COMMONWEALTH OF VIRGINIA

JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

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December 1, 2020

MEMORANDUM

TO: Members of the Senate Commerce and Labor Committee
Members of the House Labor and Commerce Committee
Members of the Joint Subcommittee to Study Mental Health Services in the 21st Century

FROM: Tracey Smith, Associate Director

SUBJECT: Oversight of Mental Health Parity in Virginia

Senate Bill 280 of the 2020 General Assembly Session directed JLARC staff to review mental health parity in Virginia. Mental health parity refers to whether insurance companies provide mental health and substance use disorder benefits in a manner that is more restrictive than medical benefits, and guidelines and criteria that are comparable to, and no more stringent than medical guidelines and criteria. JLARC was specifically directed to review the annual mental health parity reports compiled by the Bureau of Insurance (BOI) and to assess whether improvements to BOI's data collection are necessary to improve parity oversight and compliance in Virginia.

To conduct this review, JLARC staff interviewed Bureau of Insurance staff who review insurance plans for compliance before they are sold and staff who conduct "market conduct reviews" (sidebar) to oversee insurance plan operations. Interviews were also conducted with Virginia Department of Health (VDH) staff to understand their role in overseeing insurance plans that are sold in Virginia. To understand how other state and federal regulators oversee mental health parity, JLARC staff interviewed staff from five other states and reviewed documents from other states and the two federal agencies that oversee parity. To identify any existing indicators of potential parity violations, JLARC staff analyzed data collected by BOI from insurance plans each year. The data was analyzed to identify outliers in the denial rates, complaint rates, and appeal rates across each insurance plan. Finally, JLARC staff interviewed consumer advocacy groups, behavioral health provider associations, and three of the largest insurance carriers in Virginia about their perspectives on mental health parity.

Behavioral health services include services for both mental health and substance use disorder diagnoses. Federally required 'mental health parity' covers all behavioral health services, including mental health and substance use disorder services. Unless otherwise noted in this report, "behavioral health services" means mental health and substance use disorder services.

Market conduct reviews are conducted by regulators to evaluate how insurance plans are being implemented. They are in-depth reviews that are similar to audits.

Insurance plans must cover behavioral health benefits 'in parity' with medical benefits

The Mental Health Parity and Addiction Equity Act (MHPAEA) established federal requirements for insurance companies' coverage of behavioral health services. These requirements have been further refined through federal regulations, the Patient Protection and Affordable Care Act (ACA), and Virginia state laws. These laws and regulations are intended to ensure that behavioral health services are covered 'in parity' with—or equal to—medical services by requiring that insurance companies (1) cover behavioral health services and (2) do not place restrictions on them that are greater than those for medical services. In Virginia, BOI, which is part of the State Corporation Commission, is responsible for overseeing state-regulated insurance plans.

Insurance plan restrictions on behavioral health services cannot exceed restrictions for medical services

Federal law prohibits insurance plans from placing greater restrictions on behavioral health services than medical services. In general, this means that individuals must be able to access necessary behavioral health services and pay a portion of costs that is not more burdensome than for similar medical services. Federal regulations detail how states assess whether mental health parity is being achieved.

Insurance companies must achieve parity in three areas: the financial requirements they impose on members, "quantitative treatment limitations" (QTLs), and "non-quantitative treatment limitations" (NQTLs). These three categories include aspects of an insurance plan's design, cost sharing, and claim review and payment processes.

- **Financial requirements** include copays, deductibles, coinsurance, and out-of-pocket maximums;
- **QTLs** include limits on services that can be quantified, such as the number of doctor's office visits or days spent in the hospital per year; and
- **NQTLs** include limits that are more subjective, such as prior authorization requirements, 'step protocols', provider rates, and network adequacy (sidebar).

Prior authorization means that the insurance plan must review information from the doctor about the individual's condition before approving a treatment.

A **'step protocol'** is when an individual is required to try a certain treatment for a condition before a different treatment is approved.

