2022
Report

Claims - Complaints - Appeals

Mental Health, Substance Use Disorder Benefits and Network Adequacy

For the Period January 1, 2021 - December 31, 2021

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

November 1, 2022

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219
TELEPHONE: (804) 371-9741
scc.virginia.gov

November 1, 2022

Transmitted via Email

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

The Honorable Kathy J. Byron
Chair, Commerce and Energy Committee
Virginia House of Delegates

Members of Senate Commerce and Labor Committee

Members of the House Commerce and Energy Committee

Dear Chairs Saslaw and Byron:

Pursuant to § 38.2-3412.1 G of the Code of Virginia, the State Corporation Commission, submits this report on health carriers regarding denied claims, complaints, appeals, and network adequacy involving coverage of mental health and substance use disorder benefits.

Respectfully submitted,

Scott A. White
Commissioner of Insurance
State Corporation Commission Bureau of Insurance

Executive Summary

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

- develop reporting requirements for health carriers regarding denied claims, complaints, appeals, and network adequacy involving coverage of mental health and substance use disorder benefits;
- provide a report of the information gathered by November 1 of each year;
- post the report on the Bureau's website; and
- submit the report to the House Committee on Commerce and Energy and the Senate Committee on Commerce and Labor.

In order to gather the necessary information to fulfill the reporting requirements under § 38.2-3412.1 G of the Code, the Bureau developed a survey in collaboration with the Virginia Department of Behavioral Health and Developmental Services, the Virginia Association of Health Plans ("VAHP") and health carriers that are not members of VAHP. Through this survey, the Bureau receives information[1] to help it analyze: (a) whether health carriers ensure that 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; and (b) whether health carriers provide reasonable access to network providers of mental health and substance use disorder services in parity with access to network providers of medical/surgical services.

The Bureau surveyed 16 health carriers, each identified as insuring more than 5,000 lives in Virginia in the individual, small group, and large group health insurance markets during the 2021 calendar year. In total, these carriers reported more than 1.68 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, for these three benefit categories, carriers were required to

report data for the 2021 calendar year for:

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

This report provides an overview of the information obtained through the survey, broken down into four sections. Key takeaways include the following:

- Claims were generally denied more frequently for mental health and substance use disorder benefits than for medical/surgical benefits.
- Complaints concerning access to care was the reason provided most often regarding mental health benefits and substance use disorder benefits.
- Denied claims for mental health or substance use disorder benefits handled internally by a health carrier were upheld in the majority of internal appeals. Closed external reviews were upheld in a larger majority for these benefits than for medical/surgical benefits.
- Network adequacy parity or comparison of access to network providers for mental health, substance use disorder or medical/surgical services cannot be reasonably determined based on information submitted by the health insurance carriers.

Finally, the 2022 General Assembly amended the reporting requirements under § 38.2-3412.1 G of the Code to include a summary of all comparative analyses prepared by health insurance carriers pursuant to 42 U.S.C. § 300gg-26(a)(8). Since this amendment was not effective until July 1, 2022, this summary will be included in next year's report due November 1, 2023.

[1] To protect the confidentiality of individual members and health carriers, 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 39,900,793 claims received, with 5,436,821 (13.63%) claims denied. This is a higher denial rate from the previous report's denial rate of 11.99%.

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 claim categories: office visit claims, all other outpatient claims, inpatient claims, emergency care claims, and outpatient prescription (rx) drug transactions. Tables 1, 2, and 3 show the results.

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	9,904,137	9,192,504	711,633	7.2%
All Other Outpatient Claims	11,826,312	11,101,146	725,166	6.1%
Inpatient Claims	1,092,638	953,571	139,067	12.7%
Emergency Care Claims	899,888	836,800	63,088	7.0%
Outpatient Rx Drug Transactions	11,752,607	8,646,264	3,106,343	26.4%
Totals:	35,475,582	30,730,285	4,745,297	13.4%

Table 2. Claims Overview – Mental Health Benefits

Claim Category: Mental Health Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	726,992	676,049	50,943	7.0%
All Other Outpatient Claims	739,617	691,375	48,242	6.5%
Inpatient Claims	54,260	48,158	6,102	11.2%
Emergency Care Claims	47,143	44,447	2,696	5.7%
Outpatient Rx Drug Transactions	2,181,051	1,688,911	492,140	22.6%
Totals:	3,749,063	3,148,940	600,123	16.0%

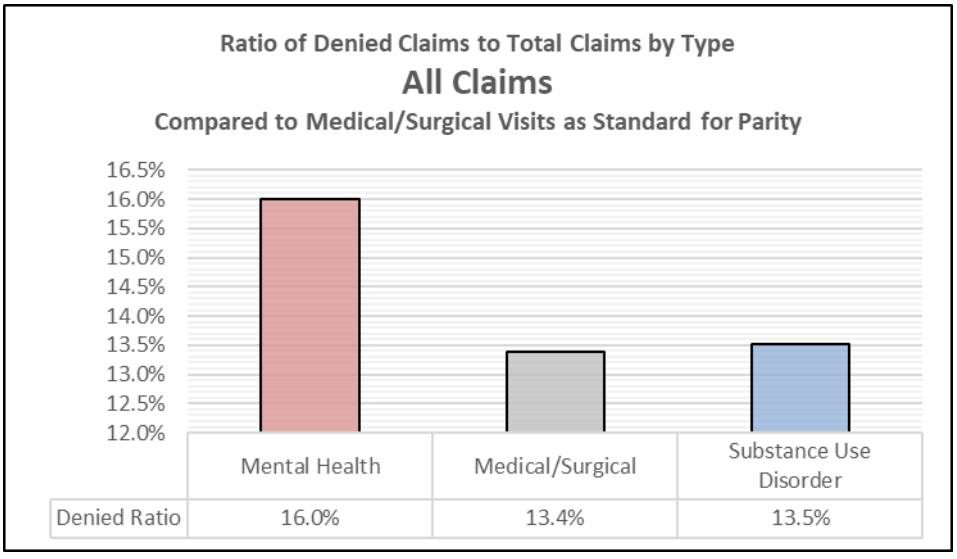
Table 3. Claims Overview – Substance Use Disorder Benefits

Claim Category: Substance Use Disorder Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	328,599	296,510	32,089	9.8%
All Other Outpatient Claims	219,200	193,231	25,969	11.8%
Inpatient Claims	45,162	36,318	8,844	19.6%
Emergency Care Claims	19,804	16,707	3,097	15.6%
Outpatient Rx Drug Transactions	63,383	41,981	21,402	33.8%
Totals:	676,148	584,747	91,401	13.5%

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 rates for claims related to mental health benefits and substance use disorder are respectively 2.6% and 0.1% greater than that for medical/surgical benefits. This represents a decrease from the previous report where these respective all-claim denial rates were 2.7% and 2.1% greater than the denial rate for medical/surgical.

