MURIEL BOWSER
MAYOR

November 30, 2021

The Honorable Phil Mendelson
Chairman, Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, NW, Suite 504
Washington, DC 20004

Dear Chairman Mendelson:

Pursuant to section 4(b) of the Behavioral Health Parity Act of 2018, effective March 13, 2019 (D.C. Law 22-242; D.C. Official Code § 31-3175.03(b)), I am pleased to transmit to the Council of the District of Columbia the "'Behavioral Health Parity Act of 2018' 2021 Compliance Report".

The report describes the methodologies used by the Department of Insurance, Securities, and Banking (DISB) to verify compliance with the requirements of the Behavioral Health Parity Act of 2018 (BHPA), provides a statement about market conduct examinations performed within the preceding year, provides a description of any educational or corrective actions DISB took to ensure health insurer compliance with the requirements of the BHPA, and provides a description of DISB's efforts to educate the public regarding mental health condition and substance use disorder protections under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the BHPA.

If you have any questions regarding the report, please contact Commissioner Woods by email at karima.woods@dc.gov or by phone at (202) 727-8000.

Sincerely,

Muriel Bowser
Mayor

Enclosure

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

BEHAVIORAL HEALTH PARITY ACT OF 2018
2021 COMPLIANCE REPORT

NOVEMBER 2021

DISB
Government of the District of Columbia
Department of Insurance, Securities and Banking

WE ARE WASHINGTON DC
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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EXECUTIVE SUMMARY

The Department of Insurance, Securities and Banking (Department) is required to produce an annual report analyzing health insurer compliance with the Behavioral Health Parity Act of 2018, which itself requires insurers to meet the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

The Department collects information on insurer compliance through the Behavioral Health Compliance Report and the Behavioral Health Parity Compliance Template. As with the 2020 report, the Department identified time-based criteria, outpatient claims administration, and claims submission coding errors as key areas to monitor for compliance.

Also consistent with the 2020 report, the Department received four complaints related to mental health and substance abuse disorder claims within the past year.

DISB consistently publishes consumer-facing information on both the Behavioral Health Parity Act and the Mental Health Parity and Addiction Equity Act on our website.

INTRODUCTION

The Behavioral Health Parity Act of 2018, effective March 13, 2019 (D.C. Law 22-242; D.C. Official Code § 31–3175.01 *et seq.*) (BHPA) requires health insurers that are offering health benefit plans in the District to comply with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, approved October 3, 2008 (Pub. L. No. 110-343; 122 Stat. 3881) (MHPAEA).

Section 4(b) of the BHPA (D.C. Official Code § 31–3175.03(b)) sets forth the following reporting requirements for the Department of Insurance, Securities and Banking (Department), and requires that the Department submit an annual report by October 1st that contains the following:

1. The methodologies used by the Department to verify compliance with the requirements of the BHPA;
2. A statement and description of any market conduct examinations performed by the Department during the preceding year;
3. A description of any educational or corrective actions the Department took to ensure health insurer compliance with the requirements of the BHPA; and
4. A description of the Department's efforts to educate the public regarding mental health conditions and substance use disorder protections under MHPAEA and the BHPA.

This report is intended to both comply with the reporting requirements of the BHPA and further educate the Council on the steps the Department has taken to ensure its own compliance and that of health insurance issuers.

1. DEPARTMENT METHODOLOGY FOR COMPLIANCE VERIFICATION

Reporting and Tool Mechanisms

The Department developed tools and reporting templates which collect uniform qualitative and quantitative data from both public and commercial insurance carriers (the issuer) subject to the reporting requirements of the BHPA. The Department created two reporting tools that ensure compliance with section 4(a) of the BHPA (D.C. Official Code § 31–3175.03(a)), which establishes the reporting requirements for insurers: (1) the *Behavioral Health Compliance Report*, which collects qualitative information, and (2) the *Behavioral Health Parity Compliance Template*, which collects quantitative data on prior authorizations and denial of claims for both medical/surgical benefits (med/surg) and mental health/substance abuse disorder (MH/SUD).