Network adequacy is a determination of whether there are enough providers in an insurance plan's network that can treat patients enrolled in the insurance plan.

An **individual** plan is sold directly to individuals and their families rather than a specific group of people, such as a small or large business.

A **fully insured** health insurance plan sets a premium that members pay each month, and the insurance plan is responsible for paying the cost of services, minus any cost sharing.

Virginia, like all states, is responsible for ensuring individual and fully insured group health plans meet parity requirements

BOI is primarily responsible for overseeing mental health parity for state-regulated health insurance plans in Virginia—individual plans and fully insured group insurance plans (sidebar). The Virginia Department of Health (VDH) also reviews plans' network adequacy as part of an annual quality assurance process.

BOI oversees parity by reviewing insurance plan filings for compliance before they are sold and conducting market conduct reviews to ensure requirements are carried out as intended. All individual and small group insurance plans must file their policy forms and actuarially certified premiums each year. BOI reviews the policy forms for compliance

With applicable state and federal requirements, including mental health parity. BOI conducts market conduct reviews, which are similar to audits, to ensure insurance plans are being implemented in accordance with the policy forms and state and federal requirements.

The 2015 General Assembly directed BOI to collect data each year from insurance plans related to mental health parity and publish their review of the data. The data is collected for any insurance plan with over 5,000 members, and BOI aggregates the data across all of these plans in an annual report to the General Assembly. BOI compares the following data among medical services, mental health services, and substance use disorder services:

- percentage of claims denied,
- member complaints, and
- member appeals.

The annual reports have concluded that aggregated statewide data show no significant differences in denial rates, complaint rates, or appeal rates between medical and behavioral health services. However, this aggregate assessment is inadequate to draw conclusions about parity compliance by *specific plans*.

BOI's process provides assurance that insurance plans meet parity requirements in two of three categories

Stakeholders generally agree that insurance plans are in compliance with financial requirements and QTLs. These requirements are measurable and therefore were the first requirements that insurance plans and state oversight agencies focused on to ensure compliance following the passage of MHPAEA.

BOI relies on insurance plans to certify compliance with MHPAEA and highlight specific parts of their policy forms as evidence of compliance. BOI staff review documents that explain each plan's covered services, cost-sharing requirements (deductibles, coinsurance and copays), and treatment limitations. BOI staff address concerns during the review process by sending "objections" to the insurance plan when they are concerned that the insurance plan may not be in compliance with mental health parity or other requirements. These objections point to the specific parts of the plan that require further explanation to demonstrate compliance. If that further explanation is not sufficient, BOI requires the insurance provider to modify the plan before selling it.

BOI's approach to overseeing financial and QTL requirements is consistent with other states and federal regulators. However, Nebraska uses a more rigorous tool that requires each insurance plan to enter extensive data on covered services, financial requirements, and QTLs. The tool automatically analyzes the data and identifies potential parity non-compliance. Nebraska state staff said their process, however,

required a significant amount of time for insurance plans to complete and for state staff to follow up on flagged items.

Using an enhanced tool to assess financial and QTL compliance is not necessary in Virginia currently because BOI's current process provides reasonable assurance that financial requirements and QTLs are in compliance. However, if concerns are raised by stakeholders, or BOI begins to identify ongoing financial and QTL compliance concerns, Virginia could consider implementing a similar tool to the one used by Nebraska. Collecting more detailed information would better indicate whether insurance plans are placing more onerous financial requirements or restrictive QTLs on behavioral health services than they do on medical services.

Behavioral health claim denial rates are high for some plans, indicating possible parity violations

NQTLs are much more difficult to assess because they focus on how the health plan is implemented rather than the more measurable aspects of the plan design. Additionally, federal regulations do not provide much specificity for NQTL parity requirements. Determining whether plans' NQTLs are compliant with parity requirements requires more time-consuming oversight strategies. The rates at which plans deny mental health service claims can indicate possible violations and help states target their oversight.