Figure 1. Denied Claims Ratio – All Claims



Claim denials were further broken down by the type of service and benefit category. Figure 2 shows that the denial ratios for office visit claims (such as physician visits) related to mental health is 0.2 % less and for substance use disorder 2.6% greater than the denial ratio for medical/surgical office visits.

The previous report showed these respective denial ratios to be 0.7% and 1.1% greater than that for medical/surgical claims.

Figure 2. Denied Claims Ratio – Office Visit Claims

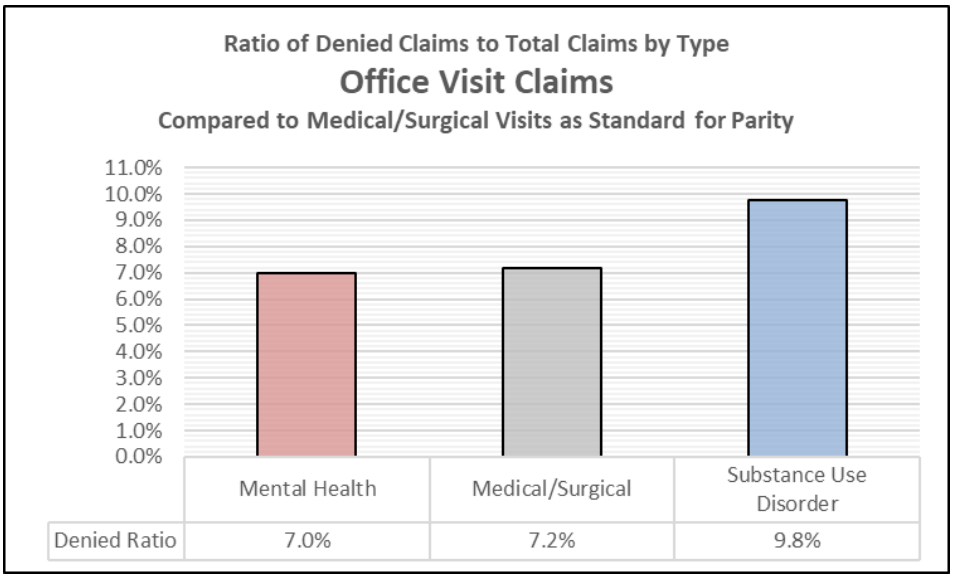


Figure 3 shows the denial ratios for all other outpatient claims to be 0.4% and 5.7% greater for mental health and substance use disorder, respectively. The previous report showed these respective denial ratios to be 0.5% and 6.8% greater than that for medical/surgical claims.

Figure 3. Denied Claims Ratio – All Other Outpatient Claims

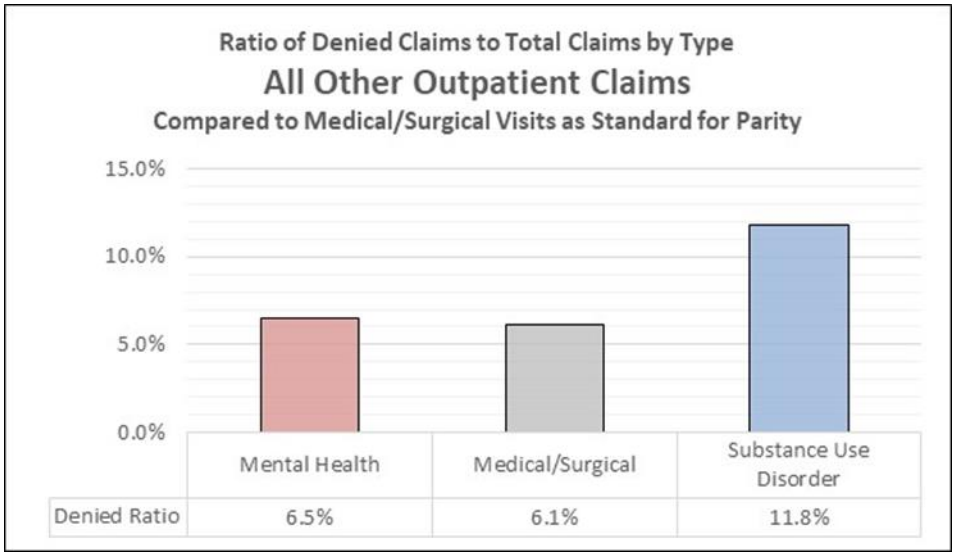


Figure 4 shows that the Inpatient Claims denial ratio is 1.5% lower for mental health and 6.9% greater for substance use disorder than the denial ratio for medical/surgical claims. The previous report showed these respective denial ratios to be 2.3% and 7.7% greater than that for medical/surgical claims.

Figure 4. Denied Claims Ratio – Inpatient Claims

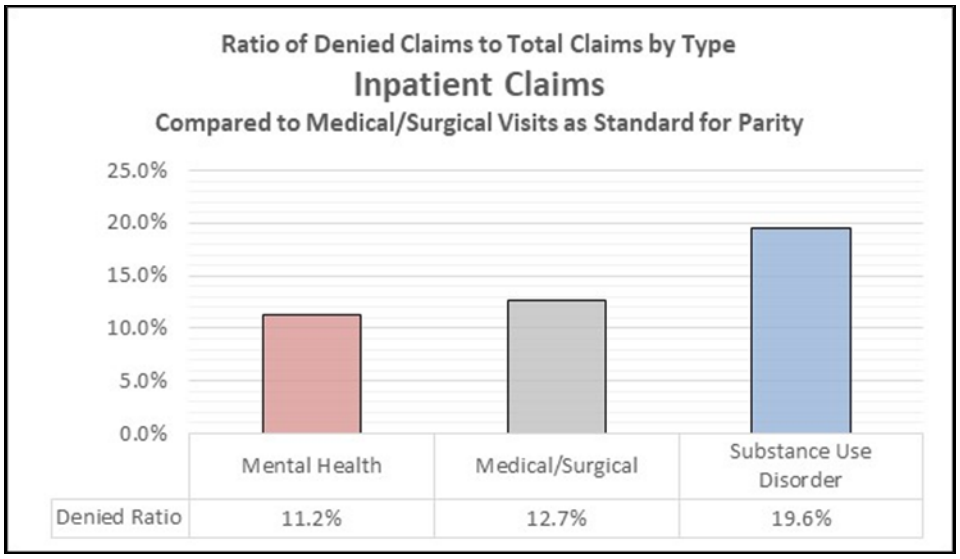


Figure 5 shows that the Emergency Care Claims denial ratio is 1.3% lower for mental health and 8.6% greater for substance use disorder than the denial ratio for medical/surgical claims. The previous report showed the respective denial ratios to be 0.8% and 5.9% greater than that for medical/surgical claims.

