2019
Report

Claims - Complaints - Appeals

Mental Health
&
Substance Use Disorder Benefits

For the Period January 1, 2018 - December 31, 2018

State Corporation Commission
Bureau of Insurance

Executive Summary

As required by § 38.2-3412.1 of the Code of Virginia and in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, mental health and substance use disorder benefits provided by group and individual health insurance coverage must be in parity with medical and surgical benefits coverage. Further, Enactment Clause 3 of Chapter 649 of the 2015 General Assembly requires:

> That the State Corporation Commission's Bureau of Insurance, in consultation with health carriers providing coverage for mental health and substance use disorder benefits pursuant to § 38.2-3412.1 of the Code of Virginia, shall develop reporting requirements regarding denied claims, complaints, and appeals involving such coverage set forth in § 38.2-3412.1 of the Code of Virginia. Beginning in 2017 for the year preceding, the Bureau shall compile the information into an annual report that: (i) ensures the confidentiality of individuals whose information has been reported; (ii) is made available to the public by, among such other means as the Bureau finds appropriate, posting the reports on the Bureau's Internet website; and (iii) is written in nontechnical, readily understandable language.

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

The results of the 2019 survey, which contains information related to calendar year 2018, are provided in this report. Overall, the survey results suggest that health insurance carriers generally treat claims, complaints and appeals related to mental health and substance use disorder benefits in parity with claims, complaints and appeals related to medical/surgical benefits.

Overview

The Bureau surveyed 16 health carriers identified as insuring greater than 5,000 lives in Virginia in the individual, small group, and large group health insurance markets during the 2018 calendar year. In total, these carriers reported more than 1.7 million covered lives. Carriers were requested to report information specific to three benefit categories: Medical/Surgical Benefits, Mental Health Benefits, and Substance Use Disorder Benefits. Further, the carriers were required to report data for the 2018 calendar year related to these specific three benefit categories for:

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

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

As required by § 38.2-3412.1 of the Code of Virginia and in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, mental health and substance use disorder benefits provided by group and individual health insurance coverage shall be in parity with the medical and surgical benefits coverage. The report provides an observation of claims, complaints and appeal denials for coverage of mental health benefits and substance use disorder benefits, compared to medical/surgical benefit coverage, based on the surveyed data.[1]

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

Section I. Claims

Overview

Carriers surveyed reported a total of 43,261,782 claims received with 6,348,060 (14.7%) of claims being denied. Each carrier reported whether each denied claim related to medical/surgical, mental health, or substance use disorder benefits. The claims reported in each of these three benefit categories were broken into five separate claims categories: Office Visit Claims, All Other Outpatient Claims, Inpatient Claims, Emergency Care Claims, and Outpatient Prescription Drug Transactions. Tables 1, 2, and 3 below provide the breakdown into the five claim categories of the total claims handled in each benefit category.

Table 1. Claims Overview – Medical/Surgical Benefits

Claim Category: Medical/ Surgical Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	11,654,784	11,054,965	599,819	5.1%
All Other Outpatient Claims	13,537,671	12,774,244	763,427	5.6%
Inpatient Claims	1,420,539	1,285,610	134,929	9.5%
Emergency Care Claims	1,431,779	1,244,425	187,354	13.1%
Outpatient Prescription Drug Transactions	11,523,077	7,553,172	3,969,905	34.5%
Totals:	39,567,850	33,912,416	5,655,434	14.3%

Table 2. Claims Overview – Mental Health Benefits

Claim Category: Mental Health Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	1,019,507	961,844	57,663	5.7%
All Other Outpatient Claims	247,950	219,944	28,006	11.3%
Inpatient Claims	57,951	50,818	7,133	12.3%
Emergency Care Claims	70,421	66,235	4,186	5.9%
Outpatient Prescription Drug Transactions	1,729,068	1,214,279	514,789	29.8%
Totals:	3,124,897	2,513,120	611,777	19.6%

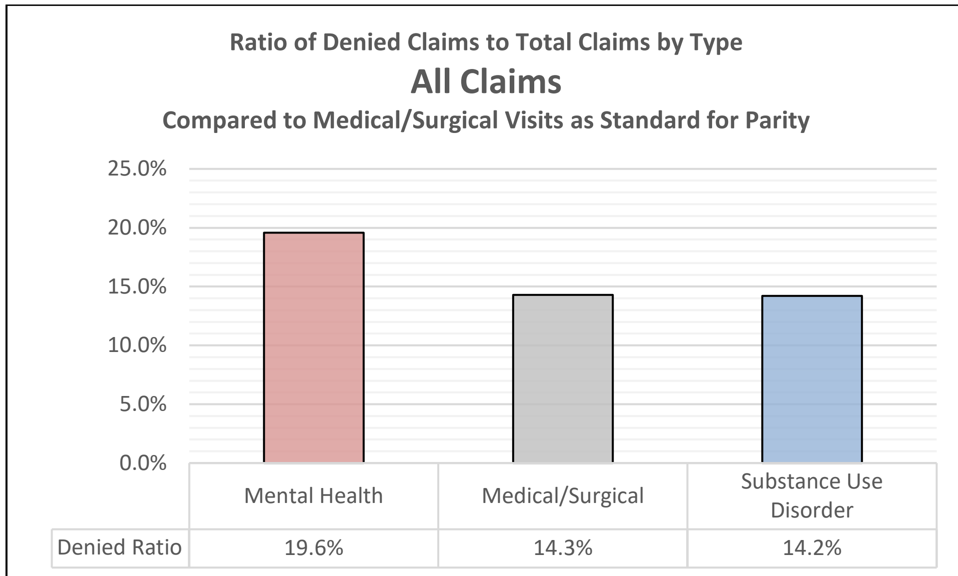
Table 3. Claims Overview – Substance Use Disorder Benefits

