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

May 31, 2024

MENTAL HEALTH PARITY 2024

2023 Plan Year

I. Introduction.

This Mental Health Parity Report for the 2023 Plan Year (2024 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. Code St. R. §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 2024 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.

There are both federal and state-based laws related to mental health parity that form the source for the annual data call and reporting requirements.

A. West Virginia law

In 2020, West Virginia passed a state "Mental Health Parity Law" (Senate Bill 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 (Report).

B. Federal law

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

[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).

reimbursement rates paid to a provider or facility, or provider network adequacy).[3] Plans and issuers that impose FRs, QTLs, and NQTLs must meet specific tests to be in compliance with the law and its regulations.[4] 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.[5]

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.[6] 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 as explained below.

1. 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.[7] 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.

---

[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 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] Please note, on July 25, 2023, the United States Departments of Labor, Health and Human Services, and Treasury proposed a new rule to strengthen enforcement of MHPAEA and assure that patients have access to medically necessary MH/SUD services. Since the new proposed rule is not final, the contents of the new proposed rule have not been considered in the review of Carrier responses or the 2024 Report.

[5] 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 and comparability and no more stringency). A plan cannot subclassify benefits for purpose of FRs and QTLs and not subclassify benefits for NQTLs. See 45 CFR 146.136(c)(3)(iii).

[6] 42 USC 300gg-26(a)(3)(A) and 45 CFR 146.136(c)(3).

[7] 42 USC 300gg-26(a)(3)(A).

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.

2. 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.[8]

Specifically, the CAA provides that plans must "perform and document comparative analyses of the design and application of NQTLs." The *comparative analyses* must *demonstrate:*[9]

> …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.[10]

The terms of the CAA require that group health plans and health insurance issuers perform the

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

comparative analyses in a manner which demonstrates compliance with MHPAEA's NQTL rule by providing the following five required information elements (the "Required Steps") as follows:

> **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;[11]
>
> **Required Step 2:** The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical/surgical benefits;[12]
>
> **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;[13]
>
> **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;[14] 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.[15]

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 connected and inter-related and each requirement is necessary for establishing compliance. Therefore, if a plan fails to meet any one of the Required Steps, it is itself a failure to provide the required information and conclusively demonstrate compliance through its comparative analysis.

III. OIC Annual Data Calls

In order to fulfill its statutory obligations, the OIC annually issues a data call to the state regulated health plans and health insurance issuers ("carriers") in West Virginia which includes information and reporting requests that are 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 ("Data Call"). The Data Call requires the Carriers to complete a Carrier Information Worksheet 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

[11] 42 U.S.C. 300gg-26(a)(8)(A)(i).
[12] 42 U.S.C. 300gg-26(a)(8)(A)(ii).
[13] 42 U.S.C. 300gg-26(a)(8)(A)(iii).
[14] 42 U.S.C. 300gg-26(a)(8)(A)(iv).
[15] 42 U.S.C. 300gg-26(a)(8)(A)(v).

used in making utilization management decisions. The Carriers must also complete a workbook to report information regarding the Carrier's FRs and QTLs and provide their comparative analyses that they have developed for each NQTL identified by the Carrier in the Carrier Information Worksheet, using a form provided by the State that comports with the Required Steps ("Required Reporting Form"). The Required Reporting Form requires the Carrier to demonstrate compliance for each NQTL by benefits classification or subclassification, if applicable, to demonstrate compliance via the Required Steps.

A. 2023 Data Call and Market Conduct Examinations

On March 20, 2023, the OIC issued the Data Call to the Carriers, requesting information and data for the 2022 plan year ("2023 Data Call"). After reviewing responses from the Carriers, the OIC issued its Report to the Joint Committee on Government and Finance on May 31, 2023 ("2023 Report").[16] Among other things, the 2023 Report generally concluded that the top 5 Carriers in West Virginia, providing coverage to 98% of the commercial market, did not sufficiently demonstrate that each NQTL imposed by the Carrier complied with the Required Steps, and therefore, did not demonstrate compliance as stipulated by 42 U.S.C. Section 300gg-26(a)(8)(A)(i)-(v) or the Mental Health Parity Law. As a result, following the issuance of the 2023 Report, the OIC worked extensively with the Carriers to identify and resolve MH/SUD parity compliance issues. Additionally, to ensure future compliance and potentially penalize past non-compliance, on September 1, 2023, the OIC commenced Market Conduct Examinations on four of the top 5 Carriers to collect and review materials related to the Carriers' compliance with MHPAEA and the Mental Health Parity Law for the period commencing January 1, 2022, through December 31, 2022 (Market Conduct Examination). At this time, the Market Conduct Examinations are ongoing, but should be completed in summer 2024. The OIC is committed to addressing any parity concerns raised by the Market Conduct Examinations.