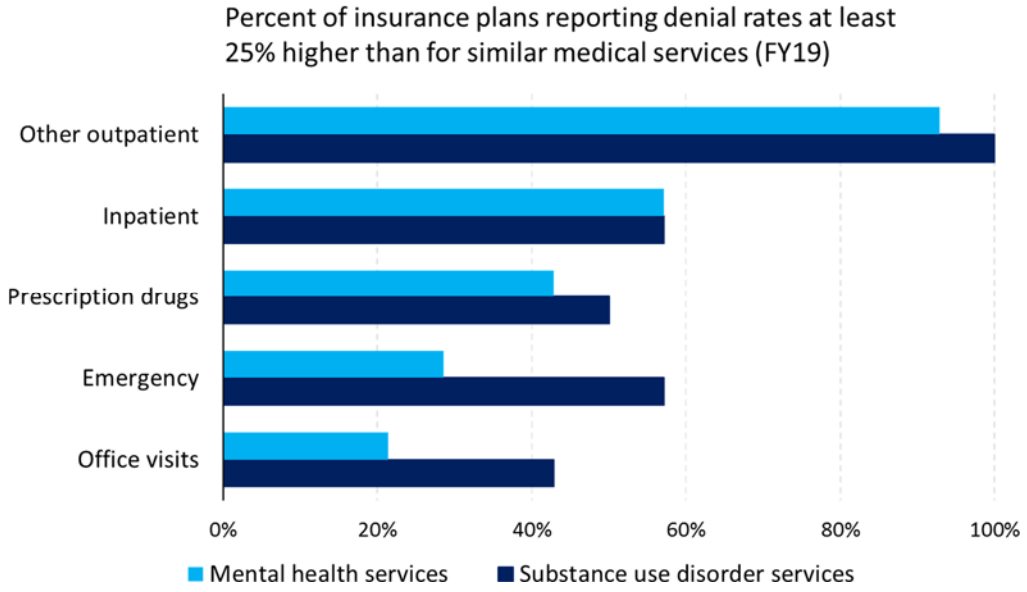
Only the largest insurance plans, those that **cover at least 5,000 individuals,** are required to submit annual data to BOI on mental health parity.

Plans are more likely to deny coverage for behavioral health services than for medical services, signaling a possible parity violation

Several large insurance plans deny behavioral health claims at significantly higher rates than medical claims. Six of the 14 insurance plans that are required to submit annual data to BOI denied both mental health and substance use disorder service claims 25 percent more often than they denied medical service claims. These differences are not apparent in BOI's annual reports to the General Assembly because BOI aggregates the data across the insurance plans to show statewide performance. However, parity compliance is required for each individual insurance plan. Therefore, any significantly higher denial rate for behavioral health services than medical services indicates that prior approval protocols or other NQTLs should be further evaluated by BOI.

When comparing specific services, outpatient services claims for both mental health and substance use disorder services are denied at higher rates than medical services. Nearly all (13 of 14) of the insurance plans had denial rates for mental health outpatient services claims that were significantly higher than for outpatient medical services, and all 14 insurance plans had significantly higher denial rates for substance use disorder services (Figure 1). These trends have been consistent over the three years for which data is available. Outpatient services include non-office visits, such as day programs, intensive outpatient programs, or partial hospitalization. Outpatient services account for 8 percent of all mental health claims and 23 percent of all substance use disorder claims.

FIGURE 1
Outpatient services have the most consistent disparities between behavioral health and medical services



SOURCE: JLARC analysis of denial data reported by health insurance plans to the Bureau of Insurance (FY19).
NOTE: The five categories of services are defined in federal regulations.

At least half of the insurance plans denied behavioral health claims at significantly higher rates than medical claims in four other service categories. Three of these were substance use disorder services: emergency services, inpatient services, and prescription drugs. Inpatient mental health services were also denied at higher rates by more than half of the insurance plans.

