Data Collection, Evaluation, and Reporting Gold Standards

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THE KENNEDY FORUM

LEGAL ACTION CENTER
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Contents

Data Collection, Evaluation, and Reporting Gold Standards

Robust data collection, evaluation, and reporting requirements are essential tools for state insurance regulators to ensure that health plans are compliant with state and federal parity laws and are providing meaningful access to mental health and substance use disorder (MH/SUD) services. Comprehensive reporting requirements allow regulators to more objectively and consistently evaluate health plan compliance, health plans to have more clarity about expectations, and consumers to gain more transparency into their coverage. When armed with comprehensive data, both health plans and regulators can take targeted action to address specific deficiencies and advance the goal of true parity in MH/SUD care.

State regulators should require health plans to annually submit their comparative analyses that they are required to perform and document under federal law. To meaningfully comply with this part of the federal law, health plans must be evaluating and reporting on outcomes data that assess parity "in operation" – that is, what the plans do in practice, not just how their benefits and policies are written. State regulators can and should identify specific data elements to be included in these reports to enable them to effectively enforce federal and state parity laws. Clear definitions, methodologies and metrics should be provided to health plans to ensure consistent and accurate data reporting.[1] Finally, state regulators should publicly report results of these findings through annual public reports and consumer-facing dashboards.

This brief offers guidance on these issues to better ensure mental health parity in states nationwide.

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Federal Requirements: Parity Compliance Analyses and Outcomes Data

The Consolidated Appropriations Act of 2021 requires plans to perform and document analyses showing that they are designing and applying NQTLs in a comparable way.[2] In demonstrating compliance with the Parity Act, plans must also collect and evaluate relevant data to assess the impact of all NQTLs "in operation," in addition to "as written."[3] That is, parity is more than just what the health plan puts on paper, it is also a requirement that the plan provides non-discriminatory coverage in its practices. Because this is, by definition, not something that is written down, the only feasible way for a plan to assess its operations is by collecting and evaluating outcomes data.[4]

While the rules do not specify the types of data plans must use, they give some examples (such as claims data, in- and out-of-network use, and reimbursement rates). "Material" differences in data around access to MH or SUD benefits compared to medical and surgical benefits are a strong indicator of noncompliance, and plans must take reasonable actions to correct such disparities when they are caused by the NQTL.[5] State law or private accreditation standards can require additional specific data.[6]

West Virginia[7] directs its Offices of the Insurance Commissioner to annually conduct a data call from health insurers to monitor their compliance and issue a detailed report on the status of MH/SUD parity, including **all** NQTLs. **Georgia** has a similar requirement for the Commissioner to conduct an annual data call focusing on the use of NQTLs, in addition to its requirement for health plans to annually submit their comparative analyses.[8] Texas also has an annual parity compliance reporting requirement for health plans, which must include specified data related to utilization management, denial rates, consumer complaints, and reimbursement rates.[9]

New York requires biennial reporting on parity compliance, which must include specified data elements related to utilization management, denial rates, access to consumer assistance, cost-sharing, benefit limitations, and network composition including network adequacy and reimbursement rates.[10] **Maryland** conducts biennial comparative analyses on commissioner-selected NQTLs. Reporting is required to be made according to specified analysis reports and data supplement templates providing detailed and specific regulatory instructions to carriers on how to properly complete the reports and templates to conduct a sufficient analysis to demonstrate NQTL parity compliance. The 2023 Interim Report provides examples of how Maryland makes these aggregated data publicly available.[11]

Washington State Office of the Insurance Commissioner has conducted ongoing market conduct exams requesting completion of NQTL comparative analyses according to specified templates and "in operation" quantitative data templates containing definitions, instructions and methodologies for completion.

Colorado, **Maryland**, and **Washington** have used the MDRF resources outlined in Appendix II. **The Colorado Division of Insurance's** parity reporting regulation[12] requires the use of the MDRF resources outlined in Appendix II as part of the NQTL compliance reporting.

GOLD STANDARD

States should require plans to annually submit parity compliance analyses – including the analyses of specified, relevant data – to assess the impact of NQTLs on access to MH/SUD benefits as compared to medical benefits and surgical procedures.

