

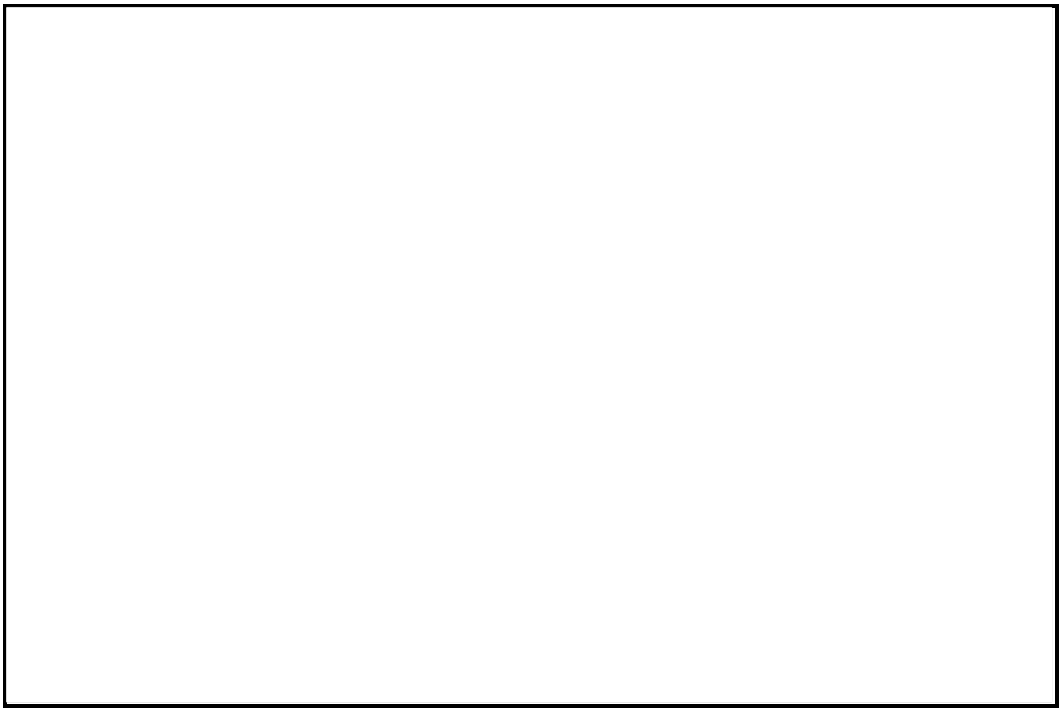
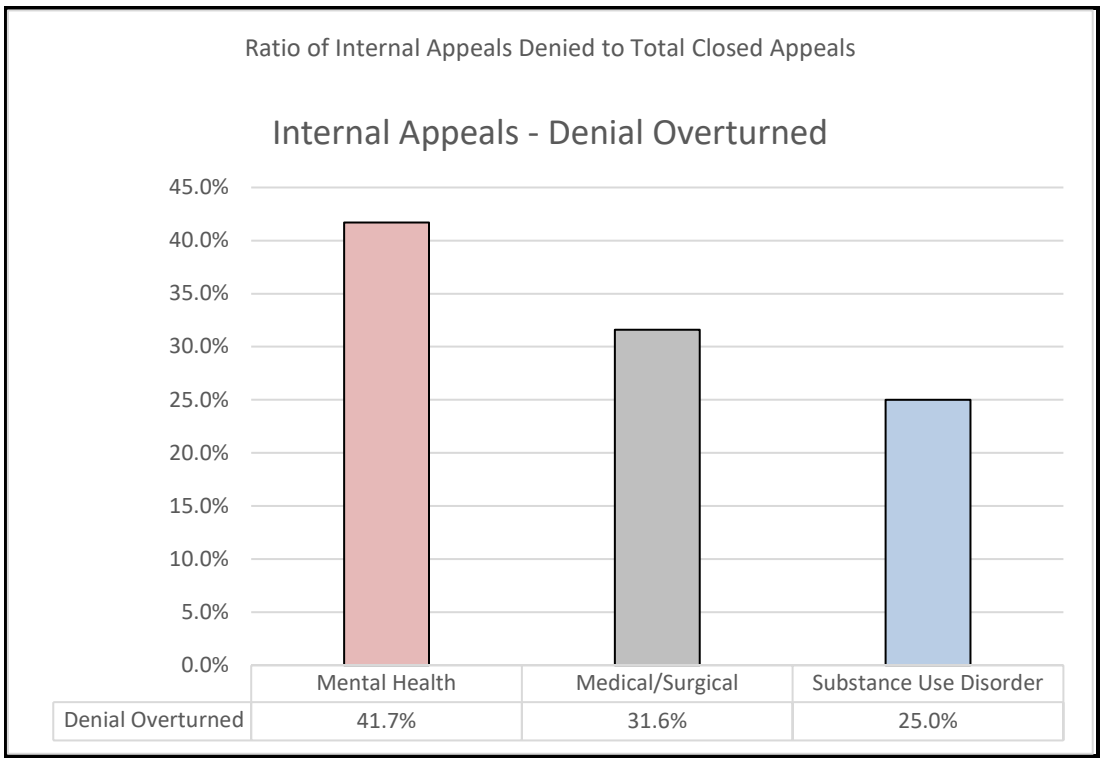


