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MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

NON-QUANTITATIVE TREATMENT LIMITS

SUMMARY REPORT

(PURSUANT TO NRS 687B.404)

12/31/2025

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Glossary of Acronyms and Terms

Below are definitions of the various abbreviations and acronyms used throughout this Report.

ACA: Affordable Care Act

Act – Nevada Mental Health Parity Act

CAR: Comparative Analysis Report

Data Call Responses: Carrier submissions including the Data Call Template and all supporting materials necessary to show compliance with MHPAEA comparative analysis provisions.

Data Review Team: Regulatory Insurance Advisors, LLC and Division staff

Data Call Template: Excel workbook and data request developed by the Data Review Team to support collection of MHPAEA compliance data and materials.

INN: In-Network

MH/SUD: Mental Health / Substance Use Disorder

MHPAEA: Mental Health Parity and Addiction Equity Act of 2008

Med/Surg: Medical/Surgical

NQTL: Non-Quantitative Treatment Limitation

Division: Nevada Division of Insurance

OON: Out-of-Network

RIA: Regulatory Insurance Advisors, LLC

U.S.C. – United States Code

I. INTRODUCTION & AUTHORITY

NRS 687B.404 (1) requires an insurer or other organization providing health coverage pursuant to chapter 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of the Nevada Revised Statutes, including, without limitation, a health maintenance organization or managed care organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid, to adhere to the applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Public Law 110-343, Division C, Title V, Subtitle B, and any federal regulations issued pursuant thereto.

NRS 687B.404 (2) also requires the Commissioner of Insurance, on or before July 1st of each year, to prescribe and provide a data request that solicits information necessary to evaluate the compliance of an insurer or other organization with MHPAEA, including the comparative analyses specified in 42 U.S.C. § 300gg-26(a)(8).

Further, NRS 687B.404 (5) requires the Commissioner on or before December 31 of each year, the Commissioner shall compile a report summarizing the information submitted to the Commissioner pursuant to this section and submit the report to:

(a) The Patient Protection Commission created by NRS 439.908;
(b) The Governor; and
(c) The Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the next regular session of the Legislature; and
(2) In odd-numbered years, the Joint Interim Standing Committee on Health and Human Services.

II. PROCESS & METHODOLOGY

The Nevada Division of Insurance ("Division") engaged Regulatory Insurance Advisors ("RIA") to create the data request required under NRS 687B.404 (1) and to review subsequent responses and supporting documentation. The information requested from the Carriers included: Comparative Analysis Reports; Medical Management Guidelines utilized to determine Utilization Management ("UM") criteria; UM Requirements for Prior-Authorization ("PA"), Concurrent Review ("CR") and Retrospective Review ("RR"); Network Adequacy; Credentialing Criteria for MH/SUD and Med/Surg providers; Reimbursement Rates; and Claims Ratios and Modification Ratios.

- Complete and accurate classification of covered services, including:
  - Accurate definitions of services as MH/SUD or Med/Surg,
  - Appropriate classification of services as in-network inpatient, out-of-network inpatient, in-network outpatient (office and other if subclassifying),

out-of-network outpatient (office and other if subclassifying), pharmacy and emergency visits.

- Complete and accurate comparisons of Medical Management protocols, including sufficient supporting documentation,
  - For PA, CR, and RR, narratives for comparability both as written and in operation.
- Complete and accurate comparisons of each Network-related Non-Quantitative Treatment Limitation ("NQTL"), including sufficient supporting documentation, with narratives identifying comparability as written and in operation.
- Complete and accurate comparisons of application of medical necessity to covered services, including supporting documentation with narratives identifying comparability as written and in operation.