States should identify the specific data points that would be most meaningful or effective, such as those that the Departments have recommended related to network composition and other meaningful metrics, which we outline below.

Essential Data Elements for Annual Reporting

State regulators should require health plans to annually submit their comparative analyses, including the detailed documentation of how non-quantitative treatment limitations (NQTLs) are designed and applied, as outlined by the Consolidated Appropriations Act of 2021:

1. A description of the NQTL and which benefits are subject to the NQTL;
2. Identification and definition of the factors and evidentiary standards used to design or apply the NQTL;
3. A description of how factors are used in the design or application of the NQTL;

4. A demonstration that the NQTL for MH and SUD benefits is comparable to and no more stringent than for medical and surgical benefits as written (i.e. in documents);

5. A demonstration that the NQTL for MH and SUD benefits is comparable to and no more stringent than for medical and surgical benefits in operation, including the outcomes data and their evaluation, an explanation of any material differences in access, and a description of reasonable actions taken to address such differences; and

6. Findings and conclusions.

As part of step 5, state regulators should require health plans to evaluate and submit, at a minimum, the following data:

Utilization Rates

- In-network utilization rates for MH services, SUD services, and medical/surgical services;
- Out-of-network utilization rates for the same categories;
- Network providers submitting claims and claim volumes.

Network Adequacy Metrics

- Time and distance data to nearest providers by specialty;
- Appointment availability and wait times (including new patients and follow-up appointments) by provider type and specialty;
- Percentage of providers accepting new patients;
- Provider-to-member ratios by specialty and geographic region;

Regulators should conduct secret shopper surveys to verify this information is correct.

Provider Reimbursement Rates

- Reimbursement rates for MH/SUD and medical/surgical services;
- Reimbursement rates benchmarked against a reference standard (e.g., Medicare rates);
- Documentation of rate-setting methodologies and factors considered.

Claims Denial Data

- Number and percentage of claims denied, disaggregated by service type;
- Reasons for denials categorized by clinical necessity, administrative issues, coding problems, etc.;
- Denial rates for MH services, SUD services, and medical services, by service type;
- Appeals rates and overturned denial percentages by service type;

Regulators should similarly review and report the results of their external appeals.

Consumer Complaint Integration

- Number and types of MH/SUD-related complaints received;
- Resolution rates and timeframes for complaint resolution;
- Patterns of complaints by service type, provider, or geographic area;
- Complaint rates for MH/SUD services compared to medical/surgical services;
- Corrective actions taken in response to complaint patterns.

Financial Resources Allocation

- Investments in MH/SUD network development compared to medical/surgical networks;
- Administrative expenses dedicated to processing MH/SUD claims;
- Reserves maintained for projected MH/SUD claims versus medical/surgical claims;
- Documentation of financial incentives or disincentives that may affect access to care;

A Note on MH/SUD Data Tracking:

Mental health and substance use disorder data should be tracked separately as combined reporting can hide serious access issues in one area.[13] By requiring separate tracking, regulators can identify and address specific areas of non-compliance rather than allowing carriers to obscure inadequacies in one area with strong performance in another.

See Appendix II for best practice reporting instructions and templates.

For more information on comparative analyses and outcomes data requirements, see our brief, **Final Parity Rules: State Codification Gold Standards**.

Network Composition

Quantitative standards for measuring network adequacy are necessary in understanding consumer's actual access to MH/SUD benefits. Effective measurement should include:

- In-network and out-of-network utilization rates, including data related to providers actively submitting claims;
- Appointment wait times (for new and existing patients);
- Time and distance standards including provider-to-enrollee ratios by specialty and geographic regions;
- Provider directory accuracy including regular verification, monitoring for accuracy, removal of providers/ provider locations no longer participating, reporting on the percentage of listed providers accepting new patients, tracking of error rates found during verification and monitoring, and implementing consumer feedback mechanisms for reporting directory inaccuracies;

Importantly, material differences in outcomes data are only considered violations of the federal parity law if they are related to an NQTL imposed by the health plan. In some cases, disparities may be beyond a health insurance plan's control. It is important to understand how specific health plan NQTLs do or do not relate to observed issues in access that are more pronounced for MH/SUD benefits. Two particular focus areas are provider reimbursement rates and provider administrative burdens.