Figure 5. Denied Claims Ratio – Emergency Care Claims

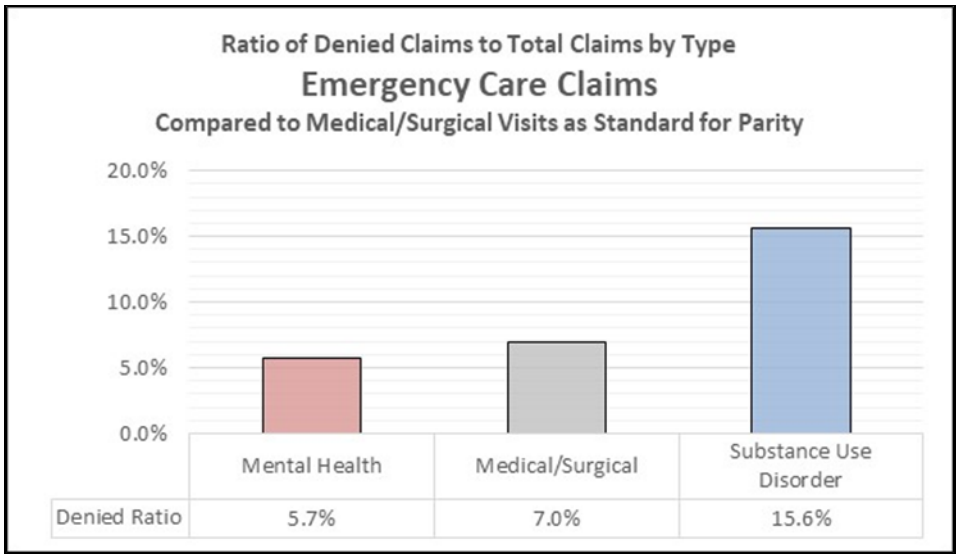
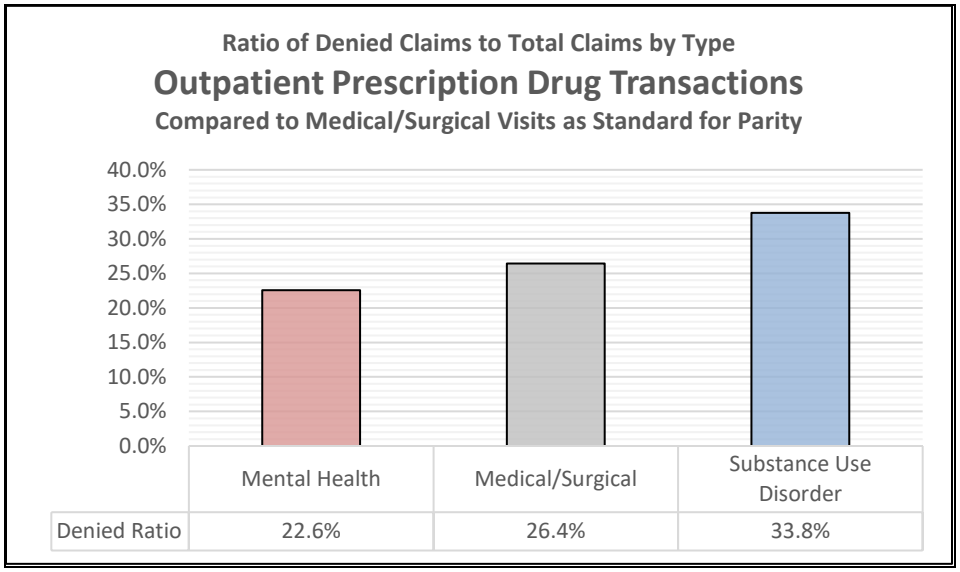


Figure 6 shows that the Outpatient Prescription Drug Transactions denied claims ratio is 3.8% lower for mental health and 7.4% greater for substance use disorder than the denial ratio for medical/surgical claims. The previous report showed these respective denial ratios to be 1.9% lower and 10.2% greater than that for medical/surgical claims.

Figure 6. Denied Claims Ratio – Outpatient Prescription Drug Transactions



Reasons for Claim Denial

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, mental health, and substance use disorder.

Carriers reported that a total of 3,817,457 denials out of the 5,436,821 total claims denials reported in "Section I. Claims" could be attributed to each carrier's top three claim denial reasons. This means that 1,619,364 reported claim denials were for reasons other than each carrier's top three reasons.

Table 4 shows the top three claim denial reasons across all carriers surveyed by the number of claim denials in each benefit category.[2]

Table 4. Top Three Denial Reasons by Ranking

Reason for Denial by Benefit Category	Number of Denials	Rank	% of Total by Category
Medical/Surgical			
Prescription refill too soon	1,062,969	1	32%
Not a covered benefit/service contractually excluded	926,998	2	16%
Exceeds benefit limits (contractual)	525,332	3	1%
Mental Health			
Prescription refill too soon	237,176	1	53%
Exceeds benefit limits (contractual)	73,295	2	16%
Individual ineligible/not insured when the services were provided	39,365	3	9%
Substance Use Disorders			
Individual ineligible/not insured when the services were provided	10,625	1	28%
Not a covered benefit/service contractually excluded	6,910	2	18%
Provider not participating with the individual's plan (See Note 2)	3,350	3	5%

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 5 shows the number of all denied claims attributable to each general category, broken down by benefit category.