As part of the Market Conduct Examinations, the OIC requested that four Carriers submit NQTL comparative analyses for all the NQTL imposed by the Carriers on MH/SUD and medical/surgical benefits. In response, the four Carriers submitted the exact same or substantially similar comparative analyses as the comparative analyses submitted as part of the 2023 Data Call and were found to not sufficiently demonstrate compliance with the law in the 2023 Report. The four Carriers were informed that their NQTL comparative analyses submissions were insufficient and, in an effort to provide an opportunity to correct the insufficiency, the Carriers were offered an opportunity to correct their comparative analyses and instructed to submit revised comparative analyses as part of the 2024 Data Call. To assist Carriers with compliance, the OIC offered the plans extensive guidance and opportunities to meet and discuss the guidance and ask questions related to compliance with federal and state laws prior to the submission.[17] Three of the four Carriers accepted the offer to discuss the guidance with the OIC and other subject matter experts. Carrier A did not.

During the ongoing Market Conduct Examinations, timeliness and notice issues have been

[16] See a copy of the 2023 Annual Report.

[17] One plan did not respond to the offer to meet with the OIC to discuss issues with the guidance provided or ask questions relate to revisions to their NQTL comparative analyses but the three other plans attended meetings with the OIC.

noted in regard to responses from all Carriers. Similar violations of W.Va. Code R. §§114-64-6.3.1, 114-64-6.3.2 and 114-64-6.3.3 have existed throughout the reviews. The reviews of the MH/SUD and autism claims have revealed that the Carriers failed to include the required notice language, explaining the covered person's right to contact the Consumer Services Division of the West Virginia Offices of the Insurance Commissioner under state and federal law, and/or failed to include the complete required contact information of the WVOIC.

Several Carriers appear to be non-compliant with requirements for adverse determinations to display notices in non-English languages. Multiple Carriers may be in violation of W.Va. Code R. §§114-95-7.3.b. Similarly, with respect to appeals, the Carriers failed to provide the information listed in W.Va. Code R. §114-96-5.8 in a culturally and linguistically appropriate manner in accordance with federal regulations. The adverse determination letters did not contain a way in which the member could be provided the required information in a non-English language.

During autism claim reviews, a violation of W.Va. Code St. R. §§114-14-4.1 and 4.2 may have been noted for failing to provide a clear and understandable explanation of benefits to the member. The explanations did not contain an adequate description of the services rendered; the procedure codes were mapped to generic explanations. For example, there was an evaluation of speech service shown as "services rendered."

There were also potential violations of W.Va. Code §33-24-7u identified "in practice" and "as written," during autism claim reviews. Certificates of Coverage were found which stated, "Applied Behavior Analysis - $30,000 Maximum per year." Multiple instances of failure to provide coverage for applied behavior analysis (ABA) were identified. Coverage up to the annual maximum benefit of $30,000.00 per individual was provided, but the claims submitted once the maximum benefit was exceeded were denied. Applying a maximum benefit limit is a quantitative treatment limitation.

Potential violations of W.Va. Code §33-25A-8r(d) have been identified when a Carrier failed to provide inpatient treatment of substance use disorders when a member's physician, psychologist or psychiatrist determined the treatment to be medically necessary.

There are pharmacy formulary, quantity limits and other potential violations identified in each of the Carriers' plans. Examples of the potential violations of W.Va. Code §33-24-7r(k) and W.Va. Code §33-24-7u(c) are listed below:

> **Buprenorphine Tablets (Quantity Limits)**
> The Carrier placed a quantity limitation on a medication, Buprenorphine tablets**,** used in the treatment of opioid dependence. Prior authorization was required to receive amounts higher than the restricted amount of 3 tablets per day.
>
> **Lucemyra (Non-Formulary)**
> The Carrier required prior authorization prior to coverage of a medication used for the treatment of opioid withdrawal. Lucemyra is used in conjunction with other medications in the treatment of substance use disorder.