Provider reimbursement rates are an important factor for understanding network composition. Transparency in Coverage (TiC) requirements mandated under the ACA and Public Health Service Act require health plans to publish machine readable files (MRFs) disclosing pricing information about in-network and out-of-network healthcare service utilization on a monthly basis. These files include information such as negotiated rates for in-network providers and allowed amounts and billed charges for out-of-network providers.

Regulators should collect information from TiC reporting on provider reimbursement rates. For example, comparing reimbursement rates for MH/SUD and M/S services using a standard benchmark across both, as was done in the RTI study using claims data, and in the Mental Health Parity Index using TiC Data.

The Kennedy Forum's Mental Health Parity Index analyzes TiC in-network payer files published by the insurance carriers themselves and provides an analysis of these key components of access to coverage including network composition, outpatient professional reimbursement, and inpatient acute reimbursement. The Mental Health Parity Index highlights areas of potential concern and opportunity for improving access and coverage to mental health and substance use services.

Health plan claims data also provides key information on reimbursement rates and can be compared to public benchmarks such as Medicaid and Medicare. (See Section 2, in Appendix II). However, these sources should only be used as a benchmark, rather than as a starting point, for analyzing reimbursement rates. That is, neither Medicare nor fee-for-service Medicare are subject to parity laws. Nonetheless, by comparing rates to a national benchmark, it is easier to see when certain provider types are reimbursed less or more than other, comparable providers.14

The **California Department of Insurance** has introduced regulations clarifying what an insurer needs to do once someone has requested assistance identifying a health care provider including by adding that if an insurer cannot identify more than three in-network providers, that it must refer the person to those three and notify the Department of the service requested, type of provider, and location. This is an important mechanism for ensuring the regulator has proactive insight into possible weakening parts of networks that could lead to or show existing network inadequacies.

Colorado's SB 24-080 requires health plans to comply with federal price transparency laws and make publicly available transparency files, including an internet-based self-service tool that provides real-time responses to carrier prices based on cost-sharing information. It also requires health plans to submit information required by federal pharmacy benefit and drug cost reporting laws to the commissioner of insurance and to make certain information regarding price transparency publicly available.[15]

The Colorado Division of Insurance established regulations[16] implementing these requirements, requiring health plans to submit files biannually on in-network rates, out-of-network allowed amounts, and a table of contents and annually prescription drug and healthcare spending data. All files must be filtered to include Colorado-specific data and providers with 20 more services performed in the last year.

Regulators can also implement regular secret shopper audits to verify accuracy of plan network composition reporting for MH/SUD. This is a tact federal and state agencies have used with success in market conduct examinations. For example, in its 2024 MHPAEA Report to Congress, EBSA reported using a secret shopper approach to find disparities between MH/SUD networks and M/S.[17] CMS also requires health plans on the federal exchange to contract with third-party entities to conduct secret shopper surveys on appointment wait time standards for MH/SUD providers and primary care providers.[18] The 2024 Managed Care Access rule also requires states to conduct annual independent secret shopper surveys to verify accuracy of provider directories in Medicaid.[19] States should mirror this same strategy for MH/SUD care in their state-regulated commercial plans.

Appeals Processes, Claims Denials, and Overturns

Consumers seeking MH/SUD care often face the unfortunate reality of receiving denials for which they must navigate both internal and external appeals processes to overturn. States that report data on external appeals find that the numbers of external reviews have gone up over time, as has the rate at which these appeals have been overturned in favor of the enrollee. For MH/SUDs, the overturn rates trend higher than for medical/surgical care. Monitoring health plan appeals process, claim denial rates, and internal and external review metrics is a critical part of understanding consumers' experience of obtaining medically necessary MH/SUD benefits.

State regulators should require plans to report on the number and percentage of claims denials, disaggregated by service type (MH and SUD according to levels of care). State regulators should also track and publicly report the findings of their external reviews, as the **California Department of Managed Health Care** does in their **IMR process**. Plans also implement a range of other utilization management techniques that may slow care, even when it is not denied, such as prior authorization. Data on these other forms of utilization management are also critical.