Table 5. Number of Claims Denied General Categories

General Categories	All	M/S	MH	SUD
	3,817,457	**3,329,007**	**451,375**	**37,075**
Non-covered benefits or services	1,873,926	1,728,772	126,626	18,528
Prescription drug services	1,335,157	1,067,056	266,603	1,498
Preauthorization or precertification	50,477	42,968	4,159	3,350
Provider or administrative billing	271,788	220,264	43,810	7,714
Non-participating providers or out of network/service area	144,149	133,680	8,262	2,207
Medical necessity or inappropriate service	141,960	136,267	1,915	3,778

Attachment A provides a breakdown of the six general categories that shows how a carrier may attribute a reason for a particular claim denial.

---

[2] Note: In approximately 38% of the 3,350 denials, the third-ranked reason for substance use disorder claims shown in Table 4 was reported by a single carrier writing narrow-network coverage in Virginia in 2020.

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 2021, as well as the number of complaints the carrier closed during 2021. A total of 10,182 submitted complaints were reported by the 16 carriers completing the survey. In the previous report, there were 3,278 complaints reported for 2020. This is also significantly less than the 10,812 complaints reported in the report for the year ending 2019. This drop in reported complaints 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 compliant areas are further explained in Attachment B of the report.

Table 6 shows the number of complaints for each complaint area and whether or not the complaint was related to a medical/surgical benefit, mental health benefit, or substance use disorder benefit. Table 7 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 6. 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	847	809	145	139	1	1	993	949
Utilization Management	1,384	1,354	54	53	8	8	1,446	1,415
Practitioners/ Providers	105	99	2	2	0	0	107	101
Administrative/ Service	3,467	3,288	111	109	5	4	3,583	3,401
Claims Processing	4,046	3,980	7	7	0	0	4,053	3,991
Totals	**9,849**	**9,530**	**319**	**310**	**14**	**13**	**10,182**	**9,853**

Table 7. Ratio of Complaints to Their Respective Totals

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	8.6%	8.5%	45.5%	44.8%	7.1%	7.7%	9.8%	9.6%
Utilization Management	14.1%	14.2%	16.9%	17.1%	57.1%	61.5%	14.2%	14.4%
Practitioners/ Providers	1.1%	1.0%	0.6%	0.6%	0.0%	0.0%	1.1%	1.0%
Administrative/ Service	35.2%	34.5%	34.8%	35.2%	35.7%	30.8%	35.2%	34.5%
Claims Processing	41.1%	41.8%	2.2%	2.3%	0.0%	0.0%	39.8%	40.5%
Totals	**9,849**	**9,530**	**319**	**310**	**14**	**13**	**10,182**	**9,853**
Ratio to All Complaints	**96.8%**	**96.7%**	**3.1%**	**3.1%**	**0.1%**	**0.1%**	**100.0%**	**100.0%**

Complaint Ratios

Figures 7 through 11 demonstrate how the different areas of complaints reported for the year ending 2021 for mental health or substance use disorder benefits compare to the same complaint areas for medical/surgical services, which services comprised 96.8% of all complaints. For example, of the total complaints that carriers received for medical/surgical benefits, 8.6% pertained to access to health care services, whereas 45.5% of the total complaints carriers received for mental health benefits were due to access to health care services. At the same time, 7.1% of complaints reported for 2021 were related to access to care for substance use disorder benefits; utilization management produced the greatest percentage, 57.1%, of complaints in this benefit category.

Attachment B of the report provides examples of the type of complaints that fall into the five categories. Figures 7 through 11 illustrate the respective complaint ratios for the year ending 2021.