While the statewide trends are consistent, the denial rates for each insurance plan vary to some extent from year to year. A consistently higher denial rate over time is more concerning than a higher rate in just one year.

Denying mental health and substance use disorder services more frequently than medical services does not necessarily constitute a parity violation, but it does indicate a potential parity problem that requires further assessment. Insurance plans and staff from oversight agencies in other states agree that data alone is not sufficient to determine if parity requirements are being violated. Instead, for NQTLs, data should be used to identify indicators of potential parity violations that can then be further evaluated through market conduct reviews.

BOI could conduct more targeted "market conduct reviews" to identify parity violations

Regulators and insurers agree that market conduct reviews are necessary to fully assess NQTL compliance with parity requirements. Regulators perform in-depth fieldwork during market conduct reviews, such as reviewing insurers' claim files, understanding how prescription drug formularies were developed, and reviewing the insurers' contracts with providers. This level of review is necessary to understand how insurers implement their plans and NQTLs (e.g., prior authorization requirements).

Market conduct reviews also provide the necessary tools to fix any problems identified. Each market conduct review includes required corrective action plans for each instance of non-compliance. These corrective action plans range from updating policies and procedures to reopening or paying claims that were previously denied.

BOI conducts market conduct reviews each year, but staff have not yet used the available data on denials, complaints, and appeals to identify insurance plans for targeted market conduct reviews on parity. BOI conducts market conduct reviews when complaints or other data analysis indicate that a potential issue warrants further review. Staff completed seven market conduct reviews on health insurance plans in 2019 and 2020, but none of them focused specifically on mental health parity.

The National Association of Insurance Commissioners is developing NQTL oversight tools and BOI staff have been involved in this national effort to improve NQTL oversight. The goal is to develop standard tools that states can use to assess NQTL compliance as part of market conduct reviews.

The Bureau of Insurance could use the data submitted by health insurance plans annually on claim denials, complaints, and appeals to identify insurance plans that may be violating the federal Mental Health Parity and Addiction Equity Act and conduct market conduct reviews of these insurance plans to determine whether violations have occurred. However, the fieldwork necessary to conduct a market conduct review is time intensive, typically requiring between three and nine months to complete. BOI has 14 staff dedicated to life and health insurance market conduct reviews, and typically has about four full-scale reviews and eight to 10 more narrowly scoped 'inquiries' open at any given time. Assessing NQTL compliance also requires particular expertise. For example, evaluating prior approval decisions or prescription drug formulary designs requires medical expertise, and evaluating provider rates and networks' adequacy requires knowledge of the labor markets for specific types of clinicians. BOI may need to contract for additional staff with this expertise or add permanent staff to initiate targeted market conduct reviews of mental health parity. If additional resources are required to initiate these reviews, BOI could request additional budgetary authority from the General Assembly.

BOI needs to collect appointment data to more accurately determine provider shortages and their impact on mental health parity

Achieving mental health parity means not only covering behavioral health services to the same extent as medical services but also providing access to those services. If

members cannot get appointments to see a provider that they need, it may not matter that the service would be covered and that other restrictions are not placed on them. Federal regulations list network development, including provider payment rates, as an example of an NQTL.

BOI is starting to collect data on network adequacy, which can be enhanced by including data on appointment availability

BOI has not collected data on network adequacy in the past, and the information reviewed by VDH each year is limited. BOI relies on VDH to review network adequacy as part of VDH's role to ensure the quality of services available through insurance plans sold in Virginia. VDH's review of network adequacy is based on each insurance plan's most recent internal analysis. Insurance plans are not required to meet external standards or benchmarks. JLARC staff reviewed examples of insurers' compliance records, which focused on how close plan members live to the nearest provider. While this is important, it does not provide insight into whether those providers meet the needs of patients or whether patients can get appointments with that provider in a timely manner.

