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MENTAL HEALTH PARITY 2025

2024 Plan Year

I. Introduction

This Mental Health Parity Report for the 2024 Plan Year (2025 Report) is in response to the West Virginia Legislature's requirement, pursuant to W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, 33-25A-8u, and W.Va. Rule 114-64-7.3 and 8, that the West Virginia Offices of the Insurance Commissioner (OIC) annually issue a mandatory data call (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 2025 Report addresses State regulated health plans and health insurance issuers' (herein referred to as Carriers) 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 federal and West Virginia state laws related to mental health parity that form the basis for the Data Call and reporting requirements. These laws are detailed below.

A. State Law

In 2020, West Virginia passed a state "Mental Health Parity Law" (S.B. 291). The law 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.[2] 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 provide an annual written report to the Joint Committee on Government and Finance on certain data collection and analyses undertaken by the OIC regarding mental health parity.

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.[3] MHPAEA's regulations address the following types of requirements and treatment limitations: (1) FRs or aspects of plan design that outline cost sharing between the plan and the enrollee (including copayments, coinsurance, deductibles and out-of-pocket limits); (2) QTLs or treatment limitations that are expressed numerically, such as calendar year limits on the number of office visits or inpatient days, or lifetime limits on the coverage of benefits; and (3) NQTLs or limits on the scope or duration of treatment that are not expressed numerically (e.g., medical management techniques like prior authorization, formulary design for prescription drugs, standards for provider admission to a network (including reimbursement rates paid to a provider or facility), provider network adequacy, etc.). Plans and issuers that impose FRs, QTLs, and NQTLs must meet specific tests to be in compliance with the

[1] See 42 USC 300gg-26. See also MHPAEA's Final Regulations at [2013-27086.pdf (govinfo.gov)].
[2] See W.Va. Code §§ 33-15-4u, 33-16-3ff,33-24- 7u, 33-25-8r and 33-25A-8u and W.Va. Code. R. §114-64-1, et seq.
[3] 42 USC 300gg-26(a)(3)(a) and 45 CFR 146.136(b)(1).

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

Once a Carrier separates benefits into benefits classifications, the Carrier must identify every FR, QTL or NQTL which is applied to MH/SUD benefits. If there is no corresponding FR, QTL, or NQTL imposed on the medical/surgical benefit, it is a separate treatment limitation and it expressly violates MHPAEA.[5] However, if the FR, QTL, or NQTL applies to both MH/SUD and medical/surgical benefits, the plan must determine if the applicable FR, QTL, or NQTL meets the compliance tests required by the law and its regulations 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.[6] An FR or QTL is considered to apply to substantially all of the medical/surgical benefits in a benefits classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. If the FR or QTL type does not apply to substantially all of the medical/surgical benefits in that benefits classification, the type of FR or QTL cannot be applied to the MH/SUD benefits in the classification.

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

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 benefits in any classification unless, under

[4] MHPAEA's Final Rules permit three sub-classifications that were established to accommodate plan design features. These subclassifications are multi-tiered prescription drug benefits, multiple network tiers, and office visits, separated from other outpatient services. Once a subclassification is established by a plan or issuer, it must perform the appropriate parity analysis within the subclassification to determine its compliance with MHPAEA's tests (i.e., substantially all and predominant 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).

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

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

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 the demonstration of compliance through 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 (Treasury) (the DOL, DHHS, and Treasury are collectively referred to herein as the "Departments") released Frequently Asked Questions (FAQ 45) on April 1, 2021, to provide important guidance to plans in conducting and documenting what comprises a sufficient comparative analysis.[7] The stipulations provided in FAQ 45 set forth governing principles respecting the Information Elements and define whether the Information Elements of a comparative analysis can be deemed sufficient or insufficient.

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

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

The terms of the CAA require that group health plans and health insurance issuers perform the comparative analyses in a manner which demonstrates compliance with MHPAEA's NQTL rule by providing the following five required information elements (the "Information Elements") as follows:

Information Element 1: The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical/surgical benefits to which each such term applies in each benefits classification;[10]
Information Element 2: The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical/surgical benefits;[11]
Information Element 3: The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence

[7]See FAQs-Part-45 (dol.gov).
[8] See 42 U.S.C. 300gg-26(a)(8)(A)(i) - (v). Note, the word "demonstrate," as defined by Merriam Webster, means to show clearly, to prove or make clear by sound reasoning or evidence and to illustrate and explain especially with many examples.
[9] 42 U.S.C. 300gg-26(a)(8)(A)(iv)).
[10] 42 U.S.C. 300gg-26(a)(8)(A)(i).
[11] 42 U.S.C. 300gg-26(a)(8)(A)(ii).

relied upon to design and apply the NQTLs to MH/SUD benefits and medical/surgical benefits;[12]

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

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

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

On September 23, 2024, new final regulations were issued, amending the existing MHPAEA regulations and adding new regulations related to the CAA's comparative analysis requirements. 45 CFR 146.137(c) provides that NQTL comparative analyses demonstrate compliance with the Information Elements through six required steps (the Steps), as follows:

Step 1: Description of the NQTL 242 U.S.C. 300gg-26(a)(8)(A)(iv);
Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL;
Step 3: Description of how factors are used in the design and application of the NQTL;
Step 4: Demonstration of comparability and stringency, as written;
Step 5: Demonstration of comparability and stringency, in operation; and
Step 6: Findings and conclusions.