Figure 14. Closed Internal Appeals – Denial Overturned



External Review

When a consumer with a fully-insured Virginia policy receives a denial after completing the health carrier's internal appeals process (unless it is an emergency in which case completion of the internal appeals process is not required), an external review, administered by the Bureau, may be available.

There are two kinds of denials which may be subject to an external review:

- A denial that involves a finding that services are not medically necessary; or
- A denial that involves a determination that a treatment is experimental or investigational.

The consumer or his authorized representative may file a written request for an external review within 120 days of the date the consumer receives the health carrier's final decision

through the internal appeals process. The notice sent by the health carrier should provide instructions for when and how the request must be filed. One of the Bureau's approved Independent Review Organization's ("IRO") external reviewers is then assigned the external review on a random basis, taking into account any potential conflict of interest. The IRO will issue a final decision within 45 days for a standard external review and within either 72 hours or six days for an expedited review, depending on whether the review relates to a treatment denied on the basis that it is experimental or investigational. The IRO will either uphold the health carrier's denial or overturn it. The health carrier is required by law to accept the external reviewer's decision.

The health carriers responding to the survey reported that 137 external reviews were performed in 2020. Table 7 shows the number of closed external reviews related to medical/surgical, mental health, or substance use disorder benefits and the results of those external reviews. Figures 15 and 17 demonstrate the frequency with which denials were upheld or overturned in external reviews for medical/surgical benefits, mental health benefits, and substance use disorder benefits. As shown in Figure 16, there were no external review decisions regarding mental health or substance use disorder that resulted in a denied appeal being partially upheld during 2020.

Table 7. Closed External Reviews

Closed External Reviews	Number Related to Medical/ Surgical Benefits	Number Related to Mental Health Benefits	Number Related to Substance Use Disorder Benefits
External Reviews – Denial Upheld	**75**	**6**	**2**
External Reviews – Denial Partially Upheld	**2**	**0**	**0**
External Reviews – Denial Overturned	**60**	**0**	**0**
Total Closed External Reviews	**137**	**6**	**2**