Narcan/Naloxone/Kloxxado (Quantity Limit)
The Carrier placed a quantity limitation on Narcan, Naloxone, and Kloxxado during the examination period. All three medications are used for the emergency treatment of known or suspected opioid overdose. From January to October, the Carrier limited a member to two packages of medication in 180 days. In October, the quantity limit was changed from two per 180 days to two per 25 days. Despite the change, the Carrier still imposed a quantity limitation on the medications. The policy restricted access and availability to life saving treatment.

Naloxone Quantity Limit (Parity)
The Carrier place a quantity limit on Narcan, Naloxone, and Kloxxado during the examination period. A comparable medication in the medical/surgical world is Epipen. The Carrier limited a member to two packages per 25 days of Epipen. However, from January to October, the Carrier limited a member to two packages per 180 days on Narcan, Naloxone, and Kloxxado. The quantity limit is more restrictive to substance use disorder medications.

Naloxone Excluded from Mail Order Benefits (Parity)
The Carrier did not allow a member to fill Narcan/naloxone via the mail order benefit, but allowed members to fill Epipen via mail order. The benefit design was not applied in the same manner to substance used disorder medications.

Smoking Cessation Medication (Quantity Limits)
All medications used for assistance in smoking cessation were limited to 180 days. After the two 90-day treatments would be used, the patient was required to get a prior authorization for coverage. The Carrier imposed a quantity limitation on substance use disorder medications (nicotine patches/gum/lozenges, Chantix, bupropion SR (Zyban), and Nicotrol).

Suboxone (Non-Formulary)
The Carrier required prior authorization for the coverage of Suboxone. Suboxone is for the treatment of opioid dependence.

Suboxone, Zubsolv, Buprenorphine/ Naloxone Tablets and Films (Quantity Limit)
The Carrier imposed a quantity limitation on Suboxone, Zubsolv, Buprenorphine/naloxone tablets and films. To receive doses higher than the quantity limit, patients were required to obtain prior authorization. Higher dosages are used for patients that have a higher tolerance to opioids or abused heroin and/or fentanyl.

Desvenlafaxine Quantity Limit (Parity)
The Carrier restricted Desvenlafaxine to one tablet per day.

Desvenlafaxine is an antidepressant used for the treatment of depression. The FDA approved maximum dose is 400mg per day. The highest quantity commercially available is 100mg. The Carrier has no comparable policies where prior authorization is needed to obtain the FDA allowed maximum dose.

Sublocade (Non-Formulary)
The Carrier required prior authorization for coverage of Sublocade. Sublocade is a specialty medication in the form of an injection given at a provider's office. Sublocade is indicated for the treatment of moderate to severe opioid use disorder.

Suboxone, Zubsolv, Buprenorphine/Naloxone Tablets (Quantity Limit)
The Carrier limited Suboxone, Zubsolv, Buprenorphine/naloxone tablets to a supply limit of 30 days only. When compared to medication comparable in nature, Butrans (buprenorphine) indicated for the use in pain was not limited to a 30-day supply.

Buprenorphine Tablets (Non-Formulary)
The Carrier required prior authorization for the coverage of buprenorphine tablets. Buprenorphine is used for the treatment of opioid dependence. This medication is usually used during the induction phase of therapy or used for patients that are pregnant. The alternatives are not pregnancy safe.

Vyvanse Non-Formulary (Parity)
The Carrier required prior authorization for the coverage of Vyvanse. Vyvanse is the only medication FDA approved for binge eating disorder, a mental health disorder. The Carrier did not have any other instances where 100% of the FDA approved medications for a medical/surgical diagnosis were not on the formulary.

Zubsolv (Non-Formulary)
The Carrier required prior authorization for the coverage of Zubsolv. Zubsolv is for the treatment of opioid dependence.

Interrelated Finding (Monetary Incentive for Using Mail Order Pharmacy)
The Carrier provided the consumer with a monetary incentive to use its mail order services. The Carrier used a 2.5x copay at mail order and 3x copay at retail for 90-day supplies. This may be a violation of state Pharmacy Benefit Manager/Freedom of Choice laws.

Aripiprazole (Parity)
The Carrier created a barrier to access by subjecting a medication that is a standard of care for treatment of schizophrenia, and mania prevention in bipolar disorder to a prior authorization. The Company

required a doctor to submit documentation to show the medical necessity of the medication for a patient with schizophrenia and manic bipolar disorder.