For group health plans, 45 CFR 146.137 became effective on January 1, 2025, except for certain provisions related to the prohibition of discriminatory factors and evidentiary standards and relevant data evaluation requirements (which become effective on January 1, 2026). For individual plans, the regulations become effective on January 1, 2026.

On January 17, 2025, the ERISA Industry Committee filed suit in the U.S. District Court for the District of Columbia challenging certain provisions of the final regulations. On May 15, 2025, the Departments issued a Statement which states that they have requested that the litigation be held in abeyance while the Departments reconsider the final regulations and that the Departments will not enforce the final regulations. However, the Departments noted that the statutory obligations, including the CAA's amendments, continue to have effect.

As part of the Data Call, which was published prior to the Statement provided by the Departments, the OIC required Carriers to provide comparative analyses using an NQTL

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

submission form provided in the instructions (the Reporting Form). The Reporting Form reflects the Steps described above. While the regulations, as issued, did not apply to individual plans until 2026 and parts of the regulations did not apply to comparative analyses prepared for the 2024 Plan Year for group plans, it is the position of the OIC that the elements of 45 CFR 146.137(c) do not materially differ than the Information Elements but provided clarity on what the reporting and analysis should have included. In the opinion of the OIC, the regulations did not add any new requirements that the plans and issuers should not have already taken into consideration when preparing its comparative analysis for Plan Year 2024. Nevertheless, in light of the Departments' Statement, the Reporting Forms were reviewed to assess compliance with the Information Elements and consistency with federal guidance, including FAQ 45, and not any new information required by the new regulations.

III. OIC Annual Data Call

In order to fulfill its statutory obligations, the OIC annually issues a Data Call to the 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 of West Virginia and federal mental health parity laws and regulations. The Data Call requires the Carriers to complete a Carrier Information Worksheet in order to report information regarding the plans operated in West Virginia, including claims expense data, vendor and delegate information, adverse determinations, all Carrier identified NQTLs, and medical necessity criteria used in making utilization management decisions. The Carriers must also complete a workbook to report information regarding the Carrier's FRs and QTLs and provide their comparative analyses for each NQTL identified by the Carrier in the Carrier Information Worksheet, using the Reporting Form provided by the State. The Reporting Form requires the Carrier to demonstrate compliance for each NQTL by benefits classification or subclassification (if applicable) in order to demonstrate compliance via the Information Elements.

A. 2024 Data Call and Market Conduct Examination

On February 9, 2024, the OIC issued the Data Call to the Carriers, requesting information and data for the 2023 plan year (2024 Data Call). After reviewing responses from the Carriers, the OIC issued its Report to the Joint Committee on Government and Finance on May 31, 2024 (2024 Report).[15] Among other things, the 2024 Report generally concluded that the top five 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 Information Elements, 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 and 2024 Reports, the OIC worked with the Carriers to identify and resolve MH/SUD parity compliance issues as follows.

1) Market Conduct Examinations Commenced in 2023

As reported last year, the OIC previously called Market Conduct Examinations of four of the top five 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. At the time of this 2025 Report, three of the four targeted

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[15] See a copy of the 2023 and 2024 Annual Reports at ***Reports (wvinsurance.gov)***.

examinations have concluded. The fourth Carrier's examination is also nearly complete.

Findings from the four Market Conduct Examinations included:

a) Timeliness and notice issues were found with all four Carriers. Similar violations of W.Va. Code R. §§114-64-6.3.1, 114-64-6.3.2 and 114-64-6.3.3 existed throughout the reviews. The reviews of the MH/SUD claims, including autism, 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 OIC under state and federal law, and/or failed to include the complete required contact information of the OIC.

b) Several Carriers were not in compliance with requirements for adverse determinations to display notices in non-English languages. Multiple Carriers were 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.

c) During autism claim reviews, a Carrier was found to have violated W.Va. Code R. §§114-14-4.1 and 4.2 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".

d) Certain Carriers were found to have violated the W.Va. Code §33-24-7u 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 Behavioral 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 this maximum benefit limit is a QTL.

e) Violations of W.Va. Code §33-25A-8r(d) were identified when a Carrier failed to provide inpatient treatment of SUDs when a member's physician, psychologist or psychiatrist determined the treatment to be medically necessary. The member had only been admitted for 24 to 48 hours and coverage for the inpatient stay was denied.