Claim Category: Substance Use Disorder Benefits	Total Claims Received	Claims Paid	Claims Denied	% Denied to Total Claims
Office Visit Claims	318,691	302,610	16,081	5.0%
All Other Outpatient Claims	129,727	104,651	25,076	19.3%
Inpatient Claims	33,142	28,181	4,961	15.0%
Emergency Care Claims	22,616	20,549	2,067	9.1%
Outpatient Prescription Drug Transactions	64,859	32,195	32,664	50.4%
Totals:	569,035	488,186	80,849	14.2%

Denied Claim Ratios

The following charts compare the ratios of denied claims to total claims for medical/surgical, mental health, and substance use disorder benefits. Figure 1 shows that the denial rate for claims related to mental health benefits are 5.3% greater than that for medical surgical benefits and 5.4% greater than that for substance use disorder benefits.

Figure 1. Denied Claims Ratio – All Claims



Claim denials were further broken down by the type of service and benefit category. Figure 2 shows the denial rate for Office Visit Claims (such as physician visits) is slightly higher for mental health benefits substance use disorder benefits than for medical/surgical and lower than that for substance use disorder benefits.

Figure 2. Denied Claims Ratio – Office Visit Claims

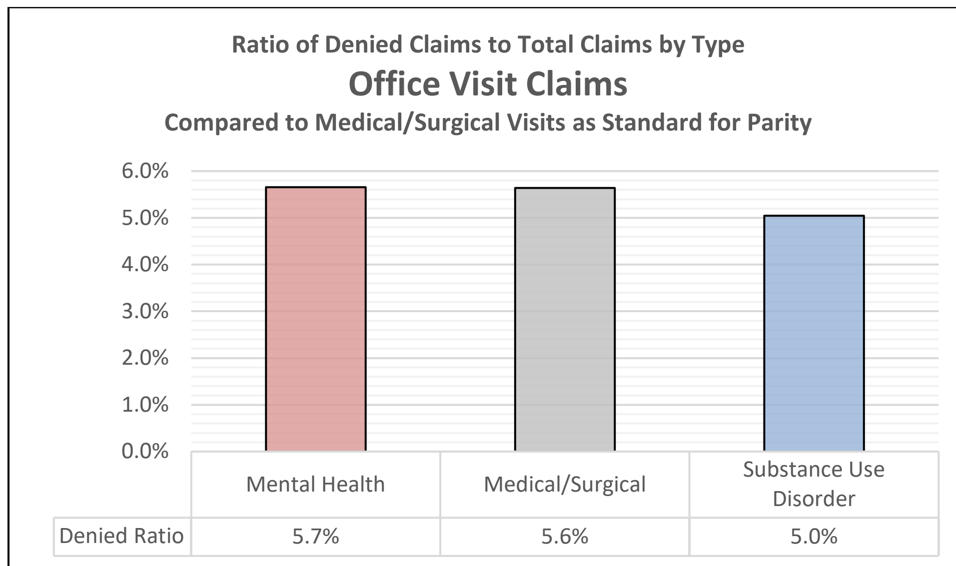


Figure 3 shows that the denial ratio for All Other Outpatient Claims (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items) for substance use disorders exceeds claims denied for mental health benefits and medical/surgical benefits.

Figure 3. Denied Claims Ratio – All Other Outpatient Claims

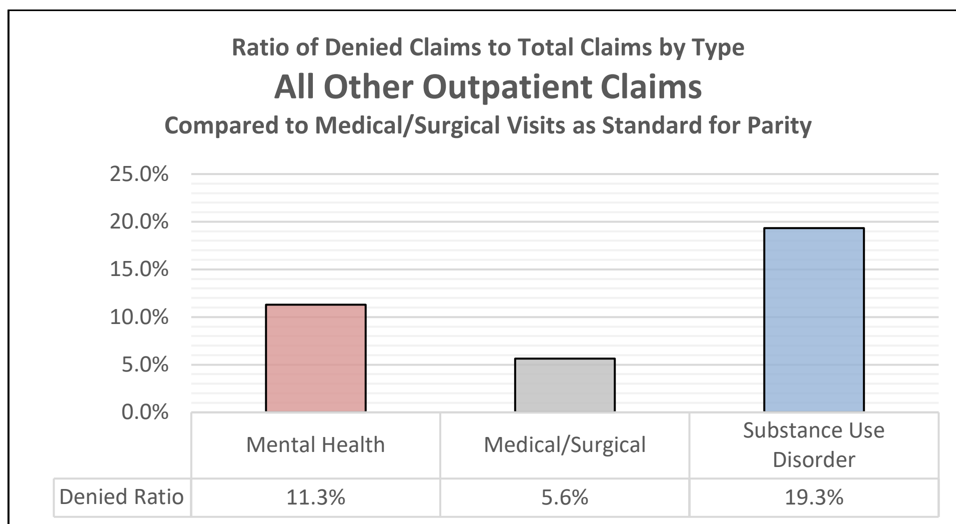


Figure 4 shows the denial rate for Inpatient Claims related to mental health benefits or substance use disorder benefits both exceed claims denied for medical/surgical benefits.