The Federal Regulations define an NQTL as follows:

> **45 CFR 146.136: Parity in mental health and substance use disorder benefits**
>
> (a) Meaning of terms. For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:
>
> …
>
> *(4) Nonquantitative treatment limitations—*
> *(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification* ***are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.***
> *(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include—*
> *(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;*
> *(B) Formulary design for prescription drugs;*
> *(C) Standards for provider admission to participate in a network, including reimbursement rates;*

(D) Plan methods for determining usual, customary, and reasonable charges;
(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail first policies or step therapy protocols); and,
(F) Exclusions based on failure to complete a course of treatment

Nevada Revised Statute 687B.404(1) provides the authority for the Division to enforce this federal law:

NRS 687B.404 Adherence by insurer or organization providing health coverage to certain federal laws regarding mental health and addiction data request; submission of data or report to Commissioner; confidentiality of information; report by Commissioner; regulations.

1. An insurer or other organization providing health coverage pursuant to chapter 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of NRS, including, without limitation, a health maintenance organization or managed care organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid, shall adhere to the applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, Division C, Title V, Subtitle B, and any federal regulations issued pursuant thereto.

It is important to understand that an NQTL in and of itself is not a violation, but pursuant to Federal Regulation, the NQTL must be comparable to, and applied no more stringently to MH/SUD providers than to Med/Surg providers. For example, assume a claims administrator has discretion to approve benefits for treatment based on medical necessity. If that discretion is routinely used to approve Med/Surg benefits while simultaneously used to deny MH/SUD benefits and recognized clinically appropriate standards of care do not permit such a difference, the processes used in applying the medical necessity standard are applied more stringently to MH/SUD benefits. The use of discretion in the matter would be an NQTL parity violation.

Additional information in the form of universe data files for claims, including pharmacy, credentialing activity, and utilization management activity for the period was requested from the Carriers. “In operation” data reviews include identifying and reviewing how the Carriers are performing and providing services in application to insureds, to identify NQTL concerns or potential violations, as well as but not limited to the following:

- Clinical review practices which include the act of providing clinical judgment to a utilization review case, typically involving a utilization review manual. An NQTL concern or violation would occur when the Clinical review practices that are utilized in application as compared to the “as written” materials presented are inconsistent.

- Expert reviewer consultation in which the Carrier seeks out the opinion of a practitioner or reviewer who manages the care in question. For example, a health plan may need to seek out the opinion of a dermatologist if they do not have one on their medical director staff, and when a request may be for a service or item in which dermatology is the appropriate prescribing specialty. An NQTL concern or violation would occur when the Carrier utilizes expert reviewer consultation for Med/Surg reviews and determinations with the appropriate background and education but does not utilize experts with the appropriate background and education for MH/SUD reviews and determinations.
- Carrier application of medical or professional judgement that includes a professional exercising the scope of their expertise or licensure, likely acting only within that scope, and not consulting a utilization review manual. An NQTL concern or violation would occur if the Carrier used medical or professional judgement with appropriate background and education for Med/Surg reviews and developing medical management guidelines, while using medical or professional judgement that do not have the appropriate background and education to perform MH/SUD reviews and develop medical management guidelines.
- Provider contract negotiation involves staff from the health plan entering into agreement and terms of a contract with a medical or behavioral health provider. This process may include negotiating rates upon which the provider will be reimbursed when submitting claims for services. An NQTL concern or violation would occur when more stringent or difficult provider contract negotiations exist for MH/SUD providers than Med/Surg providers, and decreased reimbursements for the same services.
- In network and out-of-network utilization refers to the actual number of claims utilized or submitted for in-network, contracted plan providers, versus out-of-network, non-contracted providers. An NQTL concern or violation may occur when access to in-network providers is more prominent for Med/Surg benefits than MH/SUD benefits.

The “in operation” data request required the Carriers to submit raw data universes for the 2024 period. The data request was specific to: Claims, including Pharmacy, Utilization Management, and Credentialing. This raw data was also utilized to determine Network Adequacy and Reimbursement Rates. Comprehensive data analytics were performed on the data provided to compare the “as written” responses to the “in operation” data. For example, if a Carrier states in their “as written” documentation that they do not require prior authorization on any MH/SUD benefits, analytics were performed to identify any MH/SUD claims that were denied for no prior authorization.