f) All four Carriers were found to have more restrictive quantity limits on MH/SUD drugs, mail order exclusions, and prior authorization requirements for non-formulary drugs, which were detailed in the 2024 Report. Additionally, the examiners identified issues with the Carriers not paying all pharmacies at the state mandated NADAC + $10.49 rate in violation of W.Va. Code §33-51-11(a)(5). One Carrier's pharmacy benefit manager (PBM) paid claims using lower of logic pricing methodology that imposed a monetary advantage or penalty under a health plan that would affect a beneficiary's choice of pharmacies. There was also a violation of W.Va. Code §§33-16-3aa(c)(2)(C) and 33-25A-8o(c)(2)(C) identified due to a Carrier implementing a non-formulary exception policy with step therapy processes that was more restrictive than allowable by the W.Va. code. The policy did not allow for approval when the patient had tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event. A Carrier was found to prohibit members from filing 90-day supplies of prescription drugs at a retail pharmacy; only allowing 90-day supplies to be filled when utilizing the Carrier's

affiliated mail order pharmacy, in violation of W.Va. Code §33-51-11(a)(10).

g) A violation of 42 U.S.C. 300gg-26(a)(8)(A) and W.Va. Code §§33-16-3ff(c)(2), (4) and 33-25A-8u(c)(2), (4); §33-16-3ff(g)(4) and §33-25A-8u(g)(4) was identified when a Carrier failed to provide separate NQTL comparative analyses for separate entities. One NQTL comparative analysis was submitted and later, the Carrier stated it applied to all plans and entities. Because the contents of the comparative analysis was not sufficiently specific, detailed, and reasoned to demonstrate that each of the Carrier's plan's processes, strategies, evidentiary standards, and other factors used to design and apply the NQTL to MH/SUD benefits, as written and in operation, were comparable to, and were applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to design and apply the NQTL to medical or surgical benefits in the applicable benefits classification, the Carrier did not comply with the requirements of MHPAEA or §33-25A-8u(c)(2), (4) and §33-16-3ff(g)(4) and §33-25A-8u(g)(4).

h) Prior to the closing of the examination, one Carrier requested the opportunity to submit supplemental responses to multiple issues identified. In the supplemental responses, the Carrier agreed to remove certain restrictive barriers related to MH/SUD drugs outlined below:

- The Carrier removed naloxone from the mail order exclusion list;
- The Carrier removed certain more restrictive quantity limits applied to Desvenlafaxine;
- The Carrier included Lucemyra on the formulary and removed all prospective utilization management requirements in effect during the examination; and
- The Carrier removed quantity limitations on Narcan, generic naloxone nasal spray, and Kloxxado.

This same Carrier stated it would update its exception policy to state that "the patient will not be required to try a prescription drug the patient has already tried while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, where such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event."

2) Market Conduct Examination Commenced in 2024

On June 15, 2024, the OIC commenced a Market Conduct Examination of the last of the top five Carriers not previously subject to examination in order to collect and review materials related to the Carrier's compliance with MHPAEA and the Mental Health Parity Law for the period commencing January 1, 2022, through May 31, 2024. At the time of the 2025 Report, the Market Conduct Examination is still ongoing and the OIC remains committed to addressing any federal or State parity concerns raised by the Market Conduct Examination.

As part of the Market Conduct Examination, the OIC requested that the Carrier submit NQTL comparative analyses for all of the NQTLs imposed by the Carrier on MH/SUD and medical/surgical benefits. In response to this request, the Carrier submitted comparative analyses that were found not to demonstrate compliance with MHPAEA. As a result, the Carrier was required to revise the comparative analyses and submit them as part of the 2025 Data Call.

During the Market Conduct Examination, other potential violations of federal and state laws were identified. These potential violations include:

a) Potential violations related to the Carrier's notices for adverse determinations and timeliness of claims payments for both medical/surgical and MH/SUD claims/benefits. Initial findings were issued for the Carrier's failure to include required notice language specific to MH/SUD denied claims regarding a covered person's protection under state and federal law, potentially violating W.Va. Code §33-45-2(a)(1). Another initial finding was issued for failure to pay clean MH/SUD claims within 30 days of receipt; violating W.Va. Code R. §114-64-6.3.1.

b) Certain MH/SUD utilization review samples failed to include the treatment code and its corresponding meaning in the statement of availability of the adverse determination notice, potentially violating W.Va. Code R. §114-95-7.3.a.2.

c) In one instance, the Carrier failed to provide the inpatient treatment for an SUD when a member's physician, psychologist or psychiatrist determined the treatment to be medically necessary, potentially violating W.Va. Code §33-16-cc(d) and W.Va. Code R. §114-64-6.1.