Behavioral Health Compliance Report

The *Behavioral Health Compliance Report* is an open response form that collects information regarding processes in place for determining medical necessity criteria and non-quantitative treatment limitations, the reasons for denial of claims, and medication-assisted treatment attestation for Medicaid products.

Behavioral Health Parity Compliance Template

The *Behavioral Health Parity Compliance Template* collects quantitative prior authorization and denial of claims data for both med/surg and MH/SUD services at the product level for all market types. The tool also has a functionality to internally flag potential parity issues between the two service categories. For example, if inpatient med/surg claims are denied at a lower rate than in-patient MH/SUD services, then the tool will indicate this. This allows the Department to act quickly and follow up with the issuer about any flagged parity violations.

Parity Issues Overview

The Department defined potential parity issues as any instance where the rate of denial for MH/SUD Services was higher than the rate of denial for Med/Surg Services. An exception is in the claims administration criterion of *Claims denied within 0-30 days*, in which case a potential parity issue is flagged if the rate for MH/SUD services is lower than that of Med/Surg Services. This is because a higher claim denial rate for MH/SUD is preferable early on so that insurers don't delay addressing claims and end up denying them later on. Percentage differences between 0-10% were flagged in yellow and percentage differences greater than 10% in red. This differentiated minor parity issues from major ones.

Within the time-based categories, the most parity issues were found within the category *Claims denied within 0-30 days* for both in-network and out-of-network claims. Time-based categories as a whole had more parity issues than the non-time-based categories. The Department observed the most major parity issues in the *Claims Submission Coding Errors* categories between in-network and out-of-network claims. A further summary of these observations is provided in the **Efforts to Ensure Health Insurer Compliance** section below.

In review of previous submissions and in discussion with issuers the following three themes have emerged as areas to monitor:

- **Time-based criteria:** Time-based criteria was consistently flagged as a potential parity issue throughout the data template review process. Issuers across the different claims categories consistently take longer amounts of time to adjudicate claims regarding MH/SUD services than they do for Med/Surg services.

- **Outpatient Claim Administration:** The total Percentage of potential parity issues for Claims Administration, Excluding Pharmacy.
- **Claims Submission Coding Error(s):** The Department flagged parity issues related to claims submission coding error(s) and why MH/SUD claims are experiencing this barrier to administration more often than Med/Surg.

For more details and sample data analysis to support the findings please refer to Appendix A.

2. MARKET CONDUCT EXAMINATIONS

Updates on market conduct examinations both initiated and completed will be provided to the Council if such action is necessary in the future.

3. EFFORTS TO ENSURE HEALTH INSURER COMPLIANCE

Since last year's report to Council containing data up to September 30, 2020, through September 21, 2021, the Department has received the following complaints (included herein without any indication of their merit) related to mental health/substance use disorders:

INSURER/PRODUCT	REASON FOR COMPLAINT
CAREFIRST BLUECHOICE, INC., Group HMO Product	Claim handling
CAREFIRST BLUECHOICE, INC., Group Product	Claim handling (denial)
CAREFIRST BLUECHOICE, INC., Group HMO Product	Claim handling
AETNA HEALTH INSURANCE COMPANY, Group Product	Claim handling

4. EDUCATION AND OUTREACH

The Department has embraced the BHPA as an opportunity to provide consumer education on mental health and substance abuse treatment services within the District. The COVID-19 pandemic precluded in-person, consumer-facing meetings during the relevant time period, but Department of Health rules relating to the pandemic facilitating telemedicine, and DISB orders requiring insurers to cover telehealth services at the same rate as in-person services, helped persons to gain or maintain access to their mental and behavioral health providers, who played a critical role in providing services that were critically needed when so many persons experienced extra psychological and economic challenges arising from the pandemic itself.. In addition, the Department continued to share information about MHPAEA and BHPA on its website for consumers.