Rexulti (Parity)
The Carrier implemented the design of a more restrictive step therapy policy on a mental health medication, Rexulti, when compared to step therapy policies designed for medical/surgical medications.

Qelbree (Parity)
The Carrier implemented the design of a more restrictive step therapy policy on a mental health medication, Qelbree, when compared to step therapy policies designed for medical/surgical medications.

Suboxone Quantity Limit (Parity)
The Carrier imposed more restrictive quantity limitations on Suboxone, Zubsolv, Buprenorphine/naloxone tablets and films. When a prior authorization was approved for higher dosage limits, the Carrier imposed only a 30-day approval when used for titration purposes. The policy had prior authorization requirements that were more restrictive in policy design to obtain approval. When compared to Butrans (buprenorphine), which is used for pain, the same policies are designs were not implemented. This is a policy design that is more restrictive in design for substance use disorders.

Smoking Cessation (Quantity Limits)
All medications used for assistance in smoking cessation were limited to 180 days. After the six 30-day treatments would be used, the patient was required to get a prior authorization for coverage. The Carrier imposed a quantity limitation on substance use disorder medications (nicotine patches/gum/lozenges, Chantix, bupropion SR (Zyban), and Nicotrol).

Smoking Cessation Limited to 30-Day Supply Only (Parity)
The Carrier only allowed members to fill medications used for smoking cessation treatment at a 30-day supply. There were no other medications listed on the 30-day restriction list.

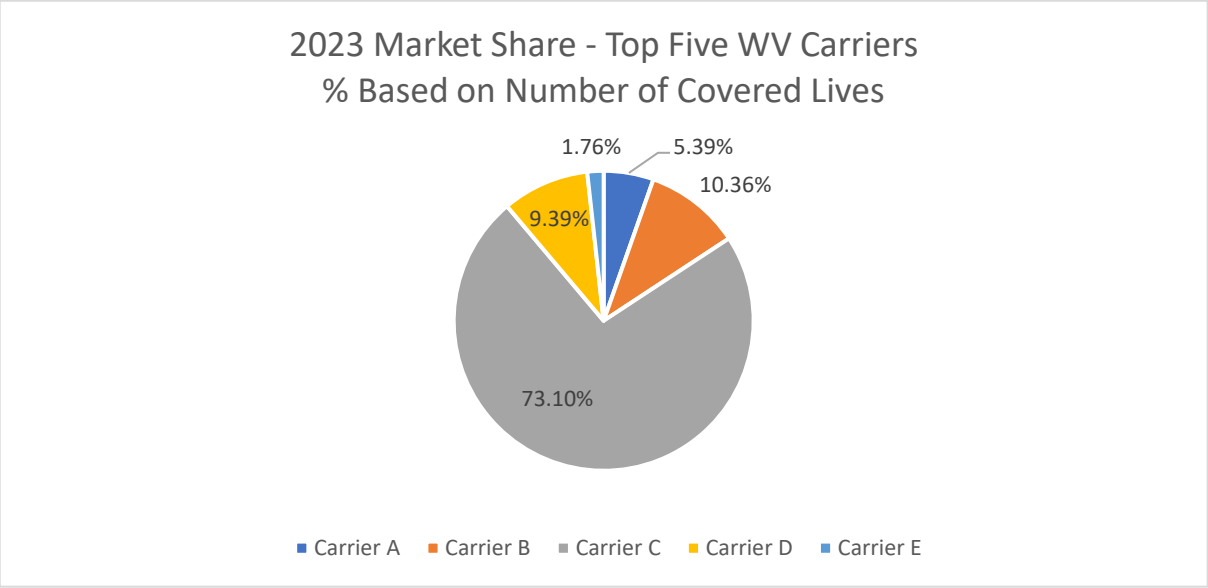
Sublocade (Prior Authorization)
The Carrier required a prior authorization for coverage of Sublocade. Sublocade is a specialty medication in the form of an injection given at a provider's office. Sublocade is indicated for the treatment of moderate to severe opioid use disorder.