d) The review of the MH/SUD utilization review samples highlighted a difference in the handling of MH/SUD utilization review requests from that of medical/surgical utilization review requests. The Carrier uses a vendor to manage and administer its MH/SUD benefit. The vendor uses an online authorization review process for making utilization review requests, whereas the Carrier does not use the online process and implements a different process. For MH/SUD benefits, if a request is not approved using the online system, it is referred to a manual medical necessity review with a clinician. If the request is reduced or modified (e.g., a lesser number of days or a lower level of care) and the requesting provider agrees to the reduction, it is not recorded as a denial but an approval of the reduced service. Therefore, MH/SUD utilization review requests could go straight to a peer-to-peer review without the Carrier ever providing the required notices for adverse determinations, potentially in violation of W.Va. Code R. §§114-95-7 and 114-97-3. If a provider withdraws its original request and submits a new request for the reduced service, the case is considered an approval of the newly requested MH/SUD services. Also, the vendor's online process for the MH/SUD utilization review requests could not document the required electronic notification to the healthcare provider confirming receipt of the prior authorization request, potentially violating W.Va. Code §§33-25A-8s and 33-16-3dd, whereas the medical/surgical utilization review requests submitted electronically does document this electronic notification to the requesting providers. Given these differences in process, the OIC requested that the Carrier provide a comparative analysis of the online process. However, the Carrier submitted a comparative analysis for prior authorization that includes the online process as a deviation from a factor and the Carrier did not provide a comparative analysis that analyzes the differences in process considering the Information Elements.

e) The medical/surgical utilization reviews did not provide all of the statutory notification or language required for adverse determinations. The Carrier failed to include a form approved by the Commissioner for a covered person to authorize the Carrier and health care provider to disclose protected health information pertinent to an external review, with multiple potential violations of W.Va. Code R. §§114-97-3 and 114-95-7.

f) The Carrier had potential pharmacy formulary, quantity limits and other pharmacy violations. Examples of the potential violations of W.Va. Code §§33-16-3cc(k), 33-25A-8r(k), 33-16-3ff(c) and 33-25A-8u(c) as follows:

Desvenlafaxine Quantity Limit (Parity) The Carrier imposed more restrictive quantity limitations on desvenlafaxine when compared to quantity limitations on medical/surgical medications. The Carrier limited members to one tablet daily on all strengths of Pristiq, Khedezla and desvenlafaxine ER tablets. These products are indicated for the treatment of major depressive disorder and are commercially available in strengths of 25mg, 50mg, and 100mg per tablet. The FDA approved maximum dose of desvenlafaxine is 400mg/day for MDD. As a result of this quantity limitation, a provider would be required to submit a prior authorization to obtain a dose over 100mg/day, thus creating barriers of access to mental health medications.

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.

Buprenorphine Tablets (Quantity Limits)
The Carrier placed a quantity limitation on all strengths of Buprenorphine tablets**,** a medication used in the treatment of opioid dependence, during 2022, 2023, and 2024. The policy creates a barrier to treatment when a member is prescribed above label dosing on these medications for fentanyl abuse or other high dose opioid abuse.

Lucemyra (Non-Formulary)
The Carrier required prior authorization prior to coverage of a medication used for the treatment of opioid withdrawal. Lucemyra may be used for withdrawal management in an outpatient setting, where monitoring of blood pressure and management of hypotension is more difficult.

Narcan/Naloxone/Kloxxado (Quantity Limit)
The Carrier placed a quantity limitation on Narcan, generic naloxone nasal spray, Evzio and Kloxxado during the examination period. Naloxone is indicated for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or central nervous system (“CNS”) depression. The policy restricted access and availability to life saving treatment.

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

SUD Medication (Quantity Limit)
The Carrier limited SUD medications acamprosate, naltrexone, generic buprenorphine SL tablets, generic buprenorphine-naloxone SL tablets/films, Zubsolv SL tablets, and Suboxone SL films in determining whether they were maintenance medications, compared to the evidentiary standards used in determining whether medical/surgical medications were maintenance medications. The Carrier excluded these from their maintenance medication list, therefore designating them as non-maintenance medications. This classification is accompanied by a quantity restriction of a 30-day supply or less, creating a barrier to access these SUD medications.

Lucemyra (Quantity Limit)
The Carrier placed a quantity limit on Lucemyra during the examination period. This medication is indicated for the mitigation of opioid withdrawal symptoms and used to facilitate abrupt opioid discontinuation in adults and members were limited to 192 tablets per year.

Opvee (Non-formulary Exclusion)
The Carrier limited access to SUD treatment when designating Opvee as non-formulary and excluded the drug from its formularies in December of 2023. Opvee is a nasal spray formulation of Nalmefene indicated for the emergency treatment of known or suspected overdose of natural or synthetic opioids. This coverage restriction creates a barrier in the overall treatment plan of a member diagnosed with substance use disorder. The coverage restriction creates a barrier in the overall treatment plan of a member diagnosed with SUD.