Figure 15. Closed External Reviews - Denial Upheld

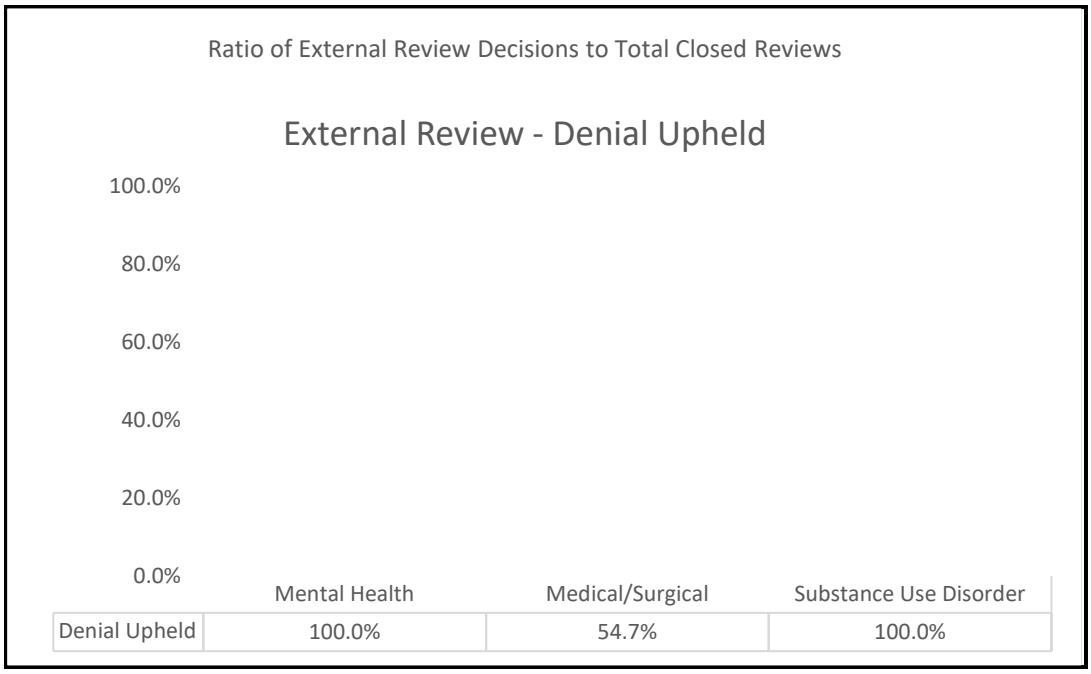


Figure 16. Closed External Reviews – Denial Partially Upheld

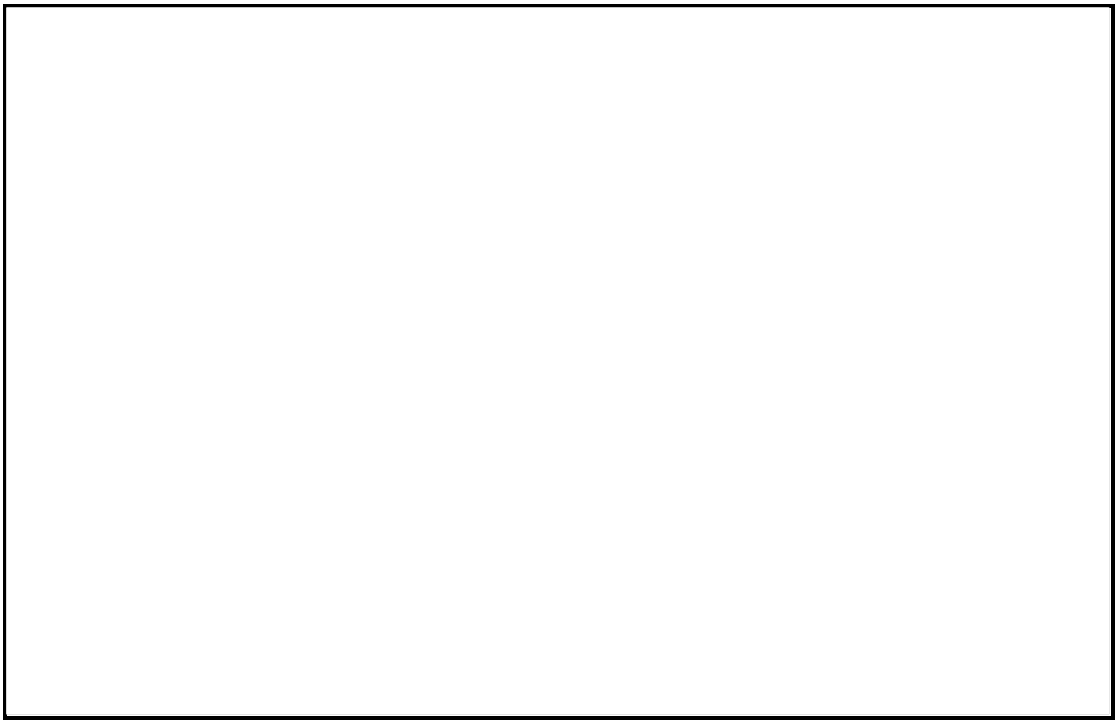
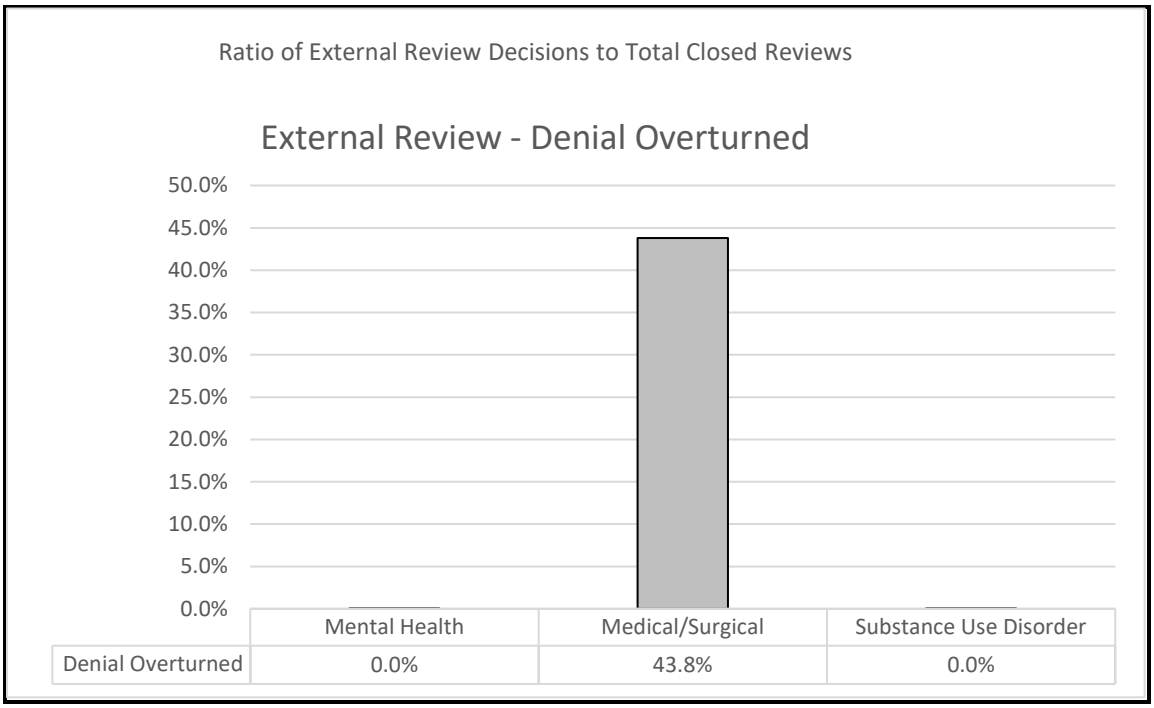