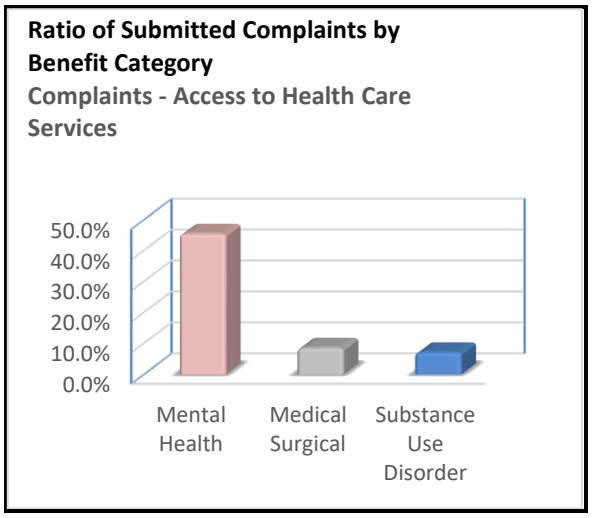


Figure 7. Access to Health Care Services Complaints

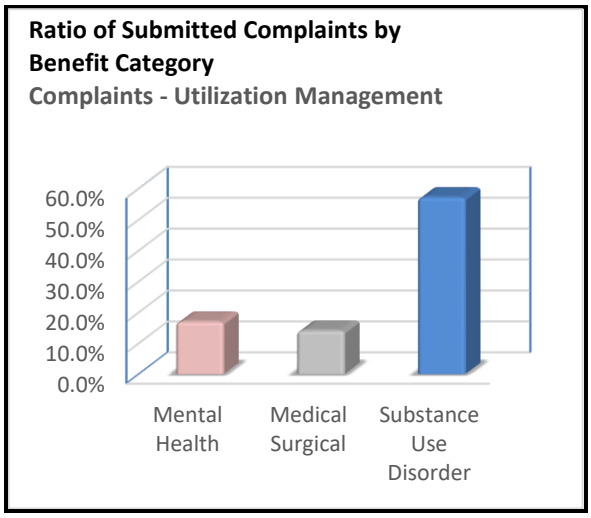


Figure 8. Utilization of Management

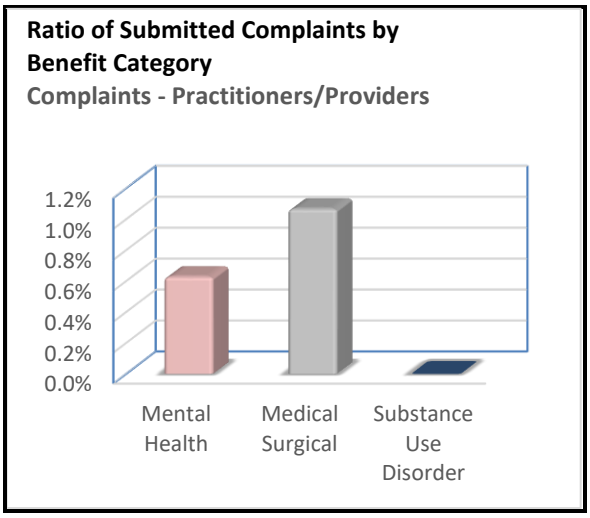


Figure 9. Complaints Practitioners/Providers

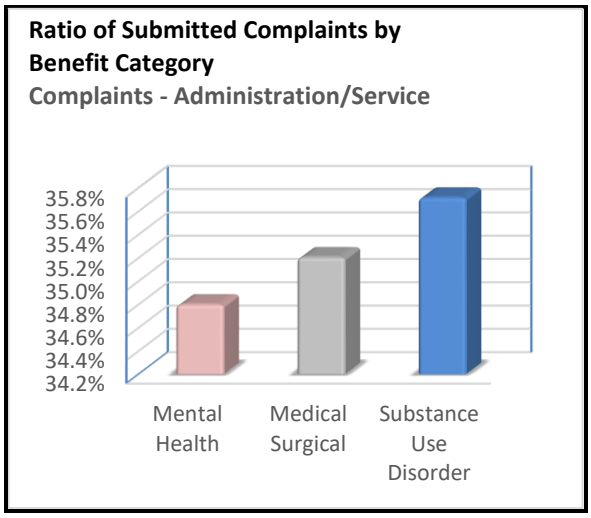


Figure 10. Administrative/Services

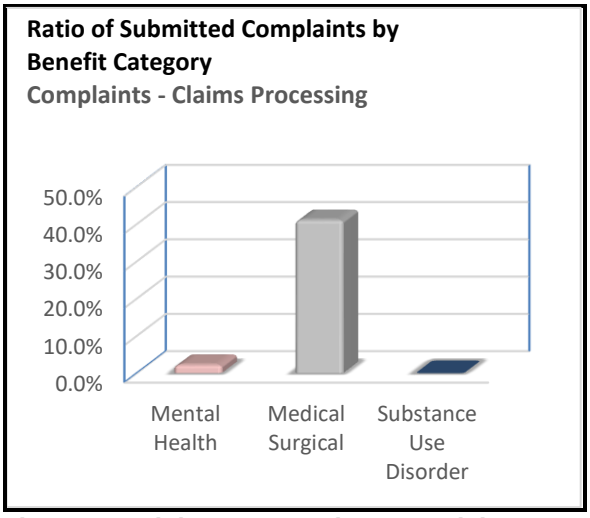


Figure 11. Claims Processing Complaints

Section III. Appeals

Overview

If a health insurer denies a health care service claim payment there are two ways the denial decision may be appealed: (a) through the health carrier's internal review process, or (b) through an external process using independent reviews of the denial outside that of the health carrier.

An internal appeal is filed by a healthcare provider or consumer to obtain approval for services that a managed care health insurance plan (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 consumer 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 consumer or the healthcare provider can request an urgent care appeal. In such a case, the MCHIP has 72 hours to make a decision. Appeals seeking a prescription to alleviate cancer pain must be responded to within 24 hours.

When a consumer with a fully insured Virginia policy receives a denial after completing the health carrier's internal appeals process, an external review, facilitated by the Bureau, may be available. An expedited external review process, including an option that does not require the person to exhaust the internal appeals process, is available in certain situations. There are two kinds of denials which may be subject to external review:

- A denial that services are not medically necessary; or
- A denial because services are experimental or investigational.
- The denial notice sent by the health carrier should provide forms and instructions for filing the eternal review request.

The consumer or "covered person" or authorized representative must file a written request for an external review within 120 days of the date the consumer receives the

health carrier's final decision. If eligible, the Bureau will assign the external review to an approved Independent Review Organization. The assignment will be made on a random basis, only taking into account any potential conflict of interest. The Independent Review Organization will issue a final decision within 45 days for a standard external review and within either 72 hours or six days for an expedited external review, depending on the reason for the denial. The Independent Review Organization will either uphold the health carrier's denial or overturn it. This decision is binding on the health carrier, and on the covered person, except to the extent that the covered person has other remedies under state or federal law.

Internal Appeals

The health carriers responding to the survey reported that a total of 9,557 internal appeals were processed and closed in 2021, an increase from 5,523 closed in 2020. Table 8 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 through14 demonstrate the appeal outcome for the three benefit categories.

Table 8. 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	5,894	120	34
Internal Appeals – Denial Partially Upheld	228	1	6
Internal Appeals – Denial Overturned	3,170	86	18
Total Closed Internal Appeals	9,292	207	58