Figure 4. Denied Claims Ratio – Inpatient Claims

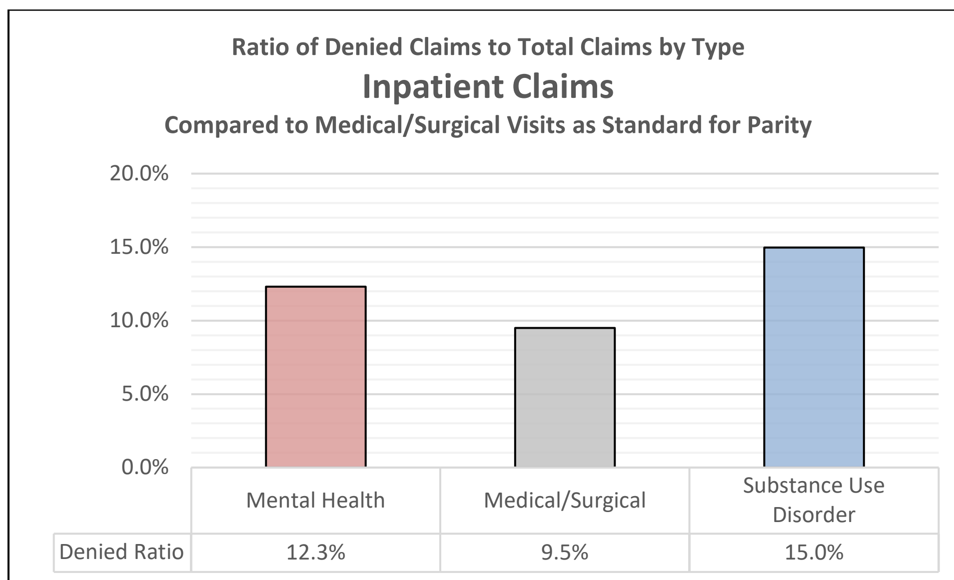


Figure 5 shows the denial rate for Emergency Care Claims related to mental health benefits or substance use disorder benefits are both less than claims denied for medical/surgical benefits.

Figure 5. Denied Claims Ratio – Emergency Care Claims

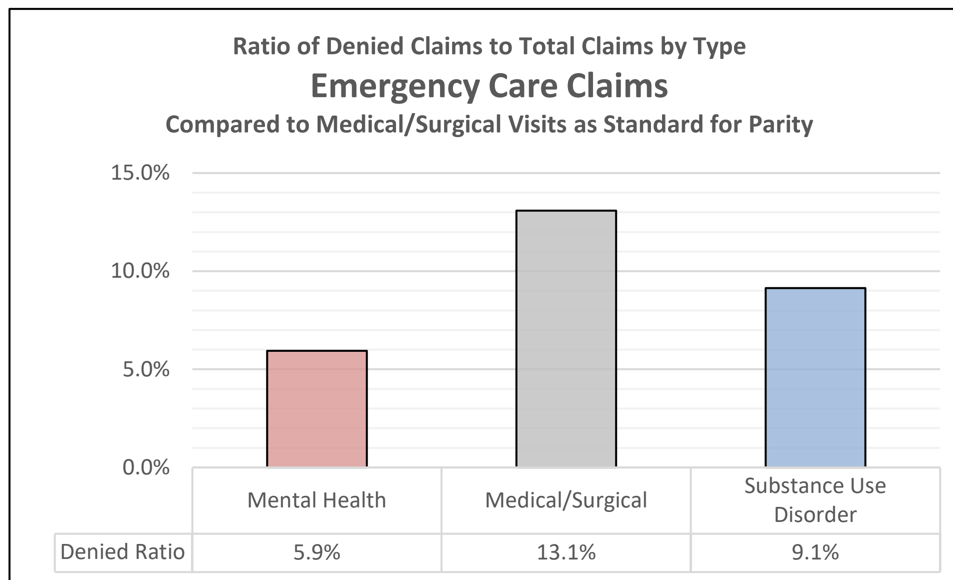
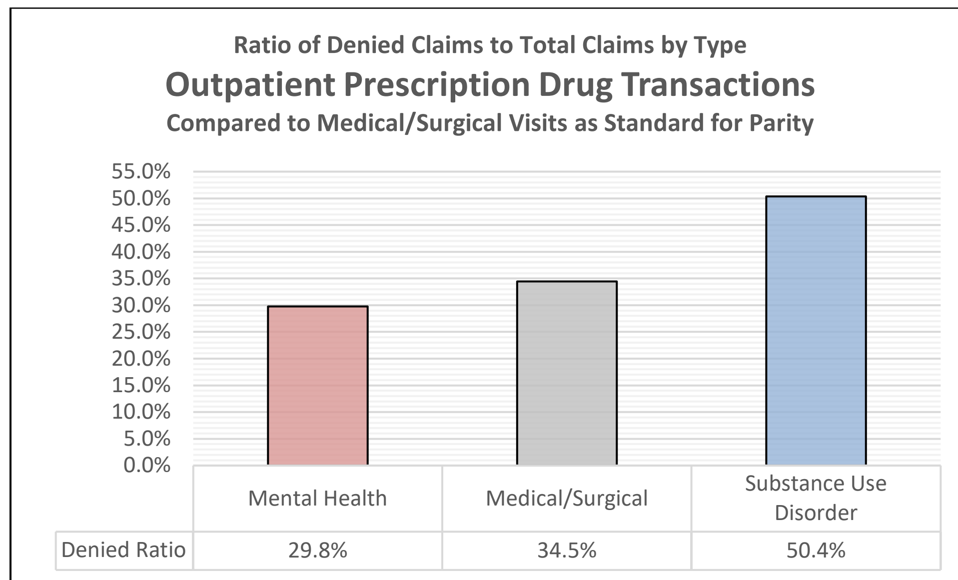


