



Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report



Authors:

Megan Douglas, JD¹; Glenda Wrenn, MD, MSHP¹; Samantha Bent-Weber, JD;
Lauren Tonti, JD, MPH; Garry Carneal, JD²; Torie Keeton²; Jessica Grillo, JD²;
Sharon Rachel, MA, MPH¹; David Lloyd, MBA²; Eve Byrd, DNP, MPH³; Benjamin F. Miller, PsyD⁴;
Albert Lang⁴; Ron Manderscheid, PhD^{5,6}; Joe Parks, MD⁷

Author Affiliations:

¹Morehouse School of Medicine, ²The Kennedy Forum, ³The Carter Center, ⁴Well Being Trust,
⁵National Association of County Behavioral Health and Developmental Disabilities Directors,
⁶National Association for Rural Mental Health, ⁷National Council for Behavioral Health

Acknowledgements:

We would like to acknowledge and thank Joe Pyle, Tim Clement, and Amanda Mauri for their initial conceptualization of this project and pilot application of the scoring methodology. We also thank Kiana Burgin for data collection of state behavioral health statistics.

Funding Sources:

This work was funded with generous support from The Scattergood Foundation, The Kennedy Forum, The Kennedy-Satcher Center for Mental Health Equity in the Satcher Health Leadership Institute at Morehouse School of Medicine, and The Carter Center and Well Being Trust.

Recommended Citation:

Douglas, M., Wrenn, G., Bent-Weber, S., Tonti, L., Carneal, G., Keeton, T., Grillo, J. Rachel, S., Lloyd, D., Byrd, E., Miller, B., Lang, A., Manderscheid, R., Parks, J. *Evaluating State Mental Health and Addiction Parity Laws: A Technical Report*. The Kennedy Forum; 2018.

Corresponding Author:

Megan Douglas, JD, mdouglas@msm.edu



KENNEDY-SATCHER CENTER FOR MENTAL HEALTH EQUITY

at Morehouse School of Medicine

Mission

To work collaboratively toward equal treatment of mental health and substance use disorders through targeted efforts to aggregate and elevate parity implementation work, conduct research that informs mental health policy, and engage key stakeholders to advance mental and behavioral health equity.

Vision

To ensure that all people have equitable access to behavioral health care and the opportunities to achieve optimal health outcomes.

Core Impact Areas

Parity. Promotion of Parity Track (<https://paritytrack.org/>) and Parity Registry (<https://parityregistry.org/>), which is a collaborative forum to aggregate and elevate parity implementation work.

Equitable Systems of Care. Assessment of state, regional, and national systems of care for mental/behavioral health disorders.

Culturally Centered, Integrated Care. Continued development of best practice models for culturally informed integration of primary and behavioral health care, including assessment of policy implications and solutions to policy and system-level barriers.

Community Engagement to Promote Resilience. Assessment of policy level interventions that address community-level risk and protective factors to mitigate risk and maximize resilience. Promote expansion of education reform to 1) include the development of productive school-community partnerships, 2) increase equitable access to school-based mental health services, 3) provide for universal mental health screening, 4) create a nation of mindful educators, and 5) develop innovative ways to support sustainability of these programs. Increase awareness and understanding of the impact of Adverse Childhood Experiences on a child's ability learn. Facilitate resiliency through the promotion of social emotional learning and character education programs in schools.

Research

The Kennedy-Satcher Center for Mental Health Equity (KSCMHE) research portfolio reflects our commitment to implement science that advances behavioral health equity; improves efficiency within local, state and national health care systems; and supports the agency of underserved communities to achieve optimal health and wellness.

Policy

The Kennedy-Satcher Center for Mental Health Equity (KSCMHE) seeks to inform evidence-based policy through translation of scientific evidence for policymakers and other decision makers. The KSCMHE develops policy briefs, whitepapers, and reports that break down complex issues and highlight best practices for the advancement of mental health equity. The KSCMHE participates in the development of legislation and regulations through public comments and collaboration with federal and state policymakers.

Programs

Integrated Care Leadership Program (ICLP). The ICLP provides clinical and administrative health care professionals with the knowledge and training needed to build or strengthen capacity to successfully develop and sustain integrated behavioral health and primary care practices. The overarching goal of the ICLP is to promote health equity among economically disadvantaged, minority, and lower income populations. The program consists of a self-paced online training curriculum, mentorship and coaching from established integrated practices and integrated care experts, in-person engagement with the ICLP training team, and informative webinars designed to catalyze integrated practice change and quality improvement.

Smart and Secure Children Parent Leadership Program (SSC). The Satcher Health Leadership Institute at Morehouse School of Medicine (SHLI/MSM) developed a unique parent leadership model, designed with and for members of disparate targeted communities, as a framework to reduce and eliminate health inequities in early childhood. The focus of SSC is to transform vulnerable parents into community leaders who can learn and lead in the development of their children and their peers. Evaluation of this project indicated improved mental health, competency, confidence, and parenting knowledge and skills among participants, and reduced social isolation.