BOI will start including network adequacy data in its 2020 parity data collection following the passage of SB280 (2020). The data being collected in 2020 focuses on the number of active providers and out-of-network utilization. Both of these data points are useful indicators of whether an insurance plan's behavioral health provider network enables access to services in parity with its medical provider network. Specifically, the data will enable the calculation of two important metrics:

- **Member-to-provider ratios:** shows the number of active providers in the network compared with the number of total members in the insurance plan in a region, indicating whether or not there are enough total providers in the network.
- **Percentage of claims from out-of-network providers:** shows the percentage of claims that came from out-of-network providers in a region. A high percentage can indicate that there are not enough providers in the network, forcing members to choose out-of-network providers.

These two data points are useful, but they do not measure how long it takes an individual to get an appointment when they need one. This is the most direct way to measure network adequacy. An insurance plan could have a large number of active providers in their network and have low out-of-network utilization, but individuals' access to services largely depends on whether they can get appointments with these providers in a timely manner.

Collecting additional data from providers should balance the usefulness of the data with the burden of collecting it. Other states that have started collecting significant amounts of data to assess parity indicate that data should be limited to what is necessary to identify indicators of possible problems. Collecting too much data limits

its usefulness because regulators do not have the resources to fully analyze it, and even if they could, the data alone are not sufficient to determine whether a parity violation exists.

Most insurance plans already analyze appointment availability as part of their national accreditation or internal quality assurance processes. BOI can work with insurance plans to identify data that can be collected with limited additional resources and that can be quickly analyzed by BOI staff to identify red flags for further assessment. JLARC made a similar recommendation to the Department of Medical Assistance Services to improve its oversight of network adequacy within Virginia's Medicaid program (see briefing titled *Medicaid Expansion – Access to Services* from the September 16, 2019 JLARC meeting).

The Bureau of Insurance could collect data from the fully insured health insurance plans on appointment wait times for medical, mental health, and substance use disorder services as part of its annual mental health parity data collection. BOI could analyze that data to evaluate the extent to which Virginians have difficulty accessing medical and behavioral health services, determine whether differences in appointment wait times by service type indicate possible violations of MHPAEA, and conduct market conduct reviews of outlier insurance plans to determine whether they are in violation of MHPAEA.

Availability of behavioral health providers is a significant challenge to providing parity with medical services

The most common concern around Virginians' ability to access needed behavioral health services is that providers that accept their insurance are not available. Having an adequate provider network that gives individuals access to needed behavioral health services is a form of NQTL, making provider availability a relevant indicator of MHPAEA compliance.

Insufficient provider availability can be due to a complete lack of providers, providers being available but not participating with insurance networks, or providers not providing services that meet client needs. Many clinicians in the counseling professions are not participating in insurance networks, citing low reimbursement rates and burdensome documentation requirements. Additionally, provider groups in Virginia reported that reimbursement rates are leading to insufficient networks. A 2019 report by the actuarial firm Milliman found that nationwide, behavioral health providers are reimbursed at lower rates than medical providers for comparable services. The majority of the claims analyzed in the 2019 Milliman report were for 'evaluation and management' which are used to pay both medical and behavioral health providers for the time spent treating patients, and is the most comparable comparison between the two types of providers.

If in the future BOI finds that provider networks are insufficient, an analysis of rates could be conducted to determine if improving rates would increase provider

availability. Paying different rates across providers may not constitute a parity violation on its own. However, rates would need to be examined to ensure they are not the cause of an inadequate network of behavioral health providers.

CHAPTER 847

An Act to amend and reenact § 38.2-3412.1 of the Code of Virginia and to repeal the third enactment of Chapter 649 of the Acts of Assembly of 2015, relating to health insurance; mental health parity; required report.

[S 280]

Approved April 7, 2020

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3412.1 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3412.1. Coverage for mental health and substance use disorders.

A. As used in this section:

"Adult" means any person who is 19 years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of 19 years.