Figure 12. Closed Internal Appeals – Denial Upheld

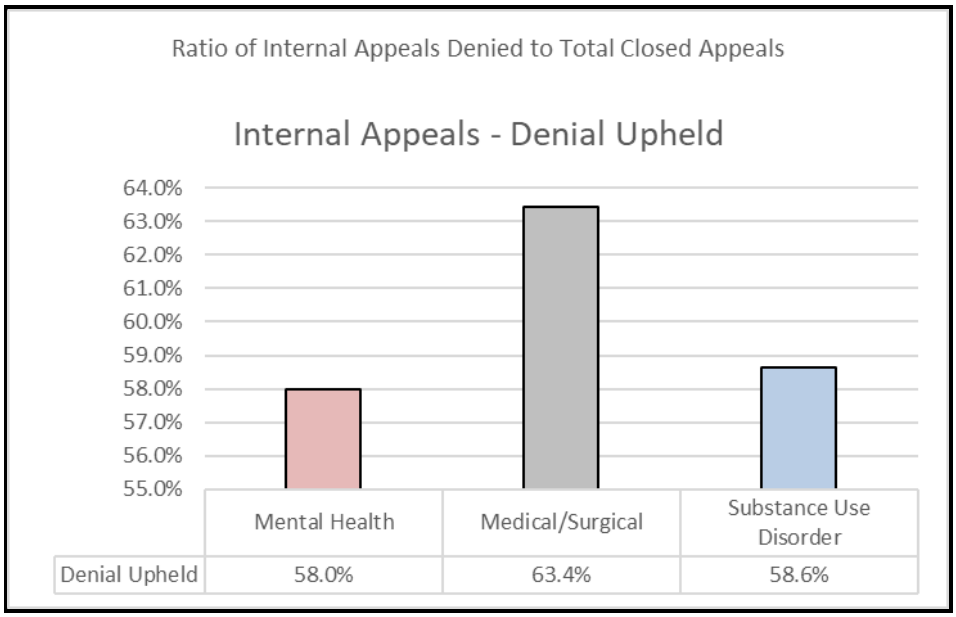


Figure 13. Closed Internal Appeals – Denial Partially Upheld

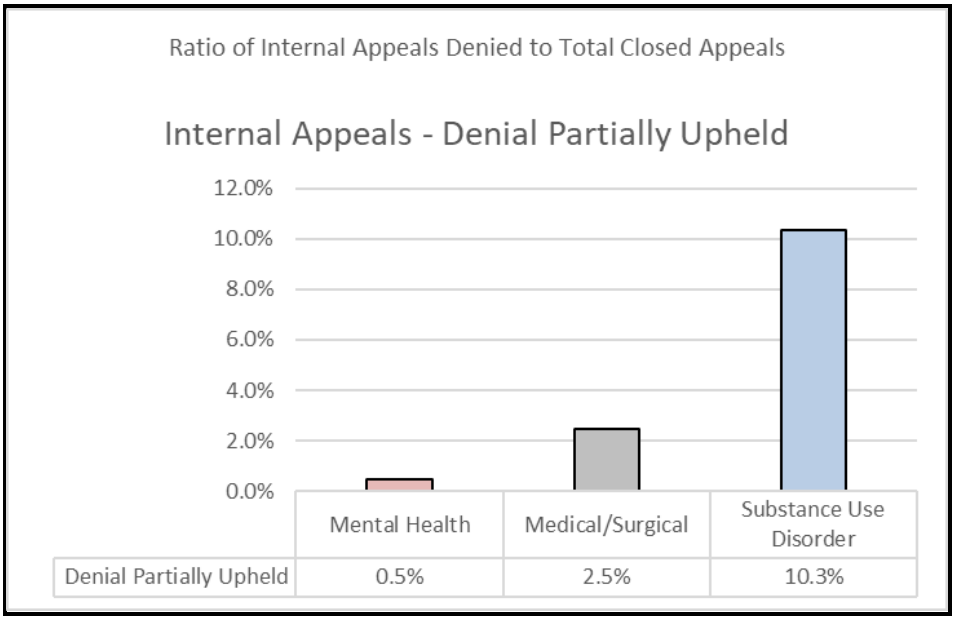
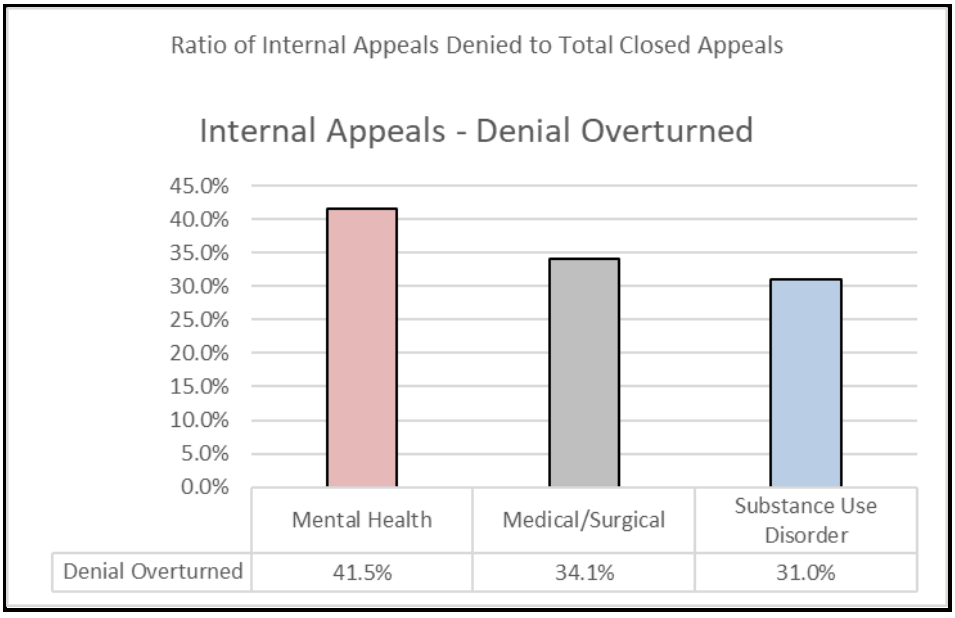


Figure 14. Closed Internal Appeals – Denial Overturned



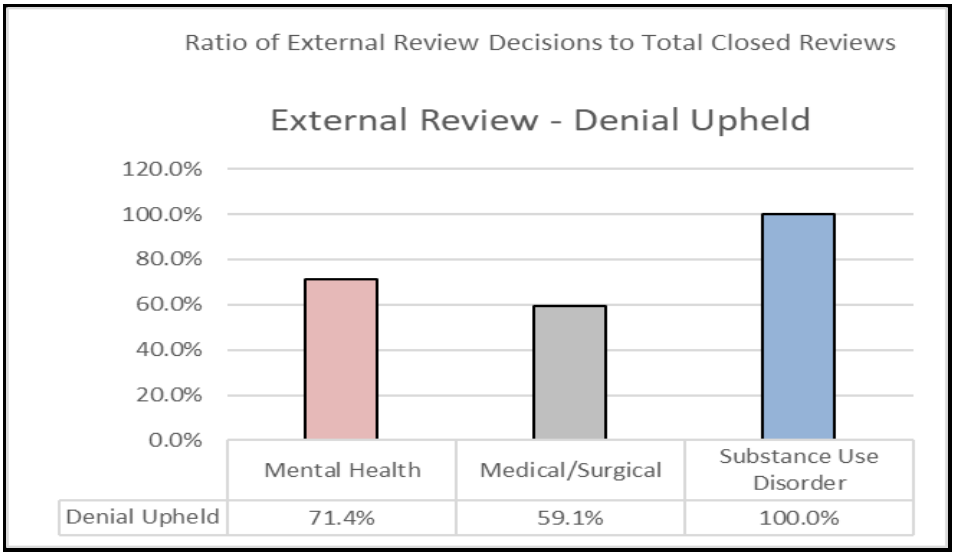
External Review

The health carriers responding to the survey reported that 194 external reviews were performed in 2021. Table 9 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 through 17 demonstrate the frequency with which denials were upheld or overturned for medical/surgical benefits, mental health benefits, and substance use disorder benefits. As shown in Figures 16 and 17, there were no decisions regarding substance use disorder that resulted in a denied appeal being partially upheld or overturned during 2021.