Tracking Appeals

California's Senate Bill 363, The Health Insurance Accountability Act, was proposed in the 2025 legislative session and would require health plans to report to state regulators denials and modifications made to provider-recommended care. The agencies would be required to publish this information publicly in annual reports. Health plans would be assessed for overturn rates under three categories of care: medical, behavioral, and surgical. For each category, if over 50% of external appeals are overturned in favor of the enrollee, the health plan would incur a fine for each additional case in that category that is overturned above the 50% threshold. Failure to report the required data would also incur a fine.

Public Reporting

In addition to the yearly reporting discussed above, state regulators should publicly disclose results of findings and enforcement actions including, through:

Annual Public Reports
State-issued reports summarizing industry-wide compliance and highlighting areas of concern.

Consumer-Facing Dashboards
Publicly accessible websites that display carrier performance on key MH/SUD parity metrics with uniform reporting templates and summaries that allow consumers to make apples-to-apples comparisons.

The Minnesota Department of Commerce publishes an annual report on MHPAEA compliance and oversight efforts and details enforcement actions taken in the last year.[20] **The Maryland Insurance Administration** issues interim reports summarizing findings on carriers' MHPAEA NQTL reports and enforcement actions. [21]

Market Conduct Examinations as a Data Transparency Tool

Market conduct examinations are a core regulatory tool for assessing insurer compliance with MHPAEA and following up on identified MHPAEA or MH/SUD-related violations. These examinations allow regulators to review an insurer's policies, procedures, claims, prior authorization practices, and appeals at a granular level, often uncovering patterns of noncompliance that are not visible through complaint data alone. **The National Association of Insurance Commissioners (NAIC)** has developed a **Market Conduct Examination MHPAEA Data Call and Review Process** to standardize how regulators collect and analyze data related to quantitative treatment limits (QTLs), nonquantitative treatment limits (NQTLs), network adequacy, and claims outcomes.

States have increasingly used these examinations to find and monitor MHPAEA violations.

- **Georgia**

  In 2025, Georgia's Office of Commissioner of Insurance and Safety Fire levied $20 million in fines on all 22 insurers whose market conduct exams it reviewed.[22] Upon reviewing plan-submitted annual comparative analyses, the Commissioner launched deeper investigations via market conduct exams, finding all reviewed insurers were out of compliance with the state's parity laws.

- **Delaware**

  In 2024, the Department of Insurance's market conduct exam of Highmark identified parity violations and resulted in a $329,000 fine and a corrective action plan.[23]

- **Illinois**

  Market conduct exams between 2015–2017 led to over $2 million in fines for MHPAEA violations[24]; a 2023 exam of Quartz Health produced an additional $500,000 fine and required reprocessing of claims.[25]

- **Pennsylvania**

  Since 2016, the Insurance Department's parity-focused exams have produced $5.89 million in restitution to over 60,000 consumers and mandated substantial corrective actions.[26]

- **New Hampshire**

  In 2020, exams of Anthem, Harvard Pilgrim, and Ambetter found network adequacy and NQTL issues, requiring corrective action plans and multi-year compliance reporting. Insurers were fined $1,332,000 for these violations.[27]

- **Washington**

  In 2023, **Washington's Office of Insurance Commissioner's** market conduct exam of United Healthcare Insurance Company identified insufficient information, data and comparative analyses for NQTLs and resulted in a $500,000 fine and corrective action plan.[28]

Market conduct examinations, paired with standardized reporting under the NAIC model, create a powerful mechanism for both data-driven enforcement and public accountability.

Appendix

Appendix I. **Parity Compliance Analyses (45 C.F.R. § 146.137)**

(a) ***In general.*** *In the case of a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits and that imposes any nonquantitative treatment limitation on mental health or substance use disorder benefits, the plan or issuer must perform and document a comparative analysis of the design and application of each nonquantitative treatment limitation applicable to mental health or substance use disorder benefits. Each comparative analysis must comply with the content requirements of this section.*