III. AS WRITTEN FINDINGS

Data analytics performed identified clear NQTL violations as well as indications of violations where additional reviews may be beneficial with the "in operation" data. This report presents a breakdown of the violations and indicators by data category.

A. UTILIZATION MANAGEMENT/MEDICAL MANAGEMENT

Concerns were identified with the consistent application of utilization management requirements, including prior authorization/precertification, for all carriers providing data. Within these concerns, MHPAEA NQTL Violations were identified.

***Concerns*:**

1. The Utilization Management as written documentation provided for multiple carriers only presented one (1) to three (3) instances where Prior Authorization (PA) was applied to MH/SUD claims, however the raw claims data presented documented a greater number of claims that were denied for "no prior authorization". This indicates that the carriers are not correctly identifying Utilization Management (UM) cases in their data, or that the data was presented incompletely. Additionally, UM data files for certain carriers document no UM files for PA. However, claims data shows high denial rates with denial codes that are historically **indicative of** medical management denial occurring post-service. These include:

- "Claim Denied Due to Information Not Received Following Requests for Information"
- "This Service, Supply, or Procedure is Not Medically Necessary According to the Plan Definition"

2. Carriers use the terms "Prior Authorization" and "Pre-Certification" interchangeably and inconsistently throughout their Certificates of Coverage ("COC's") and in member facing documentation provided to consumers. The COC's outline services requiring Pre-Certification, and on-line guidance outlines services requiring Prior-Authorizations. Numerous instances were noted whereby claims were denied for not having "Prior-Authorization", but the denial reasons presented were for lack of "Pre-Certification". The inconsistent application of the terms is ambiguous and lead to significant consumer confusion in knowing when it is a requirement to obtain Prior-Authorization. This has been proven to lead to a consumer not obtaining proper Prior-Authorization which results in denials of claims.

Violations:

1. Multiple Carriers provided general service categories and/or failed to complete the tabs in the "as written" responses when asked to identify which benefits required Prior-

Authorization or Pre-Certification however the “in operation” analytics confirmed that PA requirements were applied to specific service codes.

2. It was also identified that multiple Carriers provided a listing on their website of diagnosis or place of service that required PA and those that did not. Utilization Management denials documented multiple instances of claims that were denied due to not having PA when the website confirmed that PA was not required for that service or place.

3. Data analytics confirmed that PA is applied more frequently to MH/SUD benefits than to Med/Surg benefits. For one carrier only **5%** of Med/Surg benefits required PA while **22%** of MH/SUD required PA. While medical management guidelines will apply prior authorization requirements more frequently to MH/SUD appropriately, this, coupled with the greater frequency of denials for not having prior authorization confirms additional barriers to treatment for MH/SUD benefits than Med/Surg benefits.

4. Data analytics confirmed that prior authorization denials often occurred with much greater frequency for MH/SUD claims versus Med/Surg claims. For one Carrier **16%** of MH/SUD denied claims were denied for “No Prior Auth or Referral” as compared to only **6%** of Med/Surg denied claims being denied for “No Prior Auth or Referral”. This also is a further **indicator** that PA is being applied with greater frequency to MH/SUD benefits than Med/Surg.

These four (4) findings rise to the level of a violation of **45 CFR 146.136** because the as written and in operation, processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits for Utilization Management/Medical Management **are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.**

Because of this disparity, there are additional barriers to obtaining services and treatments for MH/SUD benefits than presented for standard Med/Surg benefits.

B. NETWORK ADEQUACY

Concerns:

1. Data analytics confirmed that a significant percentage of claims were denied as “not submitted timely” with a greater frequently for MH/SUD claims compared to Med/Surg claims. This **indicates** potential credentialing delays for MH/SUD providers in which the providers are awaiting confirmation of being credentialed as in-network, and then claims are subsequently denied as not submitted timely because the timeframe from treatment to when the providers are credentialed has exceeded the timeframe for submission. This could also **indicate** that providers are forced to hold on to claims while awaiting credentialing into the network.