Suboxone, Zubsolv and Burprenorphine/Naloxone Tablets and Films 30 Day Fill Per RX (Parity)
The Carrier imposed dispensing limitations on Buprenorphine/naloxone products during the examination period

compared to medical/surgical maintenance medications. The Carrier implemented maximum quantities per prescription that would only amount to a 30- day supply. When asked if any medications were limited to a specific day's supply, the Carrier provided an excel spreadsheet that did not include the buprenorphine products. Furthermore, after review of the policies it shows the opioid dependence medications were restricted to a 30-day supply.

B. 2024 Data Call

On February 9, 2024, the OIC issued another data call to the Carriers, requesting information and data for the 2023 plan year ("2024 Data Call"). The OIC has conducted an initial review of the Carriers' responses to the 2024 Data Call, a summary of the OIC's review and findings is provided below. As with the 2023 Report, the 2024 Report focuses on the top 5 Carriers in West Virginia, providing coverage to 98% of the commercial market.[18] The top 5 Carriers are identified herein as Carriers A, B, C, D and E. 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 results of the OIC's review of the top 5 Carrier submissions is 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.

[18] 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.

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 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. Reasons for a Failure to Demonstrate Compliance.

There are several 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 or subclassification.

ii. The Carrier's comparative analyses do not correlate with the Required Reporting Form or instructions provided by the OIC as part of the 2024 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 identify or 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 did not include data in the comparative analysis or included data with (a) annual, book-of-business data and not data specific to West Virginia plans; (b) data for combined benefits classifications or subclassifications; and/or (c) no explanation or an inadequate

explanation as to how the data was collected or how the data demonstrates compliance with the comparability and equitable stringency application tests.

ix. The Carrier did not provide a detailed discussion of the Carrier's 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. Other Issues Identified

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. Some Carriers failed to submit comparative analyses related to certain NQTLs that they identified and provided in 2023. While Carriers provided the comparative analyses for the NQTLs listed, there are likely to 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:[19]

NQTL	Carrier A[20]	Carrier B	Carrier C	Carrier D[21]	Carrier E[22]
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[23]					
Reimbursement Rates[24]	x	x	x	x	x
Network Adequacy	x			x	x
Experimental/Investigational	x	x	x	x	x
Formulary Development	x	x	x	x	x
Rx Prior Authorization		x	x	x	x
Step Therapy/Fail First	x	x	x	x	
Quantity Limits	x	x	x		
Network Tiering					
Geographic Restrictions					x
Facility Restrictions					
Exclusions		x	x		
Treatment Plan Requirements	x				
Scope Limits					
Expedited Claims					
Coding Edits					x
Sequenced Treatment	x				
Outlier Review Management			x	x	

[19] 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.

[20] Carrier A did not provide comparative analyses for Quantity Limits, Exclusions, Treatment Plan Requirements, or Sequenced Treatment but did provide comparative analyses for these NQTLs in 2023.

[21] Carrier D provided NQTL comparative analyses for Quantity Limits, Network Tiering, Facility Restrictions, Exclusions, Treatment Plan Limitations, Scope Limits and Expedited Claims for the 2023 Data Call but did not provide comparative analyses for these NQTLs in the 2024 Data Call and did not state why it was not submitting them (e.g., these NQTLs are no longer being imposed).

[22] 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.

[23] Carrier C provided a comparative analysis for the fraud waste and abuse program NQTL pursuant to the 2023 Data Call but did not provide a comparative analysis for the NQTL pursuant to the 2024 Data Call.

[24] Carriers A, C and D submitted comparative analyses for in-network and non-participating providers. Carrier B submitted one comparative analysis that is to address in- or out-of-network providers. Carrier E provided comparative analyses for in-network facility and professional reimbursement and out of network reimbursement.

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 sufficiently 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. Four of the five Carriers provided a definition for medical necessity but for Carriers that use vendors to administer the MH/SUD benefit, the Carrier did not specify what the vendor's policies and procedures are with respect to medical necessity and whether the vendor employs the same definition for MH/SUD benefits as the plan uses for medical/surgical benefits. All of the Carriers state that they use nationally recognized, evidence-based clinical criteria (e.g., ASAM, InterQual, LOCUS, CALOCUS, MCG, etc.) and internally developed medical criteria and policies but the Carriers did not provide sufficient responses for all of the Required Steps in order to demonstrate comparability and application stringency. At least one Carrier has stated that it develops criteria for certain MH/SUD benefits (e.g., Applied Behavioral Analysis and Transcranial Magnetic Stimulation) that is more restrictive than criteria applied to other MH/SUD services and develops more restrictive criteria for some medical/surgical services (i.e., breast reconstruction surgery and metabolic and bariatric surgery), but doesn't compare the MH/SUD and medical/surgical criteria in order to demonstrate comparability and application stringency. 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 in order to enable appropriate assessment of Carrier compliance.