Sublocade (Non-Formulary)
The Carrier required prior authorization for coverage of Sublocade and Brixadi. These medications are brand only buprenorphine extended-release injections indicated for the treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a single dose of a transmucosal buprenorphine product or who are already being treated with buprenorphine. Both Sublocade and Brixadi are SUD medications that provide a long-acting therapeutic option.

Interrelated Finding (Mail Order Copay Incentive)
The Carrier imposed a monetary advantage under the health benefit plan that would affect a member's choice among pharmacies. The Carrier offered a copay incentive for all members that filled a 90-day supply at mail order of 2.5x copay. This may be a violation of state Pharmacy Benefit Manager/Freedom of Choice laws.

Interrelated Finding (Mail Order Quantity Incentive)
The Carrier imposed quantity limitations under the health benefit plan that would affect a member's choice among pharmacies. The Carrier restricted members to a 31-day supply limit at Retail Network Pharmacies but allowed a 90-day supply limit at Mail Order Network Pharmacies and Preferred 90-day Retail Network Pharmacies.

3) Carrier Training

To assist Carriers with compliance, in addition to extensive written guidance previously provided, the OIC required that the Carriers meet with the OIC and discuss the guidance. The Carriers were afforded an opportunity to ask questions related to compliance with federal and state laws and the preparation of NQTL comparative analyses. Each plan attended training and was given time to ask questions. The OIC offered each Carrier the opportunity to ask follow-up questions at a later date. One of the five Carriers, Carrier B (defined below), provided follow-up questions regarding the training and guidance provided.

B. 2025 Data Call

On December 11, 2024, the OIC issued the Data Call to the Carriers, requesting information and

data for the 2024 plan year (2025 Data Call). The OIC has conducted a review of the Carriers' responses to the 2025 Data Call. A summary of the OIC's review and findings is provided below. As with the 2024 Report, the 2025 Report focuses on the top five Carriers in West Virginia, providing coverage to 98% of the commercial market.[16] The top five Carriers, identified herein as Carriers A, B, C, D and E, responded to the Data Call.

IV. Review of Plan Submissions

A. FRs and QTLs

A review of the data per the required quantitative testing reporting format submitted by the Carriers to demonstrate compliance with the required predominant and substantially all tests reveals that all of the Carriers have potential violations of the quantitative testing rules which require additional inquiry and review. Specifically, the OIC reviewed the quantitative testing reporting format submitted by each Carrier and compared the format responses with the schedule of benefits provided by the Carrier for each Carrier plan. The OIC identified issues which include, without limitation, the following:

1) It was found that each Carrier may impose certain FRs when the results of the testing indicated that they should not impose such FRs.
2) Some of the Carriers submitted a quantitative testing reporting format that had different FRs than the FRs reflected on the Carrier's schedule of benefits.
3) Some of the Carriers appear to have submitted certain data and information in their quantitative testing reporting format that appears to be incorrect or inconsistent with other information provided and/or the schedule of benefits.
4) Some of the Carriers may have misclassified benefits and included data as applying to MH/SUD benefits as opposed to medical/surgical benefits or vice versa.

An inquiry and review, along with the data validation, will be conducted and a final determination of compliance will be made by the OIC.

B. NQTLs

With respect to NQTLs, after an examination of the NQTL comparative analyses and other information provided by the top five Carriers, except for certain NQTL comparative analyses submitted by three of the Carriers in the pharmacy benefits classification, the OIC has generally determined that the Carriers have not sufficiently demonstrated that each NQTL imposed complies with the Information Elements, 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 Failure to Demonstrate Compliance

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

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[16] 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) 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 separate comparative analysis for each NQTL in each benefits classification or subclassification.
b) The Carrier's comparative analyses do not correlate with the Reporting Form or instructions provided by the OIC as part of the 2025 Data Call, which may include failing to provide a detailed and specific explanation of policies, procedures and processes in Step 1, inserting side-by-side or chart responses instead of a narrative format in Step 4, or providing a separate comparative analysis for each NQTL for each benefits classification (where applicable).
c) The Carrier did not appropriately define or explain its relationships with vendors or separate departments or divisions 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.
d) 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).
e) 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). The Carrier did not sufficiently and specifically explain its policies, procedures and processes and its vendors', departments', or divisions' policies, procedures and processes related to the NQTL.
f) 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.
g) The Carrier did not sufficiently identify or define the factors the Carrier uses to design and apply the NQTL and/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).
h) 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).
i) The Carrier did not include data in the comparative analysis or included data without a specific and adequate explanation as to how the data was collected, what the data represents, or how the data demonstrates compliance with the comparability and equitable stringency application tests.
j) 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).
k) 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