(b) ***Comparative analysis content requirements.*** *With respect to each nonquantitative treatment limitation applicable to mental health or substance use disorder benefits under a health plan, the comparative analysis performed by the plan or issuer must include, at minimum, the elements specified in this paragraph. In addition to the comparative analysis for each nonquantitative treatment limitation, each plan or issuer must prepare and make available to the [Department of Insurance], upon request, a written list of all nonquantitative treatment limitations imposed under the plan or coverage.*

(1) ***Description of the nonquantitative treatment limitation.*** *The comparative analysis must include, with respect to the nonquantitative treatment limitation that is the subject of the comparative analysis:*

(i) Identification of the nonquantitative treatment limitation, including the specific terms of the plan or coverage or other relevant terms regarding the nonquantitative treatment limitation, the policies or guidelines (internal or external) in which the nonquantitative treatment limitation appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the nonquantitative treatment limitation;

(ii) Identification of all mental health or substance use disorder benefits and medical/surgical benefits to which the nonquantitative treatment limitation applies, including a list of which benefits are considered mental health or substance use

disorder benefits and which benefits are considered medical/surgical benefits; and

(iii) A description of which benefits are included in each classification.

(2) ***Identification and definition of the factors and evidentiary standards used to design or apply the nonquantitative treatment limitation.*** *The comparative analysis must include, with respect to every factor considered or relied upon to design the nonquantitative treatment limitation or apply the nonquantitative treatment limitation to mental health or substance use disorder benefits and medical/surgical benefits:*

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which mental health or substance use disorder benefits and which medical/surgical benefits are subject to the nonquantitative treatment limitation; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (b)(2)(i) of this section; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective in the absence of such steps.

(3) ***Description of how factors are used in the design and application of the nonquantitative treatment limitation.*** *The comparative analysis must include a description of how each factor identified and defined under paragraph (b)(2) of this section is used in the design or application of the nonquantitative treatment limitation to mental health and substance use disorder benefits and medical/surgical benefits in a classification, including:*

(i) A detailed explanation of how each factor identified and defined in paragraph (b)(2) of this section is used to determine which mental health or substance use disorder benefits and which medical/surgical benefits are subject to the nonquantitative treatment limitation;

(ii) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the nonquantitative treatment limitation, including in the determination of whether and how mental health or substance use disorder benefits or medical/surgical benefits are subject to the nonquantitative treatment limitation;

(iii) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualifications of each decision maker;

(iv) If more than one factor is identified and defined in paragraph (b)(2) of this section, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors; and

(v) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which each evidentiary standard was derived), such as how the factor is used differently to apply the nonquantitative treatment limitation to mental health or substance use disorder benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

(4) ***Demonstration of comparability and stringency as written.*** *The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation with respect to medical/surgical benefits. The comparative analysis must include, with respect to the nonquantitative treatment limitation and the factors used in designing and applying the nonquantitative treatment limitation:*

(i) Documentation of each factor identified and defined in paragraph (b)(2) of this section that was applied to determine whether the nonquantitative treatment limitation applies to mental health or substance use disorder benefits and medical/surgical benefits in a classification, including, as relevant:

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the nonquantitative treatment limitation applies, mental health or substance use disorder benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the nonquantitative treatment limitation would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(ii) In each classification in which the nonquantitative treatment limitation applies to mental health or substance use disorder benefits, a comparison of how the nonquantitative treatment limitation, as written, is designed and applied to mental health or substance use disorder benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the nonquantitative treatment limitation or that address the application of the nonquantitative treatment limitation;

(iii) Documentation demonstrating how the factors are comparably applied, as written, to mental health or substance use disorder benefits and medical/surgical benefits in each classification, to determine which benefits are subject to the nonquantitative treatment limitation; and

(iv) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the nonquantitative treatment limitation, or the application of the nonquantitative treatment limitation, to mental health or substance use disorder benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the nonquantitative treatment limitation.