Table 9. 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	110	5	1
External Reviews – Denial Partially Upheld	1	1	0
External Reviews – Denial Overturned	75	1	0
Total Closed External Reviews	186	7	1

Figure 15. Closed External Reviews - Denial Upheld



16. Closed External Reviews – Denial Partially Upheld

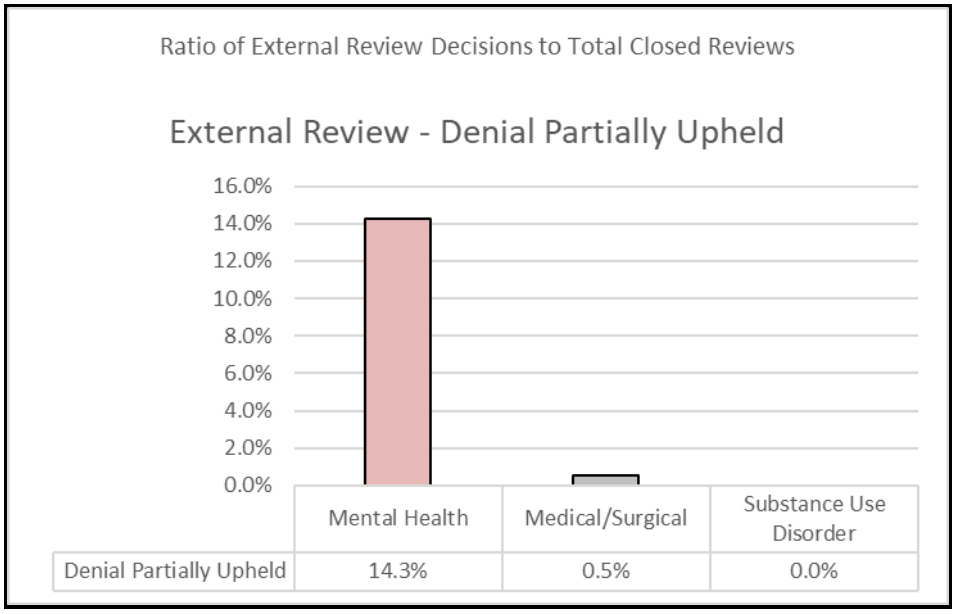
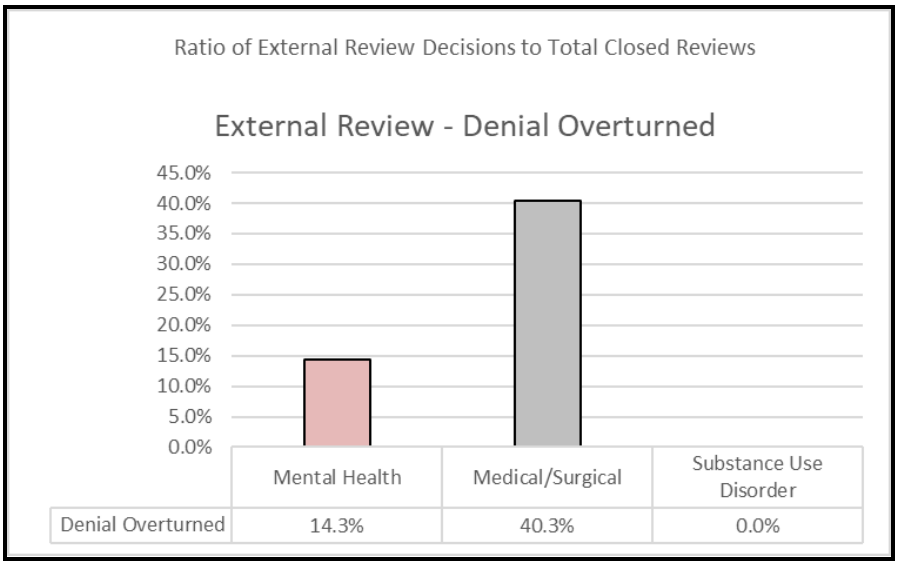


Figure 17. Closed External Reviews – Denial Overturned



Section IV. Network Adequacy

Overview

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all other health care services included under the terms of the contract. To date, determining network adequacy has remained an elusive endeavor. This is due to several factors, including:

- There is no national standard for network adequacy and the standards that do exist vary significantly across states and types of coverage.
- Evaluation of health plan networks relies on plan provider directory data which may be inaccurate or out of date.
- No national standard for the accuracy of information in health plan provider network directories exists.
- There is no standard measure of network size or breadth, nor any way for consumers or regulators to easily discern differences in network size.

With measurement of network adequacy elusive, determining parity between medical/surgical, mental health, and substance use disorder network services provisions has yet to be solved by any accurate measure.

Network Adequacy Parity Analysis

In the past, the Bureau has compared complaint ratios to analyze parity of network adequacy between these three categories, which 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 benefits and there are enough complaints for results to be credible.

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

Table 10. Comparison to Total Claims

Category	Total Claims Presented in 2021	% of Total Claims Presented in 2021	Total Complaints in 2021	Ratio of Complaints to Total Claims
Medical/Surgical	35,475,582	88.9%	9,849	1 in 3,602
Mental Health	3,749,063	9.4%	319	1 in 11,753
Substance Use Disorder	676,148	1.7%	14	1 in 48,296
Total	**39,900,793**	**100%**	**10,182**	**1 in 3,919**

In contrast, Table 11 shows the subcategory of access to health care services complaints by type of benefit provided. 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.

Table 11. Complaints - Access to Health Care Services

Complaint Type	Mental Health	Medical/Surgical	Substance Use Disorder
Access to Health Care Services	45.5% 145 of 319	8.6% 847 of 9,849	7.1% 1 of 14

The mental health complaint ratio for the access to health care services subcategory is 5.0 times that of the medical/surgical ratio (up from 1.6 times in the 2021 report and up from the 3.0 times reported in the 2020 report). However, outliers in a survey are problematic for accurate results. Health carriers with a narrow-network plan of limited providers have been identified that make up the majority of complaints in this category while only insuring some ten percent of the covered lives included in this report. This type of outlier provides a concern for the ratio results and the Bureau will be conducting reviews of these health insurance carriers.

Research into network adequacy determination for any service points to in-network (INN) versus out-of-network (OON) provider availability is 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 was 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 INN; INN and receiving any payment in 2021; OON and receiving payment in 2021; and OON and denied payment for being OON in 2021.