2. Data analytics additionally confirmed that a significantly higher percentage of MH/SUD UM records were required to have Urgent decisions than Med/Surg UM records. This **indicates** a lack of availability of MH/SUD providers in the network, which has been proven to escalate situations in which members with MH/SUD conditions are forced to seek treatment for Urgent situations.

Violations:

1. Data analytics confirmed that the frequency for denial of claims as Out of Network (OON) was consistently higher across *the majority of carriers* for MH/SUD claims versus Med/Surg claims, which confirms that network adequacy deficiencies are more prominent for obtaining MH/SUD services than Med/Surg services.

While the issue was identified in the majority of carriers, we are providing examples of the disparity for illustrative purposes.

For example, one carrier had a denial rate of **7%** as out-of-network for Med/Surg claims versus **37%** OON for MH/SUD claims. Additionally, another carrier had **22%** of Utilization Management denials for Med/Surg that were due to services performed at an OON provider compared to **43%** of denials for MH/SUD Utilization Management services performed at an OON provider.

For another carrier, data analytics confirmed the following: **95%** of total claims are for In Network Providers (INN) and **5%** for OON providers for Med/Surg benefits, while **87%** of total claims are for INN Providers and **13%** for OON provider for MH/SUD benefits. Additionally, MH/SUD claims are approximately **6%** of the denied claims population, however the volume of denials as OON is very disparate compared to the weighed volume. Additionally, claims denials for Med/Surg services are comprised of **88%** for INN providers and **12%** for OON providers, while claims denials for MH/SUD services are comprised of **66%** for INN providers and **34%** for OON Providers.

These findings rise to the level of a violation of **45 CFR 146.136** because the as written and in operation, processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits for Network Adequacy **are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.**

The greater frequency of denials for OON providers for MH/SUD benefits highlight the issue with network adequacy and confirm that the lack of access to a network provider is much more prominent in the MH/SUD area then in the Med/Surg area, which presents an additional barrier for MH/SUD services and treatments.

C. CREDENTIALING & REIMBURSEMENT

Concerns:

1. Due to the extremely low reimbursement rates for MH/SUD office visit procedure codes (90833 and 90844), the claims data confirmed that several MH/SUD healthcare providers are frequently billing a general office visit code (99213, 99214, and 99215) to obtain higher reimbursement rates. Under these circumstances the data documents that MH/SUD providers are still reimbursed at a lower rate than Med/Surg providers for the same procedure code and diagnosis.

2. In reviewing the credentialing and reimbursement data against the claims data, it was also indicated that the same carrier could have several different fee schedules and was not reimbursed at a consistent rate for all treatments. This occurred with much more frequency for the MH/SUD providers than the Med/Surg providers.

Violations:

1. Data Analytics of claims payments confirmed that reimbursement rates were consistently lower for MH/SUD services compared to Med/Surg services. The following table represents the most used Procedure Codes for office visits and the average reimbursement rates for the services billed under these codes for Med/Surg claims in contrast to MH/SUD claims and the % of difference. This information was derived directly from the claim's payments data provided directly from the carriers. Please note that procedure codes 90833 and 90834 are office visits specific to MH/SUD treatment. This table reflects the disparity in reimbursement rates between licensed Medical Doctors (MD's), and licensed Psychologists (PhD's)

Procedure Code	Average Med/Surg Reimbursement Rate	Average MH/SUD Reimbursement Rate	% difference
99213	$101.01	$98.68	3%
99214	$145.05	$124.15	16%
99215	$228.48	$179.80	24%

These findings rise to the level of a violation of **45 CFR 146.136** because the as written and in operation, processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits for credentialing and reimbursement rates **are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.**