Other issues noted by the OIC that require additional review are as follows:

a) 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 or subclassification. The top five Carriers provided comparative analyses for the NQTLs listed in the chart below. While some Carriers failed to submit comparative analyses related to certain NQTLs that they identified and provided in both the 2023 and 2024 Data Calls, on average, the Carriers provided more responses than they had in the past. While the Carriers provided the comparative analyses for the NQTLs listed, there are still likely to be other NQTLs that a Carriers did not report on (e.g., fraud, waste and abuse programs; outlier management; coding edits; treatment plan requirements; etc.). Also, while some Carriers provided comparative analyses by benefits classification, despite instructions in the Data Call to the contrary, other Carriers did not provide comparative analyses by benefits classifications 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 NQTLs. 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. In addition, the instructions for the 2026 Data Call will specifically require Carriers to provide comparative analyses for Fraud, Waste and Abuse Programs, Outlier Management, Coding Edits, and Treatment Plans or require Carriers to provide a written explanation as to why they did not provide them. It is important to note that the Carriers are required by State law to provide an NQTL comparative analysis for each NQTL imposed by the Carrier on MH/SUD benefits.

NQTLs Reported by the Top Five Carriers:[17]

NQTL	Carrier A[18]	Carrier B[19]	Carrier C[20]	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		x			x

[17] The "x" in the chart indicates that the Carrier provided a response for the applicable NQTL in at least one benefits classification. A gray space indicates that the Carrier did not provide a comparative analysis for the NQTL.

[18] Carrier A did not provide comparative analyses for Exclusions for Experimental and Investigational Services but did provide a comparative analysis in the 2024 Data Call.

[19] Carrier B did not provide an NQTL comparative analysis for Benefits Exclusions but did so in the 2024 Data Call.

[20] Carrier C did not provide an NQTL comparative analysis for its Fraud, Waste and Abuse Programs but did provide one in the 2024 Data Call.

[21] Carrier D did not provide an NQTL comparative analyses for its Fraud, Waste and Abuse Program. Carrier D did not provide a comparative analysis for Step Therapy, Quantity Limits and Outlier Review Management but did provide comparative analyses in the 2024 Data Call. Carrier D also did not provide comparative analyses for Network Tiering, Facility Restrictions, Exclusions, Treatment Plan Limitations, Scope Limits and Expedited Claims in the 2024 and 2025 Data Calls but did not provide comparative analyses for these NQTLs in the 2023 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 and one comparative analysis for prior authorization, step therapy and quantity limits combined. Carrier E did not provide a separate response for each of the pharmacy NQTLs as instructed.

NQTL	Carrier A[18]	Carrier B[19]	Carrier C[20]	Carrier D[21]	Carrier E[22]
Reimbursement Rates[23]	x	x	x	x	x
Network Adequacy	x	x	x	x	x
Experimental/Investigational		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		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		
Post Claim Payment Retrospective Review				x	

b) Medical Necessity Criteria

Each Carrier provided a comparative analysis related to the medical necessity criteria that it uses and/or develops to make utilization management decisions. However, the comparative analyses provided do not sufficiently demonstrate compliance with the Information Elements 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. Most of the definitions appear to be from certificates of coverage or other consumer-friendly member documents and not from Carrier policies and procedures. For Carriers that use vendors to administer the medical/surgical and/or MH/SUD benefit or for Carrier's with a separate MH/SUD department or division, the Carrier did not specify what the vendor/department/division's policies and procedures are with respect to medical necessity and whether the vendor/department/division employs the same definition for MH/SUD benefits as the plan uses for medical/surgical benefits.[24] All of the Carriers state that they use nationally recognized, evidence-based

[23] Carriers are to provide separate NQTL comparative analyses for in-network facility and professional providers and out-of-network reimbursement rates. Some Carriers submitted analyses which combined discussions of in-network facility and professional providers and out-of-network reimbursement rates and did not provide a comprehensive discussion of each type of in-network and the out-of-network NQTL.

[24] One Carrier uses a vendor to assist in the management of medical/surgical services. The same concept would apply for this Carrier. If, for example, the vendor that assists with the management or administration of medical/surgical services uses different policies, procedures or policies or has a different definition for medical necessity than are used for MH/SUD services, the Carrier must provide an explanation in Step 1, an appropriate description and explanation of the factors, evidentiary standards, and sources in Steps 2 and 3, and a comparative analysis, both as written and in

clinical criteria (e.g., ASAM, InterQual, LOCUS, CALOCUS, MCG, etc.)[25] and internally developed medical criteria and policies but the Carriers did not provide sufficient responses for all of the Information Elements in order to demonstrate comparability and application stringency. One Carrier has stated that it develops clinical criteria for certain MH/SUD benefits (e.g., Transcranial Magnetic Stimulation)[26] and medical/surgical benefits (e.g., breast reduction and bariatric surgery), but doesn't provide a detailed and specific comparison of the MH/SUD and medical/surgical criteria in order to demonstrate that the clinical policies were developed and applied comparability and no more stringently. Without an appropriate explanation of the definitions used for medical necessity and of the criteria used to make utilization management decisions, whether obtained externally or developed internally, the OIC is unable to determine compliance with the law and regulations. The OIC has noted these deficiencies and will reach out to Carriers to address them.