Figure 6 shows that the denial rate for Outpatient Prescription Drug Transactions related to substance use disorder benefits exceeds claims denied for medical/surgical benefits or mental health benefits.

Figure 6. Denied Claims Ratio – Outpatient Prescription Drug Transactions



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

Section II. Complaints

Overview

Carriers were requested to provide the number of complaints submitted to the carrier by either covered persons or the Bureau during 2018 as well as the number of complaints the carrier closed during 2018. A total of 8,468 complaints were reported by the 16 carriers completing the survey. This information was broken down into five complaint areas for each of the three benefit categories: Access to Health Care Services, Utilization Management, Practitioners/Providers, Administrative/Service, and Claims Processing. These five areas are further explained in Attachment B, Complaint Areas.

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

Table 4. Total Complaints

Number of Complaints Related to:	Medical/ Surgical Benefits		Mental Health Benefits		Substance Use Disorder Benefits		All Complaints	
	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year
Access to Health Care Services	825	815	37	37	1	1	863	853
Utilization Management	2,493	2,435	122	122	37	37	2,652	2,594
Practitioners/ Providers	59	58	0	0	0	0	59	58
Administrative/ Service	1,823	1,785	56	56	3	3	1,882	1,844
Claims Processing	6,434	6,345	47	47	79	79	6,560	6,471
Totals	**11,634**	**11,438**	**262**	**262**	**120**	**120**	**12,016**	**11,820**

Table 5. Ratio of Complaints to Their Respective Total

Number of Complaints Related to:	Medical/ Surgical Benefits		Mental Health Benefits		Substance Use Disorder Benefits		All Complaints	
	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year	Submitted During Year	Closed During Year
Access to Health Care Services	7.1%	7.1%	14.1%	14.1%	0.8%	0.8%	7.2%	7.2%
Utilization Management	21.4%	21.3%	46.6%	46.6%	30.8%	30.8%	22.1%	21.9%
Practitioners/ Providers	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	0.5%	0.5%
Administrative/ Service	15.7%	15.6%	21.4%	21.4%	2.5%	2.5%	15.7%	15.6%
Claims Processing	55.3%	55.5%	17.9%	17.9%	65.8%	65.8%	54.6%	54.7%
Totals	11,634	11,438	262	262	120	120	12,016	11,820
Ratio to All Complaints	96.8%	96.8%	2.2%	2.2%	1.0%	1.0%	100.0%	100.0%

Complaint Ratios

The following charts demonstrate how the different areas of complaints related to mental health or substance use disorder benefits compare to those complaint areas for medical/surgical services, which comprised 96.8% of all complaints. For example, of the total complaints carriers received for medical/surgical benefits, 7.1% pertain to complaints regarding access to health care services, whereas 14.1% of the total complaints carriers received for mental health benefits were due to access to health care services. At the same time there were no complaints regarding practitioners/providers for substance use disorder benefits; claims processing produced the greatest percentage of complaints in this benefit category. The charts below are an illustration of the respective ratios.