Figure 17. Closed External Reviews – Denial Overturned



Conclusion

This report provides an overview of how health carriers respond to submitted claims, complaints received, and requests regarding health benefit plan enrollees' appeals of a coverage denial as an internal appeal or external review insofar as the claim, complaint or appeal was related to a health care service for medical/surgical benefits, mental health benefits, or substance use disorder benefits.

The carriers reported that of some four million denied claims, 12.2% were denied for health care services relating to mental health benefits (11.0%) or substance use disorder benefits (1.2%). When comparing the ratio of denied claims to total claims by type, mental health claims are denied at a higher rate (13.4%) than substance use disorder claims (12.8%) and medical/surgical benefits claims (10.7%). The aggregated data in the report shows that depending on the type of claim (office visits, other outpatient claims, inpatient claims, emergency care claims or outpatient prescription drug transactions), claims were generally denied more frequently for mental health benefits (4 of 5 categories) and substance use disorder (5 of 5 categories) than claims for medical/surgical benefits. The denial rate for outpatient prescription drug transactions relating to medical surgical benefits (20.2%) was the only category greater than the denial rate for mental health benefits (18.3%).

There was a total of 3,278 complaints reported as received in 2020 with 168 complaints (5.1%) representing a complaint on mental health or substance use disorder benefits. Of these, the largest complaint category was utilization management (39), while the fewest complaints were received in the category concerning practitioners or providers (2).

The carriers reported 251 closed internal appeals of claim denials for mental health or substance use disorder benefits with 145 (57.8%) having the denials upheld. Of the remaining closed internal appeals, the claim denial was overturned in 94 cases with 12 partially overturned. There were eight closed external reviews where all eight (100%) had the denial upheld.