c) Utilization Management Protocols

Utilization management protocols, like prior authorization, concurrent review, and retrospective review, are NQTLs, for which the Carriers are to provide comparative analyses that demonstrate compliance with MHPAEA. Accordingly, each Carrier provided a comparative analysis related to prior authorization, concurrent review, and retrospective review; however, the comparative analyses provided do not sufficiently demonstrate compliance with the Information Elements and do not provide for a demonstration of compliance with the federal and State laws and regulations. General issues with respect to comparative analyses for utilization management protocols include the following:

i. Most Carriers did not provide specific and detailed descriptions of their policies, procedures, and processes with respect to their utilization management protocols in Step 1. Some plans provided only a list of policies with no narrative response.
ii. Most Carriers did not adequately identify vendors or separate departments and divisions and did not specifically explain or analyze the policies, procedures, and processes used by the plan and the vendor or describe how compliance is coordinated with vendors/departments/divisions and ensured.
iii. One Carrier provided a reasonable description of how a service is selected for its prior authorization list but described a process where the plan retained discretion regardless of listed factors to require prior authorization for a service.
iv. Some Carriers provided identical factors, evidentiary standards and sources in Steps 2 and 3 for prior authorization, concurrent review and/or retrospective review NQTLs, when the factors, evidentiary standards, and sources used to design and apply each NQTL should be different. Some Carriers provided identical or nearly identical responses for prior authorization, concurrent review and/or retrospective review when the NQTLs are different. One Carrier described information related to prior authorization in the Steps even though the comparative analysis was for the concurrent review or retrospective review NQTL.
v. Most Carriers provided additional description in Step 4, where an as written comparative analysis is required, or did not provide a robust analysis but a conclusory

operation, of the information provided in Steps 1, 2 and 3 in Steps 4 and 5.

[25] Some Carriers do not specify which evidence-based clinical criteria is used for which benefit (i.e., medical/surgical or MH/SUD).

[26] This Carrier no longer provides ABA as an example but did last year and should address this MH/SUD service.

statement of compliance. At least one Carrier provided a chart of processes with a conclusory statement that the Carrier is compliant.

vi. Most Carriers did not explain how the data provided supported a finding of compliance in Step 5.

With respect to retrospective review, some Carriers focused primarily on traditional retrospective review or retrospective review where a provider or member failed to obtain prior authorization before a service is rendered and did not explain or provide analysis of all forms of retrospective review, which include pre-claim payment and post-claim payment retrospective review.

The OIC has noted these deficiencies in the comparative analyses for utilization management protocols and will reach out to Carriers to address the deficiencies.

d) NQTL Comparative Analyses for the Pharmacy Benefits Classification

After a review of the NQTL comparative analyses in the pharmacy benefits classification (i.e., formulary design, prior authorization, step therapy and quantity limits), the OIC found improvement from four of the five Carriers from analyses submitted for Plan Year 2023. In particular, while some of the analyses provided could be more explanatory, Carrier B showed likely compliance for NQTL comparative analyses for the pharmacy benefits classification (i.e., formulary design, prior authorization, step therapy and quantity limits). Carrier C provided sufficient comparative analyses which showed likely compliance for formulary design and quantity limits and provided insufficient analyses for prior authorization and step therapy.[27] Carriers A and E showed likely compliance for the formulary design NQTL comparative analysis but did not show compliance for the remainder of the analyses. In two instances, analyses were found not compliant because contrary to instructions, the Carrier provided one analysis for several or all NQTLs.[28]

The OIC has noted these deficiencies in the comparative analyses related to the pharmacy benefits classification. The OIC will reach out to Carriers to address deficiencies and possible areas of non-compliance.

e) Adverse Determinations

The OIC has reviewed the adverse determination of the top five 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 five Carriers