"Inpatient treatment" means mental health or substance abuse services delivered on a 24-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured 24-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" or "mental health benefits" means benefits with respect to items or services for mental health conditions as defined under the terms of the health benefit plan. Any condition defined by the health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Network adequacy" means access to services by measure of distance, time, and average length of referral to scheduled visit.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" or "substance use disorder benefits" means benefits with respect to items or services for substance use disorders as defined under the terms of the health benefit plan. Any disorder defined by the health benefit plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice.

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health

treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

B. Except as provided in subsections C and D, group and individual health insurance coverage, as defined in § 38.2-3431, shall provide mental health and substance use disorder benefits. Such benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, even where those requirements would not otherwise apply directly.

C. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall either continue to provide benefits in accordance with subsection B or continue to provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 25 days per policy or contract year.

3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. Any grandfathered plan as defined in § 38.2-3438 in the small group market shall also either continue to provide benefits in accordance with subsection B or continue to provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection shall not apply to any excepted benefits policy as defined in § 38.2-3431, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

E. The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, renewed, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment made.

F. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

G. The Bureau of Insurance (the Bureau), in consultation with health carriers providing coverage for mental health and substance use disorder benefits pursuant to this section, shall develop reporting requirements regarding denied claims, complaints, appeals, and network adequacy involving such coverage set forth in this section. By September 1 of each year, the Bureau shall (i) compile the information for the preceding year into a report that ensures the confidentiality of individuals whose

information has been reported and is written in nontechnical, readily understandable language; (ii) make the report available to the public by, among such other means as the Bureau finds appropriate, posting the reports on the Bureau's website; and (iii) submit the report to the House Committee on Labor and Commerce and the Senate Committee on Commerce and Labor.

2. That the Joint Legislative Audit and Review Commission (JLARC) shall conduct a third-party review of the State Corporations Commission's Bureau of Insurance (the Bureau) report required by the provisions of this act and the third enactment of Chapter 649 of the Acts of Assembly of 2015. In conducting such review, JLARC shall examine the information compiled by the Bureau from 2017 through 2020 and any other information it deems relevant and shall report (i) its findings regarding mental health and substance abuse disorder benefits parity with medical and surgical benefits and access to mental health and substance abuse disorder services and (ii) its recommendations, if any, to the House Committee on Labor and Commerce, the Senate Committee on Commerce and Labor, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century by December 1, 2020.

3. That the third enactment of Chapter 649 of the Acts of Assembly of 2015 is repealed.

COMMONWEALTH OF VIRGINIA

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

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
scc.virginia.gov

December 1, 2020

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
919 E Main Street, Suite 2101
Richmond, VA 23219

Dear Director Greer:

We have reviewed the exposure draft of the JLARC report on Oversight of Mental Health Parity in Virginia and appreciate the opportunity to provide a written response. Mr. Lunardi met with our staff on several different occasions to gather information about the Bureau of Insurance's (BOI) ongoing efforts to gather and collect data to support oversight and compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in Virginia. We want to thank Mr. Lunardi and your staff for their professionalism and efforts to research and summarize the complex issues addressed in the report.

The following comments are intended to provide additional clarification about our current processes and the variety of different tools that we use to identify and address potential MHPAEA compliance concerns.

BOI's process provides assurance that insurance plans meet parity requirements in two of three categories

The BOI uses several different tools to ensure that each insurance plan's financial requirements and quantitative treatment limitations (QTLs) are compliant with MHPAEA. Prior to the approval of policy forms for use in Virginia, the Bureau performs a manual review of the cost-sharing requirements for mental health and substance use disorder benefits and medical/surgical benefits to identify any potential parity concerns. In addition, carriers are required to file a Plans and Benefits template with their plan binder, and that data is run through the Centers for Medicare and Medicaid Services (CMS) Non-Discrimination Cost Sharing Review Tool, which performs an outlier analysis. This tool identifies any plan that has significantly higher copay or coinsurance than other plans across the state and nation. Any mental parity concerns identified through these review processes are communicated to the company so that the necessary changes can be made prior to plan approval. Plans are required to certify MHPAEA compliance when policy forms are filed for approval, and policy forms will not be approved without this certification.