The information requested and obtained was based on the carriers' data recorded and provided to the Bureau for the calendar year ending December 31, 2020. The information presented in this report is on an aggregated basis. Given that, it is difficult to provide an overall conclusion whether all carriers are complying with statutory requirements relating to parity. However, with the data obtained for this report, the Bureau continues to examine individual

carrier mental health parity practices through its Life and Health Market Conduct Section.

Attachment A

Claim Denial Reasons

Carriers were asked to report to the Bureau the total number of claims denied for which the denial would leave the member responsible for payment and to identify the top three denial reasons in each of the three benefit categories: Medical/ Surgical ("M/S"), Mental Health ("MH") and Substance Use Disorder ("SUD").

Carriers reported that a total of 3,716,950 denials out of the 4,041,253 total claims denials reported in "Section I. Claims" could be attributed to each carrier's top three claim denial reasons. This means that 324,303 reported claim denials were for reasons other than each carrier's top three reasons.

Table A-1. shows the top three claim denial reasons across all carriers surveyed by the number of claim denials in each benefit category. [1]

Table A-1. Top Three Denial Reasons by Ranking

Denial Reason by Benefit Category	Number of Denials	Rank	% of Total by Category Table A-3
Medical/Surgical			
Prescription refill too soon	960,874	1	29%
Services not preauthorized/Referral not obtained	908,147	2	28%
Exceeds benefit limits (contractual)	609,282	3	19%
Mental Health			
Prescription refill too soon	209,469	1	49%
Exceed benefit limits (contractual)	75,916	2	18%
Individual ineligible/not insured when the services were provided	60,859	3	14%
Substance Use Disorders			
Individual ineligible/not insured when the services were provided	6,847	1	24%
Not a covered benefit/service contractually excluded	3,932	2	14%
Provider not participating with the individual's plan (See Note 1)	3,474	3	12%

For purposes of the report, the Bureau consolidated the reasons reported by carriers as the top three claim denial reasons into six general categories. Table A-2. shows those denial reasons reported by carriers and organizes those reasons into general categories. Table A-3. shows the number of all denied claims attributable to each general category, broken down by benefit category.

[1] Note: In approximately 38% of the denials, the third-ranked reason for SUD claims shown in Table A-1 were reported by a single carrier writing "narrow-network" coverage in Virginia in 2020.

Table A-2. Denial Reasons 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

Table A-3. Number of Claims Denied by General Categories

General Categories	All	M/S	MH	SUD
	3,716,950	**3,264,764**	**424,090**	**28,096**
Non-covered benefits or services	1,920,522	1,782,155	125,842	12,525
Prescription drug services	1,295,193	1,023,383	270,328	1,482
Preauthorization or precertification	139,866	126,132	9,962	3,772
Provider or administrative billing	224,584	208,737	9,819	6,028
Non-participating providers or out of network/service area	118,815	108,307	6,854	3,654
Medical necessity or inappropriate service	17,970	16,050	1,285	635

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

ADDENDUM

Network Adequacy Parity Analysis

Senate Bill 280 (2020 Acts of Assembly Chapter Text (CHAP0847) added a network adequacy reporting requirement to the previously developed reporting requirements.

The Bureau looked to the information contained in the Annual Mental Health Parity (MHP) data call to attempt to answer the question of network adequacy in the context of mental health parity.

Complaint information is collected separately for

- Medical/Surgical (M/S) Benefits,
- Mental Health (MH) Benefits, and
- Substance Use Disorders (SUD).

Comparing the complaint ratios for access to health services between these three categories could point to possible disparities in mental health or substance use disorder network adequacy if the ratio of complaints is higher for these categories than it is for medical surgical and there are a sufficient number of complaints for results to be credible.

Claims Data Table 1

Category	Total Claims Presented in 2020	% of Total Claims Presented in 2020	Total Complaints in 2020	Ratio of Complaints to Total Claims
M/S	33,084,633	89.9%	3,186	1 in 10,384
MH	3,318,147	9.0%	112	1 in 29,626
SUD	381,354	1.0%	27	1 in 14,124
Total	**36,784,134**	**100%**	**3,325**	**1 in 11,063**

According to this data, 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 disparate treatment, although the number of complaints for mental health and substance use disorders remains very low.