(5) ***Demonstration of comparability and stringency in operation.*** *The comparative analysis must evaluate whether, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits. The comparative analysis must include, with respect to the nonquantitative treatment limitation and the factors used in designing and applying the nonquantitative treatment limitation:*

(i) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation with respect to medical/surgical benefits, including:

(A) An explanation of any methodology and underlying data used to demonstrate the application of the nonquantitative treatment limitation, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the mental health or substance use disorder benefits and medical/surgical benefits to which the nonquantitative treatment limitation is applicable;

(C) With respect to a nonquantitative treatment limitation for which relevant data is temporarily unavailable, a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to a nonquantitative treatment limitation for which no data exist that can reasonably assess any relevant impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits, a reasoned justification as to the basis for the conclusion that there are no

data that can reasonably assess the nonquantitative treatment limitation's impact, an explanation of why the nature of the nonquantitative treatment limitation prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure that the nonquantitative treatment limitation complies with parity;

(ii) Identification of the relevant data collected and evaluated;

(iii) Documentation of the outcomes that resulted from the application of the nonquantitative treatment limitation to mental health or substance use disorder benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data; and

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits;

(iv) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (b)(5)(iii) of this section, including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the nonquantitative treatment limitation as applied to mental health or substance use disorder benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the nonquantitative treatment limitation; and

(B) To the extent differences in access to mental health or substance use disorder benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate mental health and substance use disorder benefits, and such standards or measures

are used as the basis for a factor or evidentiary standard used to design or apply a nonquantitative treatment limitation, documentation explaining how any such differences are attributable to those standards or measures; and

(v) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking to address material differences to comply, in operation, with parity including, as applicable:

(A) A reasoned explanation of any material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more nonquantitative treatment limitations related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network mental health and substance use disorder benefits as compared to in-network medical/surgical benefits.

(6) ***Findings and conclusions.*** *The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:*

(i) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of parity, including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(ii) A reasoned and detailed discussion of the findings and conclusions described in paragraph (b)(6)(i) of this section;

(iii) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions described in paragraph (b)(6)(i) of this section not otherwise discussed in the comparative analysis;

(iv) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(v) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the nonquantitative treatment limitation applicable to both mental health or substance use disorder benefits and medical/surgical benefits.

Appendix II: **Outcomes Data**

For use with NQTLs related to UM Protocols, Network Adequacy, and In-Network Reimbursements:

- **NQTL Multi-Step Audit Tools for UM Protocols and Network Adequacy / In-Network Reimbursements**

For use with NQTLs related to network composition, adequacy and access:

- **MDRF Section 1 Only - Out-of-Network Use**
- **MDRF Section 2 Only – Reimbursement (for INN providers)**
- **MDRF Section 3 Only - Provider Participation** (network providers actively submitting claims)

For use with medical management NQTLs:

- **MDRF Section 4 Only - Denial Rates** (both medical necessity and administrative)
- **MDRF Section 5 Only** - UR Frequency/Proportion

For use with all NQTLs:

- **2025 Model Data Request Form (MDRF) - All 5 Sections**

Appendix III: **Data Reporting Elements**

(a) A health care service plan shall report on the following data elements:

(1) Denial and modification rates (including partial denials and approvals of modified requests)

(2) Utilization management rates by utilization management type (e.g. frequency and proportion of reviews)

(3) In-network and out-of-network utilization rates (including data related to provider claim submissions)

(4) Network time and distance data

(5) Providers accepting new patients

(6) Provider reimbursement rates

(7) Provider recruitment and retention statistics

(8) Times for providers to join the network after initial application

(9) Payment times for claims once submitted

(b) A health care service plan shall report on these data elements in accordance with the following requirements:

(1) Reporting shall occur on an annual basis. A health care service plan shall submit its first report to the department on or before [Date].

(2) Reporting shall be separated by type of care or provider into the following categories:

(A) Medical/Surgical.

(B) Behavioral.

(3) Reporting shall be disaggregated by age.

(4) Reporting shall include information on the health care service plan's number of actions in each category, as well as reasons for the action, as applicable.

(5) Reporting shall include the outcome of the actions in each category, as applicable.

(6) For the purposes of this section, data shall be disaggregated by service or provider type.[29]

(c) The department shall annually compare all of the data submitted in subdivision (a). Annually, the department shall send notifications requesting justification within two months to all health care service plans with disparities between their Behavioral and Medical/Surgical data reported. If the justifications provided within two months do not meet the requirements of the Mental Health Parity and Addiction Equity Act, then the health care service plan is in violation of this section and liable for an administrative penalty and corrective action plans pursuant to subdivision (c). A health care service plan may be liable for multiple violations per annual report.