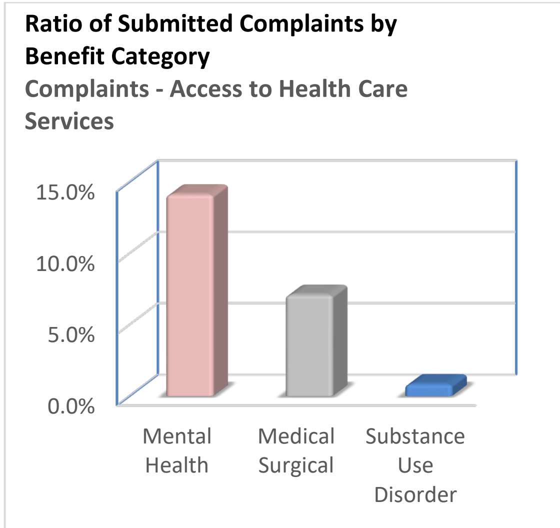


Figure 7. Access to Health Care Services Complaints

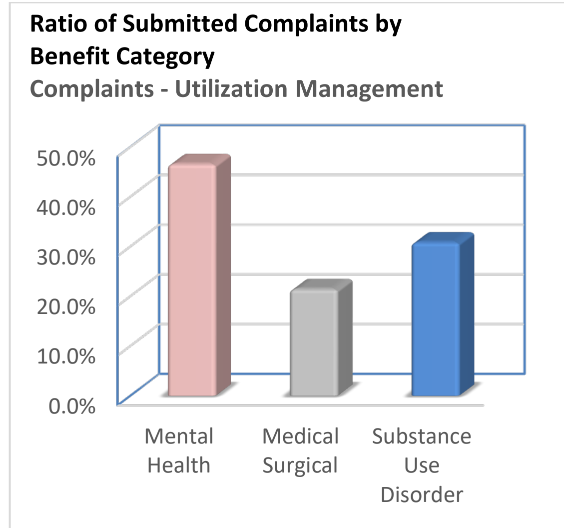


Figure 8. Utilization Management Complaints

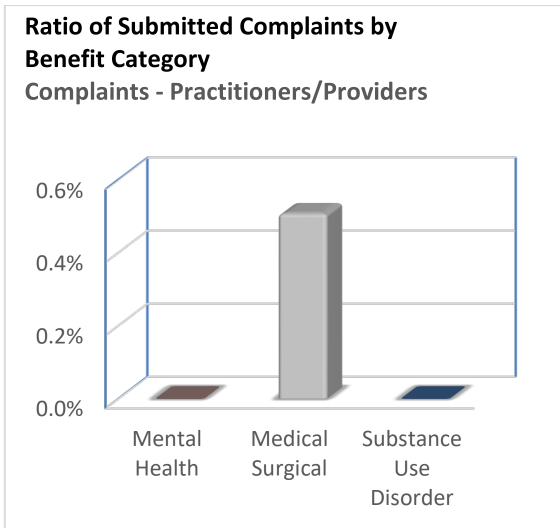


Figure 9. Complaints Regarding Practitioner/Providers

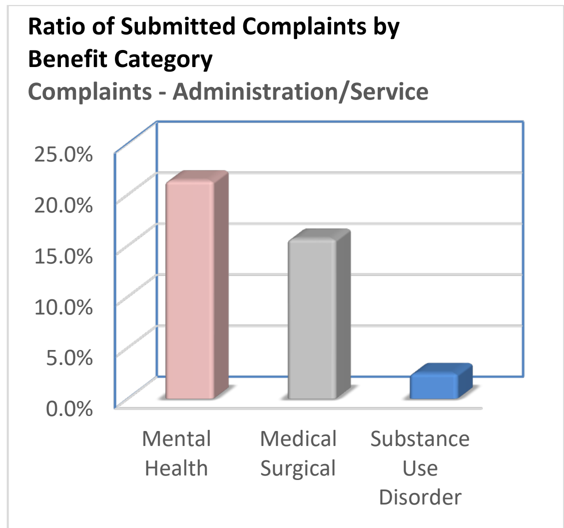


Figure 10. Administrative/Service Complaints

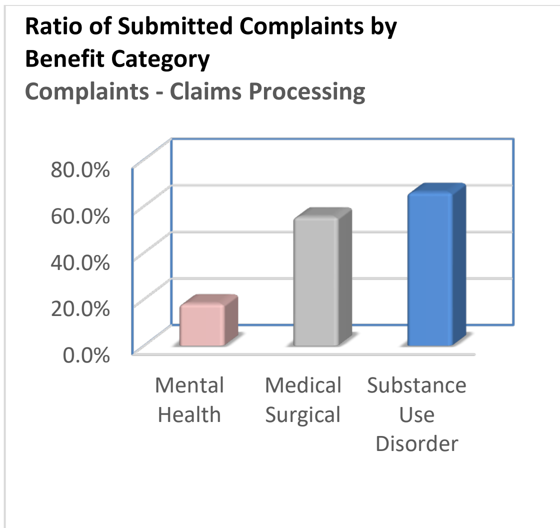


Figure 11. Claims Processing Complaints

Section III. Appeals

Internal Appeals

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

The health carriers responding to the survey reported that a total of 11,849 internal appeals were processed and closed in 2018. Table 6 shows the number of appeals related to the denial of benefits for medical/surgical, mental health, and substance use disorder services and the results of those appeals. Figures 12-14 demonstrate the appeal outcome for the three benefit categories.

Table 6. Closed Internal Appeals

Closed Internal Appeals	Number Related to Medical/ Surgical Benefits	Number Related to Mental Health Benefits	Number Related to Substance Use Disorder Benefits
Internal Appeals – Denial Upheld	**7831**	**94**	**73**
Internal Appeals – Denial Partially Upheld	**190**	**7**	**7**
Internal Appeals – Denial Overturned	**3563**	**67**	**17**
Total Closed Internal Appeals	**11584**	**168**	**97**