The data call also collects information on consumer complaints broken down into subcategories, including one related to access to health services. This category includes out-of-network service provision, availability and timeliness of appointments, and availability of providers, all of which can lend insight into network utilization and adequacy. Complaint Data Table 1 shows the access to health services complaints.

Complaint Data Table 1

Complaint Type	Mental Health	Medical/Surgical	Substance Use Disorder
Access to Health Care Services	18.8% 21 of 112	11.6% 371 of 3,186	0% 0 of 27

The mental health complaint ratio is 1.6 times that of the medical/surgical ratio (down from 3 times in the previous report). However, the fact that there were only 21 total mental health complaints and zero substance use disorder complaints related to Access to Health Care Services, raises credibility issues that prevent concluding the existence of outright disparity from this single observation.

Research into network adequacy determination for any service points to in-network (INN) versus out-of-network (OON) provider availability as a significant part of any discussions of network adequacy and ultimately mental health and substance use disorder parity. In recognition of this, the Bureau, with input from the health carriers, developed a supplemental data call issued in addition to the call producing the above data. This data call is intended to provide information to see if 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, broken out by medical/surgical, mental health, and substance use disorders the number of unique individual or group providers or facilities in-network, in-network and receiving any payment in 2020, out-of-network and receiving payment in 2020, and out-of-network and denied payment for being out-of-network in 2020.

The data call was based on the logic that potential disparities could be identified if provider networks did not include sufficient numbers of providers for patients to easily access care. This is important because the collected information, as well as the previous report, only dealt with complaints, which did not provide sufficient information to conclude that networks were disparately inadequate to the point of denying access to care.

Carriers were also asked to identify if their networks had received accreditation from any of the nationally recognized accreditation organizations.

The Bureau's data call was due August 1, 2020 and was sent to the same 16 carriers reporting data under the existing data call.

One of the primary problems in identifying the network adequacy for each carrier is that many mental health professionals also provide substance use disorder services, which could result in double counting with one provider being identified twice.

Network Adequacy Table 1:

A.			B.	C.	D.	E.
% of INN Providers receiving Payment in 2020 (Active Participants)			% of OON Providers Paid	% of OON Providers Denied Payment Due to being Out-of-Network	# Members per Month to the # of INN Providers	% of Total Claims in 2020
M/S	58.7%		9.9%	2.7%	106	89.9%
MH	59.1%		11.7%	1.5%	353	9.0%
SUD	54.7%		2.6%	0.4%	645	1.0%

Network adequacy measurements can be skewed if only a fraction of providers listed as in-network providers are treating patients. To measure this factor, the Bureau requested information from health carriers on the total number of providers in-network, along with the number of the in-network providers actually paid for services in 2020. This information is shown in Column A as a percentage of the total network. The highest active provider participation is for mental health, with medical/surgical and mental health still showing nearly the same percentage of network providers with active participation. From this information, the Bureau does not see anything in this factor that would point to network disparity issues.

The Bureau also asked for information to identify, 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 has the lowest level of providers paid out-of-network, with medical/surgical considerably higher, and mental health the highest. This confirms that it is the most difficult for a consumer to find their desired mental health 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. Medical/surgical has the highest number, with mental health and substance use disorder trailing behind correspondingly.

Column D shows that the number of members to each substance use disorder in-network provider is six times the number of members to each medical/surgical in-network provider. The number of members to mental health and substance use disorder providers in-network is about three and a half times that of medical/surgical providers. This is not unfavorable when compared to the fact that, as shown in column E of Table 1, medical/surgical benefit claims are filed at a rate of one substance use disorder claim to nine mental health claims to 90 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.

Conclusion

This is the Bureau's and the carrier's second data collection effort to assist in determining if network adequacy parity between Medical/Surgical, Mental Health, and Substance Use Disorder benefits exists. A number of the measured indicators have seen significant drops in numbers – both the total number of claims files and the number of complaints filed are down. Due to the uncertain impact COVID-19 has had on how consumers have sought and obtained medical care, it remains unclear whether the data received from 2020 is providing clear indications of no disparity. In addition, current network adequacy determination philosophy integrates time of travel measurements as a part of determining adequacy. At this time, the Bureau is investigating the feasibility of measuring this element in its continuing Mental Health and Substance Use Disorder network adequacy studies and discussions in preparation for future reporting.