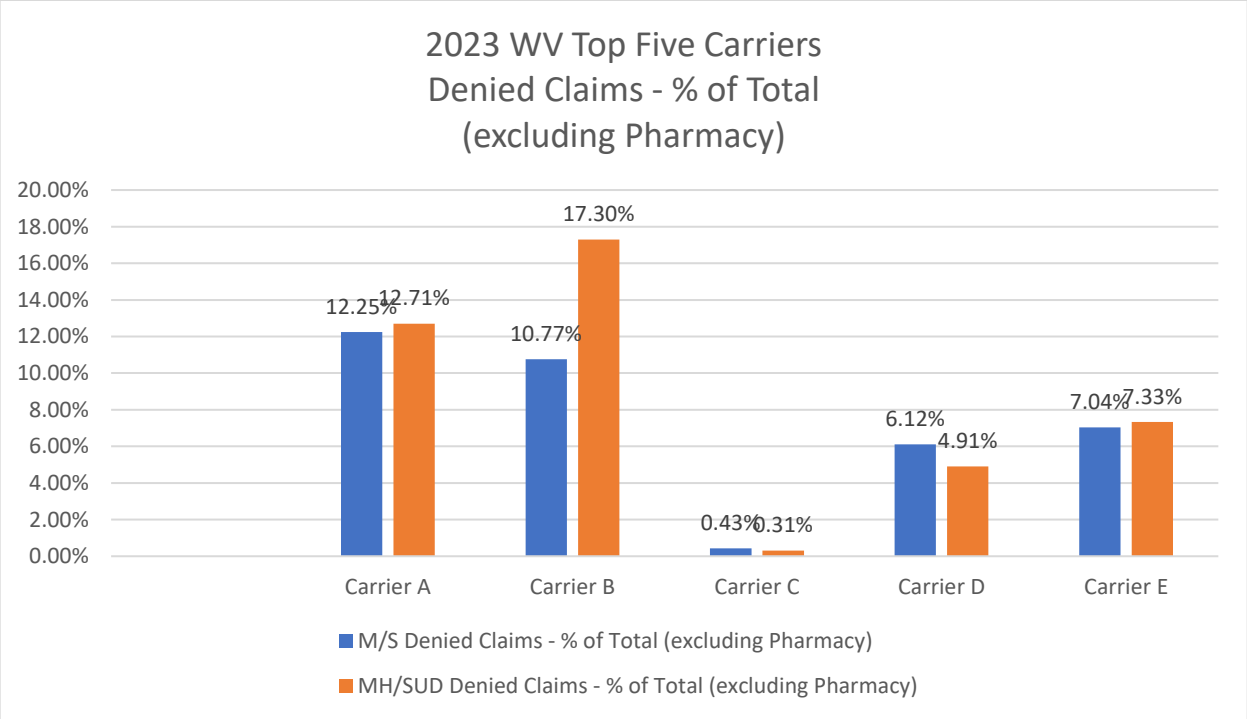
iii. Adverse Determinations

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 represents in a manner which is consistent what the OIC believes 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 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 certain conclusion that any of the Carriers are not in compliance with MHPAEA or the Mental Health Parity Law, but a preliminary finding that further review and analysis are necessary to determine the sufficiency of the comparative analyses and any potential compliance concerns related to NQTLs imposed on MH/SUD benefits.

The OIC's Market Conduct Examinations that were initiated in 2023 as a result of the 2023 Report and 2022 data is ongoing. Once the final report is adopted by the OIC, the findings and any resulting regulatory actions will be made public. Additionally, the 2023 data reporting has

caused the OIC to call a Market Conduct Exam on the fifth carrier that was not identified for examination last year. The results of the OIC's Market Conduct Examinations will likely be revealed one Carrier at a time as the examinations conclude. Depending upon the outcome, further regulatory enforcement actions may be appropriate, including additional examinations for multiple calendar years, monetary penalties or fines, or licensure actions. The OIC looks forward to engaging with the Legislature on this issue and appreciates the opportunity to be of service to West Virginians.