The data call was based on the logic that potential disparities could be identified if provider networks did not include enough providers for patients to easily access care for each of the three benefit categories. This is important because the previously collected information only dealt with complaints, which did not provide sufficient information to conclude that networks were 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. Carrier responses to this question were mixed, with approximately three quarters indicating that their provider networks had received accreditation from the National Committee for Quality Assurance (NCQA).

The Bureau's network data call was due August 1, 2022, and was sent to the same 16 carriers reporting data under the existing data call. COVID-19 continues to impact the information technology resources of many businesses, including health insurance carriers.

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 measurements can be skewed if only a fraction of providers listed as INN providers are treating patients.

Table 12 shows how this factor may be measured. The Bureau compared information on the total number of INN providers, along with the number of INN providers actually paid for services in 2021.

Table 12. Network Adequacy

A.		B.	C.	D.	E.
% of INN Providers receiving Payment in 2021 (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 2021
Medical/Surgical	58.3%	10.7%	2.6%	81	90.0%
Mental Health	59.8%	11.4%	1.3%	212	8.8%
Substance Use Disorder	53.0%	4.7%	0.7%	239	1.2%

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 analyzed information identifying, when compared to INN provider payments, the extent to which members go to OON 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 more difficult for a consumer to find their desired mental health provider INN than for either of the other two categories.

Column C shows the percentage of OON 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 mental health and substance use disorder provider INN is about three times that of members to each medical/surgical provider. This is not unfavorable when compared to the fact that, as shown in column E of Table 12, medical/surgical benefit claims are filed at a much higher rate. There is one substance use disorder claim for every nine mental health claims and every 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 report provides an overview of how health carriers respond to submitted claims, complaints received, and enrollees' appeals of coverage denials for medical/surgical benefits compared to mental health and substance use benefits. Additionally, the report looks at enrollee access to provider networks by comparing the rate of healthcare access complaints and provider payment denials between medical/surgical providers and providers of mental health and substance use disorder services.

The report demonstrates that claims were generally denied less frequently (3 of 5 categories) for mental health benefits and more frequently (5 of 5 categories) for substance use disorder than claims for medical/surgical benefits. However, in total all claims were denied more frequently for mental health and substance use disorder benefits than claims for medical/surgical benefits.

Most mental health complaints concerned access to health care while the most complaints for substance use disorders concerned practitioners or providers.

Closed internal appeals of claim denials for mental health or substance use disorder benefits had the denials upheld in more than half of the cases, 58%. Closed external reviews had the denial upheld in three-quarters of the cases, 75%.

This is the Bureau's and the carriers' third data collection effort to assist in determining if network adequacy parity exists between medical/surgical, mental health, and substance use disorder benefits. Due to the continued uncertain impact that COVID-19 has had on how consumers have sought and obtained medical care, it remains unclear whether the data received from 2021 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. With the numerous discussions at both the federal and state regulatory levels, the Bureau is continuing to participate in discussions and is monitoring methods to incorporate network adequacy measurements for use in future determinations of mental health and substance use disorder parity.

The information presented in this report is on an aggregated basis. Given that, it is difficult to provide an overall conclusion as to 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 and substance use

disorder parity practices through its Life and Health Market Conduct Section.

Attachment A
Reasons for Denial by General Category

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

Attachment B
Complaint Areas

	A. Access to Health Care Services
1	Geographic access limitations to providers and practitioners
2	Availability of Primary Care Providers/Specialists/Behavioral and Mental Health Providers
3	Primary Care Provider after-hour access
4	Access to urgent care and emergency care
5	Out of network access
6	Availability and timeliness of provider appointments and provision of services
7	Availability of outpatient services with the network (to include home health agencies, hospice, labs, physical therapy, and radiation therapy)
8	Enrollee provisions to allow transfers to another Primary Care Provider
9	Patient abandonment by Primary Care Provider
10	Pharmaceuticals (based upon patient's condition, the use of generic drugs versus brand name drugs)
11	Access to preventative care (immunizations, prenatal exams, sexually transmitted diseases, alcohol, cancer screening, coronary, smoking)

	B. Utilization Management
1	Denial of medically appropriate services covered within the enrollee contract
2	Limitations on hospital length of stays for stays covered within the enrollee contract
3	Timeliness of preauthorization reviews based on urgency
4	Inappropriate setting for care, i.e. procedure done in an outpatient setting that should be performed in an inpatient setting
5	Criteria for experimental care
6	Unnecessary tests or lack of appropriate diagnostic tests
7	Denial of specialist referrals allowed within the contract
8	Denial of emergency room care allowed within the contract
9	Failure to adequately document and make available to the members reasons for denial
10	Unexplained death
11	Denial of care for serious injuries or illnesses, the natural history of which, if untreated are likely to result in death or to progress to a more severe form
12	Organ transplant criteria questioned

	C. Practitioners/Providers
1	Appropriateness of diagnosis and/or care
2	Appropriateness of credentials to treat
3	Failure to observe professional standards of care, state and/or federal regulations governing health care quality
4	Unsanitary physical environment
5	Failure to observe sterile techniques or universal precautions
6	Medical records - failure to keep accurate and legible records, to keep them confidential and to allow patient access
7	Failure to coordinate care (example - appropriate discharge planning)

	D. Administrative/Health Carrier Service
1	Inadequate, incomplete, or untimely response to concerns by health carrier staff
2	Conflict of application of health carrier policies and procedures with evidence of coverage or policy
3	Breach of confidentiality
4	Lack of access/explanation of to health carrier complaint and grievance procedures
5	Incomplete or absent health carrier enrollee notification
6	Plan documents (evidence of coverage, enrollment information, insurance card) not received
7	Enrollee did not understand available benefits
8	Enrollee claimed plan staff members were not responsive to request for assistance, or phone calls or letters were not answered
9	Marketing or other plan materials was not clear
10	Complaints and appeals, formal or informal, were not responded to within required time frames, or were not adequately answered

	E. Claim Processing, unrelated to utilization review
1	Claim not paid in full, unrelated to utilization review decision
2	Claim not paid in a timely manner
3	Claim processed incorrectly, or an incorrect copayment or deductible was assessed
4	Claim was denied because of pre-existing condition
5	Enrollee held responsible contrary to “hold harmless” contractual agreement between the health plan and provider
6	Usual, Customary and Reasonable determination unreasonable