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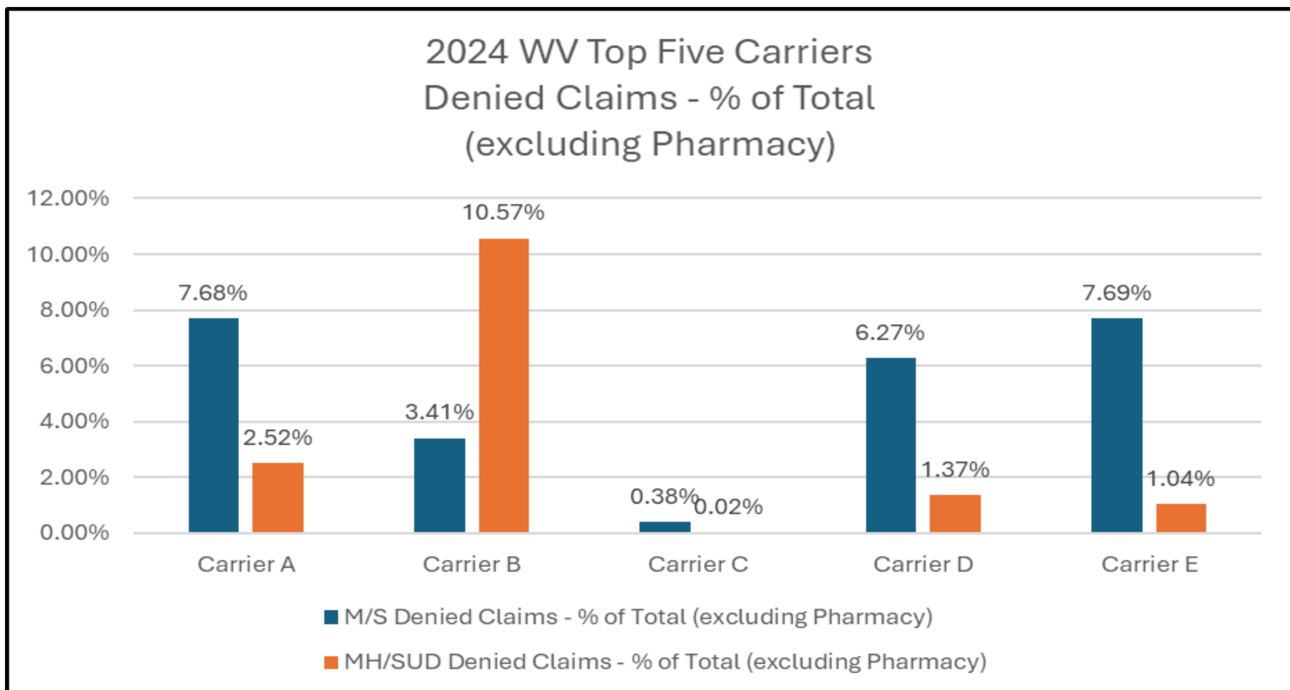
[27] The comparative analysis for step therapy, although insufficient in content to meet the requirements of the demonstration standard, contained information and data which indicates that the Carrier may be in compliance with the NQTL tests.

[28] While an NQTL in the pharmacy benefits classification may have the same or similar factors and evidentiary standards, the NQTLs are different, and a separate comparative analysis is appropriate for each NQTL in order to assess compliance. Contrary to instructions, Carrier D provided one combined analysis and referenced attachments instead of providing a narrative response and Carrier E provided a combined analysis for prior authorization, step therapy, and quantity limits. For these reasons, the combined analysis submitted were found to be insufficient for the specific the pharmacy benefits NQTLs referenced.

claims denials as a percentage of total claims is set forth in the chart below. The term "denied claims" represents 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. However, outcomes may indicate that additional questions and review may be warranted. Also, it should 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 a managed care organization 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.[29]

The OIC continues to follow up with the Carriers to review the data and ensure that compliance is demonstrated. The adverse determinations below, especially the disparity in adverse determination rates for Carrier B, require further probing. In addition, the data related to adverse determinations that was provided in the Reporting Forms by Carriers warrants a careful review. Some of the data presented by the Carriers is incomplete or unexplained. Some of the data shows disparities in denial rates or overturn rates without appropriate explanation. Further discussion with Carriers is required to determine compliance with federal and State laws and appropriate regulatory action.



[29] While administrative denials may be based on objective criteria, administrative denials are still important to review in that they may reveal a difference in process or compliance with respect to other NQTLs that may be imposed by the Carrier.

V. Conclusion

After reviewing the Carrier responses with respect to FRs and QTLs, it appears that, although progress has been made by Carriers towards compliance with MHPAEA and the Mental Health Parity Law, potential violations remain. These potential violations require further discussion and review. The OIC will seek additional data validation related to issues identified in the review of quantitative testing to ensure compliance with MHPAEA's substantially all and predominant tests. With respect to the NQTL comparative analyses, since the OIC has determined that, with the exception of certain NQTL comparative analyses for the pharmacy benefits classification, the Carriers' comparative analyses submissions were generally insufficient to demonstrate that the Carriers are in compliance with MHPAEA's comparability and stringency tests, the OIC will seek to address identified deficiencies to ensure compliance with the comparability and application stringency tests.

The OIC's Market Conduct Examinations of two of the top five Carriers is ongoing and the OIC will continue to work extensively with the two Carriers to better determine and resolve any potential violations of State and federal laws. The Market Conduct Examinations of the other three carriers have yielded monetary regulatory penalties and filed corrective action plans; two are complete and one is in the final stages.

The OIC will annually monitor Parity compliance of all carriers to determine what regulatory enforcement is appropriate and whether other functions such as audits/examinations, monetary penalty/fines, and licensure actions should be initiated. The OIC looks forward to engaging with the Legislature on this issue and appreciates the opportunity to be of service to West Virginians.