(d) Commencing [Date], and every year thereafter, the department shall issue a public report detailing findings on health care service plan data enumerated in subdivision (a) and the department's findings in enumerated in subdivision (b). Reports shall include, at a minimum, the following from the reporting period:

(1) The data contained in subdivision (a).

(2) Rates of independent medical review overturns of a health care service plan's treatment denials or modifications.

(3) Rates of treatment denials or modifications reversed by the health care service plan after an independent medical review for the denial or modification is requested, filed, or applied for.

(4) For purposes of this section, rates shall be disaggregated by service and provider type.

New York Insurance (ISC) Chapter 28, Article 3

Mental health and substance use disorder parity report.

(a) Beginning July first, two thousand nineteen and every two years thereafter, each insurer providing managed care products, individual comprehensive accident and health insurance or group or blanket comprehensive accident and health insurance, each corporation organized pursuant to article forty-three of this chapter providing comprehensive health insurance and each entity licensed pursuant to article forty-four of the public health law providing comprehensive health service plans shall submit to the superintendent, in a form and manner prescribed by the superintendent, a report detailing the entity's compliance with federal and state mental health and

substance use disorder parity laws based on the entity's record during the preceding two calendar years. The superintendent shall publish on the department's website on or before October first, two thousand nineteen, and every two years thereafter, the reports submitted pursuant to this section.

(b) Each person required to submit a report under this section shall include in the report the following information:

(1) Rates of utilization review for mental health and substance use disorder claims as compared to medical and surgical claims, including rates of approval and denial, categorized by benefits provided under the following classifications: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs;

(2) The number of prior or concurrent authorization requests for mental health services and for substance use disorder services and the number of denials for such requests, compared with the number of prior or concurrent authorization requests for medical and surgical services and the number of denials for such requests, categorized by the same classifications identified in paragraph one of this subsection;

(3) The rates of appeals of adverse determinations, including the rates of adverse determinations upheld and overturned, for mental health claims and substance use disorder claims compared with the rates of appeals of adverse determinations, including the rates of adverse determinations upheld and overturned, for medical and surgical claims;

(4) The percentage of claims paid for in-network mental health services and for substance use disorder services compared with the percentage of claims paid for in-network medical and surgical services and the percentage of claims paid for out-of-network mental health services and substance use disorder services compared with the percentage of claims paid for out-of-network medical and surgical services;

(5) The number of behavioral health advocates, pursuant to an agreement with the office of the attorney general if applicable, or staff available to assist policyholders with mental health benefits and substance use disorder benefits;

(6) A comparison of the cost sharing requirements including but not limited to co-pays and coinsurance, and the benefit limitations including limitations on the

scope and duration of coverage, for medical and surgical services, and mental health services and substance use

disorder services for coverage in the individual, small group, and large group markets, provided that the comparison captures at least seventy-five percent of a company's enrollees in each market;

(7) The number by type of providers licensed to practice in this state that provide services for the treatment and diagnosis of substance use disorder who are in-network, and the number by type of providers licensed to practice in this state that provide services for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in a company's policy, who are in-network;

(8) The percentage of providers of services for the treatment and diagnosis of substance use disorder who remained participating providers, and the percentage of providers of services for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in a company's policy, who remained participating providers; and

(9) Any other data, information, or metric the superintendent deems necessary or useful to measure compliance with mental health and substance use disorder parity including, but not limited to an evaluation and assessment of: (i) the adequacy of the company's in-network mental health services and substance use disorder provider panels pursuant to provisions of the insurance law and public health law; and (ii) the company's reimbursement for in-network and out-of-network mental health services and substance use disorder services as compared to the reimbursement for in-network and out-of-network medical and surgical services.

Appendix IV: **Transparency in Coverage Regulations**

Colorado Division of Insurance *3 CCR 702-4, Regulation 4-2-103*

Section 6 Transparency in Coverage File Submission Requirements

A. The files specified in Section 5(A) shall contain information on individual and group market coverage. Carriers may provide data on plans in which they operate as a third-party administrator, provided that carriers identify clearly to the Division when they are submitting data as a third-party administrator.