5. ONGOING MONITORING

The Department will continue to monitor the parity analysis on annual basis to determine whether MH and SUD benefits continue to meet parity requirements. DISB will also conduct reviews on an ad-hoc bases as needed in response to concerns raised by stakeholders, multi-state examinations and complaints filed by plan participants.

APPENDIX A:

METHODOLOGY FOR SUMMARY TABLE COMPLETION

Following the issuer submission period of the Behavioral Health Compliance Report, each issuer's submission was examined for potential parity issues at the plan level. The assessment of parity issues was completed by identifying the percent of total claim denials for in-network and out-of-network claims by each service setting for claims excluding pharmacy and claims including only pharmacy. The percentage of total claims denied for in-network and out-of-network claims was calculated at the plan level for each issuer. The percent of total claims was calculated as the number of claims denied for each of the eight criteria listed below divided by the total number of claim denials for in-network and out-of-network denials. The eight criteria are:

1. Claims denied within 0-30 days.
2. Claims denied within 31-60 days.
3. Claims denied within 61-90 days.
4. Claims denied beyond 90 days.
5. Percentage denied, rejected, or returned – Claims Submission Coding Error(s).
6. Percentage denied, rejected, or returned – Prior Authorization Needed.
7. Percentage denied, rejected, or returned – Non-Covered Benefit or Benefit Limitation.
8. Percentage denied, rejected, or returned – Not Medically Necessary.

For example, the percent of total for Claims denied within 0-30 days was calculated as:

$$\frac{\text{In-network/out-of-network claims denied within 0-30 days}}{\text{Number of claim denials for in-network/out-of-network claims}}$$

And the percent of total for Percentage of in-network/out-of-network denied, rejected, or returned – Claims Submission Coding Error(s) was calculated as:

$$\frac{\text{Number of in-network/out-of-network denied, rejected, or returned – Claims Submission Coding Error(s)}}{\text{Number of claim denials for in-network/out-of-network claims}}$$

Lastly, the percent of total for Prior Authorizations was calculated as:

$$\frac{\text{Number of Prior Authorizations Approved/Denied}}{\text{Number of Prior Authorizations Requested}}$$

Once each issuer's submission was assigned, a percent of total claims denied was added to each claim criterion. Those findings were summarized by issuer and by each claims category (*e.g.,* Claims Administration, Excluding Pharmacy for Inpatient Services). For claims categories where the difference between the percentages was less than 10%, the row was flagged in yellow. For claims categories where

the difference between the percentages was greater than 10%, the row was flagged in red. As such, each issuer had six summary tables by plan level. For illustrative purposes, only one summary table by claims category of the accompanying Excel workbook to this report titled 2021 BHPA Issuer Summary Reports is included here.

2021 BHPA SUBMISSION SUMMARY TABLES

Claim Administration, Excluding Pharmacy for Inpatient Services[1]

SAMPLE LARGE GROUP PLANS:

Category	Med/Surg	MH/SUD
Claims Administration Excluding Pharmacy for Inpatient Services		
Universe of claim denials for in-network claims.	100.0%	100.0%
a. In-network claims denied within 0-30 days.	75.3%	84.5%
b. In-network Claims denied within 31-60 days.	3.6%	0.6%
c. In-network Claims denied within 61-90 days.	2.6%	0.6%
d. In-network Claims denied beyond 90 days.	18.5%	14.2%
Percentage of in-network denied, rejected, or returned - Claims Submission Coding Error(s).	23.7%	20.6%
Percentage of in-network denied, rejected, or returned - Prior Authorization Needed.	9.0%	1.3%
Percentage of in-network denied, rejected, or returned - Non-Covered Benefit or Benefit Limitation.	4.8%	0.0%
Percentage of in-network denied, rejected, or returned - Not Medically Necessary.	3.8%	34.2%
Universe of claim denials for out-of-network claims.	100.0%	100.0%
a. Out-of-network claims denied within 0-30 days.	84.7%	74.1%
b. Out-of-network Claims denied within 31-60 days.	9.0%	3.6%
c. Out-of-network Claims denied within 61-90 days.	0.2%	1.8%
d. Out-of-network Claims denied beyond 90 days.	6.1%	20.5%
Percentage of out-of-network denied, rejected, or returned - Claims Submission Coding Error(s).	32.0%	14.3%
Percentage of out-of-network denied, rejected, or returned - Prior Authorization Needed.	0.8%	0.0%
Percentage of out-of-network denied, rejected, or returned - Non-Covered Benefit or Benefit Limitation.	4.3%	0.9%
Percentage of out-of-network denied, rejected, or returned - Not Medically Necessary.	1.2%	0.0%

Figure 1

[1] Please note that the percentages of each criterion do not represent the percent of all claims processed by an issuer. The percentages represent the share of claim denials of a certain criterion by all claims denied. As such, the 100% of total represented for Universe of claim denials for in-network and out-of-network claims does not indicate that all claims that were processed were denied.

Figure 1 displays the claims denials for Non-Emergency Medical/Surgical (Med/Surg) Services and for Mental Health and Substance Use Disorder (MH/SUD) Emergency Services as a percent of total claims by criteria or measure. The potential parity issues which are highlighted in yellow and red in **Figure 1** are *Percentage of in-network denied, rejected, or returned – Not Medically Necessary*, *Out of Network Claims denied within 0-30 days*, O*ut of Network Claims denied within 60-90 days* and *Out-of-Network claims denied beyond 90 days*. In all cases, the percent of all claims denied is lower for Med/Surg than it is for MH/SUD services.

CLAIMS ADMINISTRATION, EXCLUDING PHARMACY FOR OUTPATIENT SERVICES[2]
Sample Large Group Plans:

Claims Administration Excluding Pharmacy for Outpatient Services	Med/Surg	MH/SUD
Universe of claim denials for in-network claims.	100.0%	100.0%
a. In-network claims denied within 0-30 days.	95.5%	100.0%
b. In-network Claims denied within 31-60 days.	1.8%	0.0%
c. In-network Claims denied within 61-90 days.	1.5%	0.0%
d. In-network Claims denied beyond 90 days.	1.3%	0.0%
Percentage of in-network denied, rejected, or returned - Claims Submission Coding Error(s).	22.2%	40.0%
Percentage of in-network denied, rejected, or returned - Prior Authorization Needed.	0.0%	0.0%
Percentage of in-network denied, rejected, or returned - Non-Covered Benefit or Benefit Limitation.	30.7%	60.0%
Percentage of in-network denied, rejected, or returned - Not Medically Necessary.	0.0%	0.0%
Universe of claim denials for out-of-network claims.	100.0%	N/A
a. Out-of-network claims denied within 0-30 days.	83.7%	N/A
b. Out-of-network Claims denied within 31-60 days.	3.9%	N/A
c. Out-of-network Claims denied within 61-90 days.	3.7%	N/A
d. Out-of-network Claims denied beyond 90 days.	8.7%	N/A
Percentage of out-of-network denied, rejected, or returned - Claims Submission Coding Error(s).	25.7%	N/A
Percentage of out-of-network denied, rejected, or returned - Prior Authorization Needed.	0.0%	N/A
Percentage of out-of-network denied, rejected, or returned - Non-Covered Benefit or Benefit Limitation.	33.7%	N/A
Percentage of out-of-network denied, rejected, or returned - Not Medically Necessary.	0.0%	N/A

Figure 2

[2] Please note that the percentages of each criterion do not represent the percent of all claims processed by an issuer. The percentages represent the share of claim denials of a certain criterion by all claims denied. As such, the 100% of total represented for Universe of claim denials for in-network and out-of-network claims does not indicate that all claims that were processed were denied.