Figure 12. Closed Internal Appeals – Denial Upheld

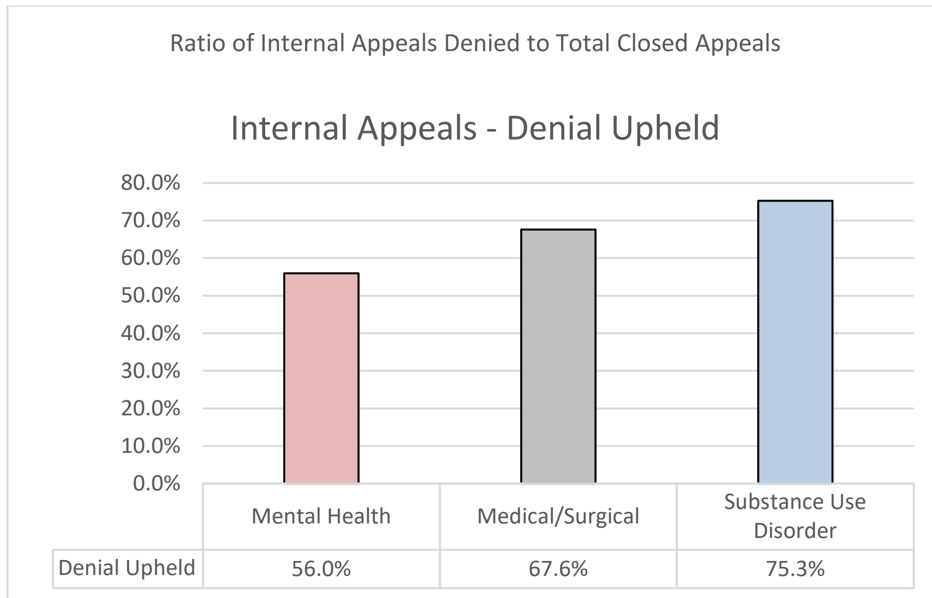


Figure 13. Closed Internal Appeals – Denial Partially Upheld

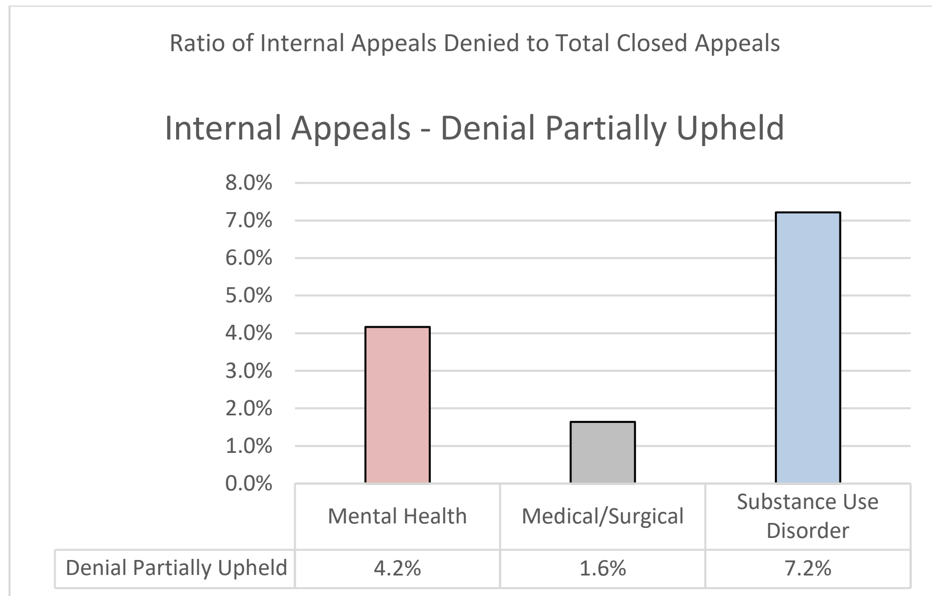
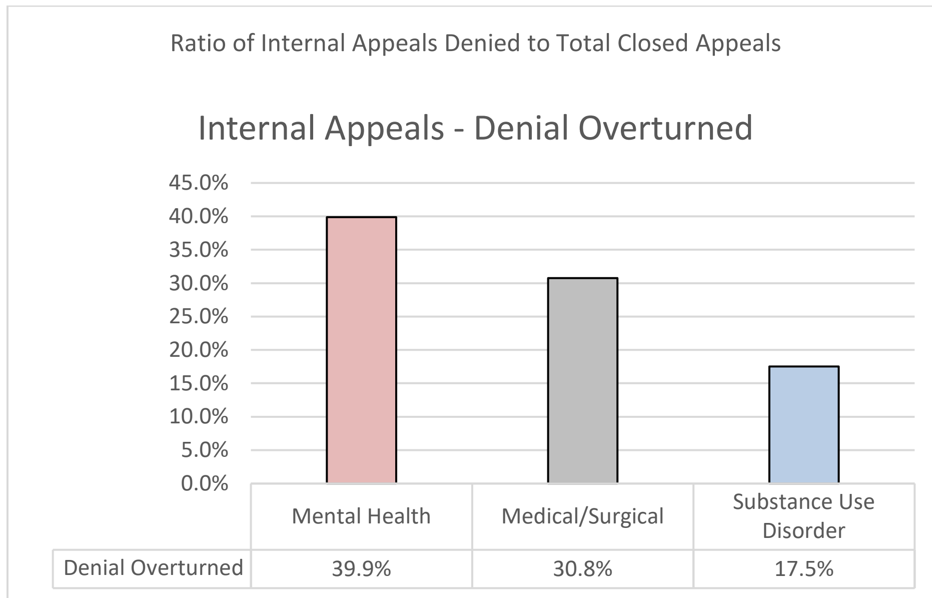


Figure 14. Closed Internal Appeals – Denial Overturned



External Review

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

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

The consumer or an authorized representative may file a written request for an external review within 120 days of the date the consumer receives the health carrier's final decision. The notice sent by the health carrier should provide instructions for when and how the request must be filed. One of the Bureau's approved Independent Review Organization's ("IRO") external reviewers is then assigned the external review on a random basis, taking into account any potential conflict of interest. The IRO will issue a final decision within 45 days for a standard external review and within either 72 hours or six days for an expedited review, depending on whether or not the review relates to a treatment denied on the basis that it is experimental or investigational. The IRO will either uphold the health carrier's denial or overturn it. The health carrier is required by law to accept the external reviewer's decision.