During a market conduct review, the carrier is required to submit plan specific data about covered services in the QTL Data Collection Tool for review and analysis. This tool is currently being used on several ongoing exams and is available on the BOI's website as a self-compliance tool for carriers. This tool identifies QTLs and financial requirements that do not meet the substantially all and predominant level tests set forth in MHPAEA. Exceptions are identified and communicated to the company for review and comment and violations may be cited.

The BOI appreciates JLARC's acknowledgement that the BOI's approach to overseeing plans' financial and QTL requirements is consistent with other states and federal regulators and an enhanced tool is not necessary at this time. However, the exposure draft does suggest that the BOI could use a tool similar to Nebraska's if concerns are raised by stakeholders, or BOI begins to identify ongoing financial and QTL compliance concerns. The BOI would like to note that the Nebraska tool is commonly referred to as the CMS MHPAEA tool and it was evaluated for use during the BOI's market conduct reviews. The BOI is of the opinion that the QTL Data Collection Tool used during our market conduct reviews is a more sophisticated and reliable tool as the CMS MHPAEA tool is largely based on assumptions from the plan data and the QTL Data Collection Tool requires the carrier to enter expected claim dollar amounts. The BOI will continue to evaluate the tools available to verify compliance with MHPAEA to ensure that the most reliable tools are used going forward.

Behavioral health claim denial rates are high for some plans, indicating possible parity violations

JLARC noted that only the largest plans that cover 5,000 individuals or more are required to submit data to the BOI annually on mental health parity. While this is accurate, most insurance plans are required to submit mental health parity data to the Bureau annually and the data submitted represents 98.94% of the comprehensive health insurance market in Virginia in 2019.

The BOI does currently analyze the mental health parity data submitted annually to determine which carriers should undergo a market conduct review for MHPAEA compliance. Concerns identified during this analysis prompted exams of 3 affiliated carriers which are currently underway. Compliance with MHPAEA will be evaluated during these exams as well as another exam that was called due to other compliance concerns.

BOI could conduct more targeted "market conduct reviews" to identify parity violations

While it is possible for some market conduct reviews to take 3 to 9 months to complete, those reviews have a very limited scope and that is not a typical time frame to complete a market conduct review. It is not feasible for an in-depth mental health parity review to be performed in 3-9 months. We are basing this on other states' experience and the BOI's ongoing mental health parity exams which were started in late 2019 and are still ongoing.

In regard to the expertise needed to perform NQTL reviews, we would add that the BOI does have a nurse on staff that will be a resource as needed. The BOI has also utilized pharmacists through federal grants to review drug formularies for compliance with MHPAEA. Several changes to drug formularies were prompted by the pharmacists' suggestions.

Availability of behavioral health providers is a significant challenge to providing parity with medical services

The exposure draft contains a recommendation that if "in the future the BOI finds that provider networks are insufficient, an analysis of rates could be conducted to determine if improving rates would increase provider availability." It should be noted that the BOI does not have explicit authority to regulate a carrier's provider reimbursement rates. If directed by the General Assembly, the BOI could potentially work to obtain more information or work with the Department of Health who has some authority over network adequacy. VDH may need additional authority for such oversight as well.

The processes for verifying compliance with MHPAEA continue to evolve, and BOI staff are actively involved in discussions with the federal government, other state agencies and the NAIC Working Groups that are developing tools and guidance for state regulators to use in these efforts. BOI staff are dedicated to identifying and addressing mental health parity concerns and working with insurers to bring their plans and procedures into compliance in an expeditious manner. Again, we appreciate JLARC providing the opportunity to respond to this exposure draft.

Sincerely,

Scott A. White
Commissioner of Insurance