B. The files specified in Section 5(A)(2) regarding in-network rates shall contain a Colorado specific Table of Contents file that includes the following standardized labels:

1. Carrier name;

2. Plan name;

3. Market segment using the following categories:

a. Individual;

c. Small Group;

d. Large Group;

or e. Third Party Administrator or TPA, if applicable.

4. Group EIN or HIOS Plan ID;

5. File size including the number of rows and file size;

6. Date files were generated; and

7. URL Link to plan specific file on the carrier's website.

C. The files shall be filtered to include:

1. Only plans issued or delivered in Colorado;

2. Only group or billing NPIs with a corresponding Colorado zip code; and

3. Only negotiated rate and procedure code combinations for providers with 20 or more services performed in the last year, at the procedure code level not accounting for modifiers. Modifiers must be included but do not change the count of claims a billing provider has for each procedure code.

References

1 See Appendix II for links to Model Data Reporting Forms (MDRFs).

2 42 U.S.C. 300gg-26(a)(8)(A).

3 42 U.S.C. 300gg-26(a)(8)(A)(iv).

4 45 C.F.R. § 146.136(c)(4)(iii).

5 See § 146.136(c)(4)(iii)

6 See § 146.136(c)(4)(iii)(A)(1)

7 West Virginia Code of State Rules (WV CSR) 114-64-7.3

8 Off. Code Ga. Ann. §§ 33-1-27(b)(4); 33-1-27(c)(1)(A) (2022).

9 28 Tex. Admin. Code §§ 21.2401-21.2441 (2021).

10 N.Y. Ins. Law § 343 (2019).

11 **https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data.pdf**

12 Colorado Regulation 3 CCR 702-4-2-64

13 A 2021 study of health insurance claims data of 22.8 million individuals with private insurance found consistently higher out-of-network usage for patients seeking SUD care compared to other MH care. **https://psychiatryonline.org/doi/10.1176/appi.ps.20240448**

14 A 2024 study but RTI International found pervasive disparities in in-network access to mental health care: patients went out-of-network 3.5 times more often to see behavioral health providers than medical/surgical providers. 8.9 times more to see a psychiatrist, 10.6 times more often to see a psychologist, 6.2 times more often for acute behavioral

inpatient care, and 19.9 times more often for sub-acute behavioral inpatient care. **https://www.rti.org/news/study-disparities-in-network-access-mental-health-sud-treatment**

15 **https://leg.colorado.gov/bills/sb24-080?utm_medium=email&utm_source=govdelivery**

16 **https://doi.colorado.gov/sites/doi/files/documents/Regulation%204-2-103%20TiC%20Reporting%20Requirements.pdf**

17 **2024 MHPAEA Report to Congress**, United States Departments of Labor, Health & Human Services, and Treasury, January 2025.

18 **2025 Final Letter to Issuers in the Federally-facilitated Exchanges**, Centers for Medicare & Medicaid Services, April 2024; **Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFE)**,Centers for Medicare & Medicaid Services, April 2024.

19 42 C.F.R. § 438.68(f).

20 **https://mn.gov/commerce/insurance/health/mental-health/report.jsp**

21 **https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data.pdf**

22 **https://oci.georgia.gov/press-releases/2025-08-15/commissioner-king-fine-insurers-over-20-million-mental-health-parity**

23 **https://news.delaware.gov/2024/10/08/highmark-exam-results-in-mental-health-parity-penalties/**

24 **https://www.illinois.gov/news/release.html?releaseid=21819**

25 **https://www.illinois.gov/news/release.html?releaseid=25897**

26 **https://www.pa.gov/agencies/insurance/newsroom/insurance-department-exam-finds-highmark-violations-results-in-restitution-for-members**

27 https://news.delaware.gov/2021/07/26/mental-health-parity-examinations-find-inequities-in-insurer-behavior/#:~:text=%E2%80%9CWe%20have%20been%20working%20toward,medications%20offered%20in%20lower%20tiers.

28 https://www.chronline.com/stories/unitedhealthcare-failed-to-meet-mental-health-requirements-washington-says,327694

29 Data can be done at the CPT code level or the benefits subclassification. NPI registry data can be used for provider type.