The health carriers responding to the survey reported that 145 external reviews were performed in 2018. Table 7 shows the number of closed external reviews related to medical/surgical, mental health, or substance use disorder benefits and the results of those external reviews. Figures 15, 16, and 17 demonstrate the frequency with which denials were upheld or overturned in external reviews for medical/surgical benefits, mental health benefits, and substance use disorder benefits.

Table 7. Closed External Reviews

Closed External Reviews	Number Related to Medical/ Surgical Benefits	Number Related to Mental Health Benefits	Number Related to Substance Use Disorder Benefits
External Reviews – Denial Upheld	**74**	**4**	**7**
External Reviews – Denial Partially Upheld	**1**	**2**	**0**
External Reviews – Denial Overturned	**56**	**0**	**1**
Total Closed External Reviews	**131**	**6**	**8**

Figure 15. Closed External Reviews - Denial Upheld

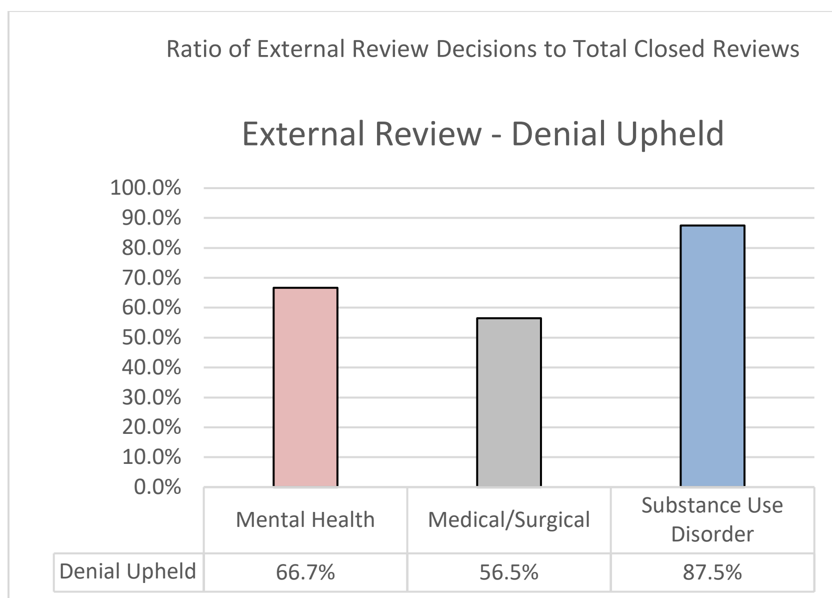


Figure 16. Closed External Reviews – Denial Partially Upheld

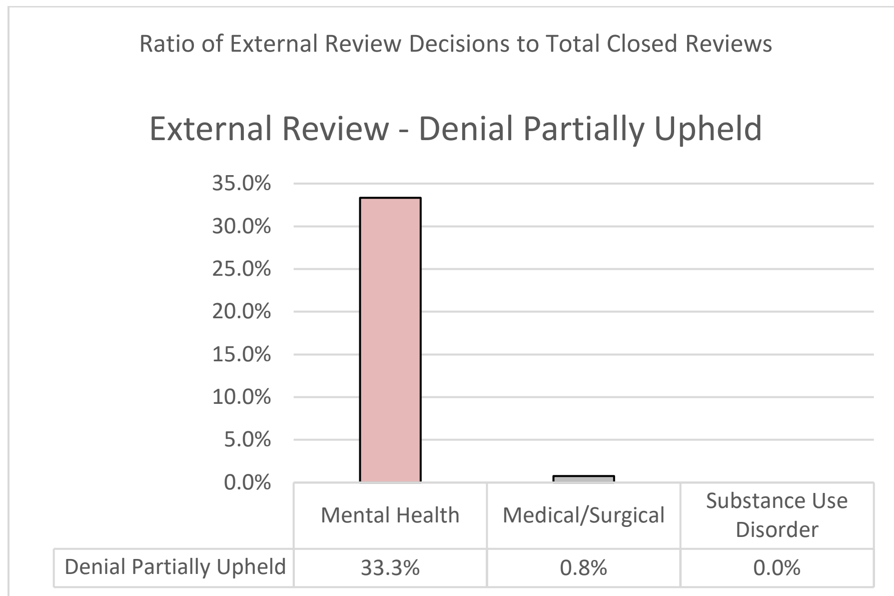
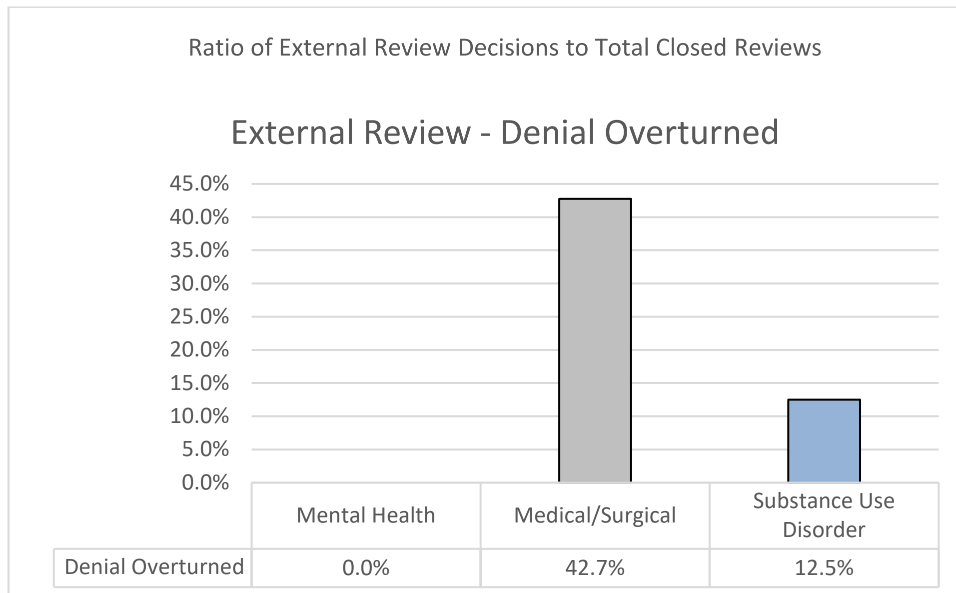