While on the surface it can be argued that the disparity in reimbursement rates is based on educational level, or contractual negotiations, the reality is that it greatly impacts patient access to care and is also a greater exposure for MH/SUD patients. MH/SUD providers are frequently not privy to the reimbursement rates provided to their Med/Surg counterparts so have limited to no negotiating powers to have comparable reimbursement rates. Oftentimes, if the MH/SUD provider is operating under a facility contract, rate negotiations are performed at the facility level and not disclosed to the provider. Further, sole member providers have less negotiation capabilities and oftentimes must take a rate the is offered which does not cover the cost of services. The overarching issue from a Mental Health Parity perspective is not the amount of income received by the provider, but rather if the provider accepts the lower reimbursement rate and agrees to be a participating provider. Many providers have determined that the reimbursement rates for network providers are too low to cover operating expenses, so they choose not to participate in the network. This decreases access to an already thin MH/SUD provider network for the consumers. Further, if a member chooses to go to an OON provider, they incur greater out of pocket expenses than if they were to go to an INN provider. Because of the perpetuated problems with access to INN providers for MH/SUD benefits, the member is forced to go to an OON MH/SUD provider and must either pay for the entire service/benefit out of pocket or must pay for anything above the Usual and Customary allowance. This creates a disparity not only in access to network MH/SUD providers, but also requires a greater financial exposure to the consumer, which perpetuates barriers to treatment for MH/SUD benefits and services.

D. CLAIMS

The claims data was utilized as a secondary verification for disparities that were seen in Utilization Management/Medical Management, Network Adequacy, and Credentialing and Reimbursement. Where data analytics provided indications of violations in these areas, the claims data provided a secondary validation step. For example, claims data was analyzed to identify the percentage of denials for Med/Surg claims versus MH/SUD. Then, taking this information further, the data was analyzed to identify the top reasons for denials for each area. This allowed the Data Review Team to determine that significant disparities existed for the denials due to Prior Authorization and Network Providers in the MH/SUD claims versus the Med/Surg claims.

The claims data was also analyzed to confirm the average payments for services for Med/Surg services compared to MH/SUD services and to identify discrepancies and disparities in payments. Because the claims information was derived directly from the carriers payment systems, this confirmed the actions of the carriers “in operation”.

IV. SUMMARY & RECOMMENDATIONS

While performing the review of the "as written" information received, the Data Review Team identified deficiencies in responses that indicated potential NQTL violations. Reviewing the "in operation" data allowed the team to perform comprehensive data analytics to confirm these areas of concern and identify additional indicators of violations. NQTL Violations were confirmed in Utilization Management/Medical Management, Network Adequacy and Credentialing and Reimbursements. Indicators for additional NQTL violations were also identified through the analytics.

Recommendations:

The Review Team believes that the Division has several options for proceeding and is providing our recommendations accordingly.

1. The Division could consider strategic targeted market conduct examinations[1] of the Carriers responsible for the areas where violations were evident. These targeted examinations would entail obtaining a sample of the files that were identified as violations to review to provide comprehensive documentation supporting the violations. The Division can then take administrative action and levy fines against the Carriers.

2. The Division could also consider presenting the violations[2] identified to the Carrier separately to have the Carrier provide an explanation and action plan for correcting deficiencies identified.

In each of these scenarios, it would be recommended that the Carrier reprocess claims correctly and make the consumers and providers whole, where appropriate.

A. IMPROVEMENT OPPORTUNITIES FOR CARRIERS

The Data Review Team recommends that the Carriers cross reference their submitted CARs for consistencies to promote efficiency and accuracy in future Data Calls. The Carrier should also ensure they provide accurate and complete supporting documentation for the responses presented. In addition, internal references within the Data Call Templates may also be used if the analyses for different NQTLs are the same. For example, if the factors used for a particular covered service are the same for all other covered services within the NQTL tab, the Carrier may reference other cells within the tab. Further, if the analyses are the same for multiple NQTLs, the Carrier may reference other tabs within the workbook. The Data Review Team also recommends that the Carrier provides clearly defined medical management ratios in support of "in operation" analyses.

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[1] Division of Insurance has submitted a work program request to fund market examinations for 2024 and 2025 results.

[2] The Division will conduct carrier-specific post-analysis reviews in January 2026.