Figure 2 displays claims denials for Med/Surg Services and for MH/SUD Emergency Services as a percent of total claims by criteria or measure. As **Figure 2** illustrates, there are some criteria which stand out as potential parity issues. 22.2% of in-network claims are denied, rejected, or returned because of claims submission coding errors for Med/Surg services compared to 40% of all claims denials in MH/SUD being denied for the same reason. Additionally, 30.7% of in-network claims were denied, rejected, or returned because of Claims Submission Coding Errors for Med/Surg services compared to 60% of claims for MH/SUD services.

CLAIM ADMINISTRATION, PHARMACY ONLY FOR INPATIENT SERVICES[3]
Sample Individual Plans:

Claims Administration, Pharmacy Only for Inpatient Services	Med/Surg	MH/SUD
Universe of claim denials for in-network claims.	100.0%	100.0%
a. In-network claims denied within 0-30 days.	80.1%	86.1%
b. In-network Claims denied within 31-60 days.	19.6%	13.1%
c. In-network Claims denied within 61-90 days.	0.2%	0.8%
d. In-network Claims denied beyond 90 days.	0.1%	0.0%
Percentage of in-network denied, rejected, or returned - Claims Submission Coding Error(s).	1.4%	10.7%
Percentage of in-network denied, rejected, or returned - Prior Authorization Needed.	9.2%	0.0%
Percentage of in-network denied, rejected, or returned - Non-Covered Benefit or Benefit Limitation.	1.1%	0.0%
Percentage of in-network denied, rejected, or returned - Not Medically Necessary.	0.0%	0.0%
Universe of claim denials for out-of-network claims.	100.0%	100.0%
a. Out-of-network claims denied within 0-30 days.	71.2%	93.4%
b. Out-of-network Claims denied within 31-60 days.	27.8%	3.3%
c. Out-of-network Claims denied within 61-90 days.	0.1%	3.3%
d. Out-of-network Claims denied beyond 90 days.	0.9%	0.0%
Percentage of out-of-network denied, rejected, or returned - Claims Submission Coding Error(s).	2.1%	0.0%
Percentage of out-of-network denied, rejected, or returned - Prior Authorization Needed.	13.0%	0.0%
Percentage of out-of-network denied, rejected, or returned - Non-Covered Benefit or Benefit Limitation.	5.2%	0.0%
Percentage of out-of-network denied, rejected or returned - Not Medically Necessary.	0.0%	0.0%

Figure 3

[3] Please note that the percentages of each criterion do not represent the percent of all claims processed by an issuer. The percentages represent the share of claim denials of a certain criterion by all claims denied. As such, the 100% of total represented for Universe of claim denials for in-network and out-of-network claims does not indicate that all claims that were processed were denied.

Some areas that appear as potential parity issues in this category are: *Percentage of in-network claims denied within 61-90 days* and *Percentage of in-network denied, rejected, or returned – Claims Submission Coding Errors*.

CLAIM ADMINISTRATION, PHARMACY ONLY FOR OUTPATIENT SERVICES[4]
Sample Large Group Plans:

Claims Administration, Pharmacy Only for Outpatient Services	Med/Surg	MH/SUD
Universe of claim denials for in-network claims.	100.0%	100.0%
a. In-network claims denied within 0-30 days.	97.8%	87.4%
b. In-network Claims denied within 31-60 days.	1.1%	1.1%
c. In-network Claims denied within 61-90 days.	0.3%	0.0%
d. In-network Claims denied beyond 90 days.	0.8%	11.6%
Percentage of in-network denied, rejected or returned - Claims Submission Coding Error(s).	7.4%	44.2%
Percentage of in-network denied, rejected or returned - Prior Authorization Needed.	0.0%	0.0%
Percentage of in-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.	1.4%	1.1%
Percentage of in-network denied, rejected or returned - Not Medically Necessary.	0.0%	0.0%
Universe of claim denials for out-of-network claims.	100.0%	100.0%
a. Out-of-network claims denied within 0-30 days.	92.5%	87.2%
b. Out-of-network Claims denied within 31-60 days.	3.2%	0.0%
c. Out-of-network Claims denied within 61-90 days.	0.8%	0.0%
d. Out-of-network Claims denied beyond 90 days.	3.5%	12.8%
Percentage of out-of-network denied, rejected or returned - Claims Submission Coding Error(s).	50.9%	51.3%
Percentage of out-of-network denied, rejected or returned - Prior Authorization Needed.	0.0%	0.0%
Percentage of out-of-network denied, rejected or returned - Non-Covered Benefit or Benefit Limitation.	4.6%	0.0%
Percentage of out-of-network denied, rejected or returned - Not Medically Necessary.	0.6%	0.0%

Figure 4

Potential parity issues in **Figure 4** include *In-network claims denied within 0-30 days*, *In-network claims denied beyond 90 days*, *Percentage of in-network denied, rejected or returned – Claims Submission Coding Error(s)*, *Out-of-network claims denied within 0-30 days, Out of network claims denied beyond 90 days*, *and Percentage of out-of-network denied, rejected or returned – Claims Submission Coding Errors*.

[4] Please note that the percentages of each criterion do not represent the percent of all claims processed by an issuer. The percentages represent the share of claim denials of a certain criterion by all claims denied. As such, the 100% of total represented for Universe of claim denials for in-network and out-of-network claims does not indicate that all claims that were processed were denied.

PRIOR AUTHORIZATIONS, EXCLUDING PHARMACY[5]
Sample Small Group Plans:

Prior Authorizations (Prospective Utilization Review Requests) Excluding Pharmacy	
Universe of prior authorizations requested.	100.0%
Percentage of prior authorizations approved.	91.1%
Percentage of prior authorizations denied.	8.9%
Universe of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders.	100.0%
Percentage of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied.	8.7%
Percentage of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved.	91.3%

Figure 5

Figure 5 illustrates that of all prior authorizations for the presented sample of Small Group Plans, 8.7% are denied for MH/SUD services compared to 8.9% for total services. Thus, 91.3% of prior authorizations are approved for MH/SUD services compared to 91.1% of total prior authorizations approved. This chart does not flag for prior authorization parity issues.

[5] Please note that the percentages of each criterion do not represent the percent of all claims processed by an issuer. The percentages represent the share of prior authorizations requested of a certain criterion by all prior authorizations requested. As such, the 100% of total represented for Universe of prior authorizations requested does not indicate that all claims that were processed required prior authorization.

PRIOR AUTHORIZATIONS, INCLUDING PHARMACY[6]
Sample Medicaid Product:

Prior Authorizations (Prospective Utilization Review Requests) Pharmacy Only	
Universe of prior authorizations requested.	100%
Percentage of prior authorizations approved.	65%
Percentage of prior authorizations denied.	35%
Universe of prior authorizations requested for mental health benefits, behavioral health benefits, and substance use disorders.	100%
Percentage of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders denied.	32%
Percentage of prior authorizations for mental health benefits, behavioral health benefits, and substance use disorders approved.	68%

Figure 6

Figure 6 illustrates that of all prior authorizations for the insurance company's Medicaid product, 32% are denied for MH/SUD services compared to 35% for all prior authorizations. Sixty-eight percent of MH/SUD prior authorizations were approved compared to 65% of total prior authorizations approved.

[6] Please note that the percentages of each criterion do not represent the percent of all claims processed by an issuer. The percentages represent the share of prior authorizations requested of a certain criterion by all prior authorizations requested. As such, the 100% of total represented for Percentage of prior authorizations requested does not indicate that all claims that were processed required prior authorization.