Figure 17. Closed External Reviews – Denial Overturned



Conclusion

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

The carriers reported that of some 6.3 million denied claims, 10.9% were denied for health care services relating to mental health benefits (9.6%) or substance use disorder benefits (1.3%). When comparing the ratio of denied claim to total claims by type, mental health claims are denied at a slightly higher rate (19.6%) than substance use disorder claims (14.2%), and medical/surgical benefits claims (14.3%). The aggregated data in the report shows that depending on the type of claim (office visits, other outpatient claims, inpatient claims, emergency care claims or outpatient prescription drug transactions), claims for mental health benefits were denied either the same or less frequently (3 of 5 categories) than services for medical/surgical benefits, whereas claims for substance use disorder services were generally denied more frequently (3 of 5 categories) than claims for medical/surgical benefits.

There was a total of 12,016 complaints reported as received in 2018 with 382 complaints (3%) representing a complaint on mental health or substance use disorder benefits. Of these, the largest complaint category was utilization management (159), while the fewest complaints were received in the category concerning practitioners or providers (0).

The carriers reported 265 closed internal appeals of claim denials for mental health or substance use disorder benefits with 167 (63%) having the denials upheld. Of the remaining closed internal appeals, the claim denial was overturned in 84 cases with 14 partially overturned. There were 19 closed external reviews with 13 (68%) having the denial upheld and 6 (32%) having the claim denial overturned.

The information requested and obtained was based on the carriers' data recorded and provided to the Bureau for the calendar year ending December 31, 2018. Based on the Bureau's analysis, this information suggests that carriers generally are complying with the statutory requirements relating to parity. The Bureau continues to examine individual carrier mental health parity practices through its Life and Health Market Conduct Section.

Attachment A

Claim Denial Reasons

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

Carriers reported that a total of 3,971,631 denials out of the 6,348,060 total claims denials reported in "Section I. Claims" could be attributed to each carrier's top three claim denial reasons. This means that 2,376,429 reported claim denials were for reasons other than each carrier's top three reasons.

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

Table A-1. Top Three Denial Reasons by Ranking

Denial Reason by Benefit Category	Number of Denials	Rank	% of Denied Claims
Medical/Surgical			
Individual ineligible/not insured when the services were provided	916,559	1	26%
Exceeds benefit limits (contractual)	854,144	2	24%
Not a covered benefit/service contractually excluded	556,864	3	15%
Mental Health			
Prescription refill too soon	104,850	1	22%
Exceeds benefit limits (contractual)	103,760	2	22%
Individual ineligible/not insured when the services were provided	101,625	3	21%
Substance Use Disorders			
Individual ineligible/not insured when the services were provided	11,500	1	26%
Not a covered benefit/service contractually excluded	7,349	2	17%
Provider not participating with the individual's plan	4,936	3	11%

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

Table A-2. Denial Reasons by General Category

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

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

General Categories	All	M/S	MH	SUD
	3,971,631	3,466,947	463,667	41,017
Non-covered benefits or services	2,504,698	2,273,308	210,864	20,526
Prescription drug services	771,458	596,588	173,910	960
Preauthorization or precertification	218,023	164,839	49,821	3,363
Provider or administrative billing	334,292	307,419	18,493	8,380
Non-participating providers or out of network/service area	136,593	119,856	10,117	6,620
Medical necessity or inappropriate service	6,567	4,937	462	1,168

Attachment B

Complaint Areas

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

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

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

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

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