Kennedy-Satcher Center for Mental Health Equity National Advisory Board

(*indicates that individual is also a member of the Parity Leadership Coalition)

Anne L. Bakar

President & CEO, TeleCare Corporation

Eve H. Byrd, DNP, MPH, FNP-BC, PMH-CNS*

Director, Mental Health Program, The Carter Center

Arthur C. Evans Jr., PhD*

CEO & Executive Vice President, American Psychological Association

Anita Everett, MD, DFAPA

Chief Medical Officer, SAMHSA

Richard G. Frank, PhD

Margaret T. Morris Professor of Health Economics, Harvard University

Mary Giliberti, JD*

CEO, National Alliance on Mental Illness

Paul Gionfriddo*

President & CEO, Mental Health America

Saul Levin, MD, MPA*

CEO & Medical Director, American Psychiatric Association

Chirlane McCray

First Lady of New York City

Carol McDaid*

Principal, Capitol Decisions

Vivek H. Murthy, MD, MBA

19th United States Surgeon General

Jerry Reed, PhD, MSW

Senior Vice President for Practice Leadership/ Injury, Violence & Suicide Prevention Portfolio Lead/National Action Alliance for Suicide Prevention Executive Committee Member, Education Development Center, Inc.

Joe Pyle, MA*

President, Thomas Scattergood Behavioral Health Foundation

Linda Rosenberg, MSW*

President & CEO, National Council for Behavioral Health

The Parity Leadership Coalition

The **Parity Leadership Coalition** was formed in 2016 to bring together all of the major behavioral health advocacy organizations to create a collective action plan on full implementation of the Federal Parity Law. Led by former Surgeon General Dr. David Satcher, author of the Surgeon General's Report on Mental Health, and the Honorable Patrick J. Kennedy, this coalition was established to develop, promote and implement strategies with the greatest impact on how the law is understood today and acted upon in the future.

The Coalition is guided by a commitment to:

- Come together as a true coalition of peers;
- Unify our approach to parity;
- Advance a co-created, collective agenda for progress;
- Adhere to critical benchmarks; and
- Coordinate our message and activities.

Coalition Members

Robert Gebbia, MA

CEO, American Foundation for Suicide Prevention

Penny Mills, MBA

Ex-Officio, Executive Vice-President/CEO, American Society of Addiction Medicine

Robert Restuccia, MPA

Executive Director, Community Catalyst

Allen Doederlein

Executive Vice President of External Affairs, Depression and Bipolar Support Alliance

Matt Selig, JD

Executive Director, Health Law Associates

Rick Kellar

President, Peg's Foundation

Ron Manderscheid, PhD

Executive Director, National Association of County Behavioral Health and Developmental Disabilities Directors

Sam Ball, MD

Director Emeritus, National Center on Addiction & Substance Abuse

Candice Sherman

CEO, Northeast Business Group on Health

Adam Brooks, PhD

Research Director, Treatment Research Institute

John Auerbach, MBA

President & CEO, Trust for America's Health

Tyler Norris, MDiv

Chief Executive, Well Being Trust

Table of Contents

Executive Summary	1
Introduction.....	4
State and Federal Shared Responsibility.....	5
The Importance of State Laws.....	6
The Statutory Coding Instrument.....	7
State Statutory Scores and Grades	10
The Importance of Regulatory Compliance, and Enforcement Efforts	12
Promising Practices	13
Conclusions.....	16
Appendix A: Glossary	18
Appendix B: State Statutory Coding Instrument	21
Appendix C: Parity Track and Proposed Legislation	28



Executive Summary

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Parity Law¹) requires insurers to treat illnesses of the brain, such as depression or substance use disorders, the same way they treat illnesses of the body, such as diabetes or cancer. In other words, large group health plans are required to cover mental health and substance use disorder (MH/SUD) care in a way that is no more restrictive than coverage for physical or other medical conditions. The Patient Protection and Affordable Care Act (ACA) expanded these requirements to small group and individual health plans by mandating behavioral health² services as an essential health benefit.

The promise of parity remains elusive for many individuals directly impacted by mental illness or substance use disorders. They are denied care when they need it most and have few resources to advocate on their own behalf. Although federal and state governments share enforcement authority, states have a critical role in ensuring the Federal Parity Law and other state-related laws are properly enforced. States are primarily responsible for monitoring compliance with the Federal Parity Law for individual and fully-insured group plans. Despite the efforts of policymakers, advocates, and other stakeholders, major coverage and access disparities persist a decade later. Most states have not enacted strong state parity statutes, which would ensure that state regulators have a full set of tools to make parity a reality, in large part by holding both health plan executives and state officials accountable.

Strong state parity laws are foundational to robust parity enforcement, because without such laws, there often is little transparency or accountability relating to health plans' parity compliance and regulatory agencies' enforcement activities. In advance of the 10th anniversary of the signing of the Federal Parity Law, we examined how states enact strong parity statutes in order to ensure that state regulators can fulfill the intent of the Federal Parity Law. This report is a result of research assessing the strength and quality of state statutes using a quantitative and systematic coding methodology that was applied to all 50 states. Based on input from experts in parity, the Statutory Coding Instrument (SCI) was developed to provide a quantitative, comparative assessment of state parity statutes. The SCI assigns points based on the inclusion of important statutory language in the state codes. Each state statute was assigned a letter grade based on the total points earned using the SCI (total possible score of 100).

¹ **“Law”** refers to the entire body of **statutory**, administrative, and common law provisions that regulate our society. A **“statute”** is the specific, codified statement of a law that has been approved by the legislative body (and often endorsed by the executive body) of a government.

² **Behavioral Health** is an all-encompassing term for both mental health and substance use disorders. This includes the full spectrum of conditions covered in the American Psychiatric Association's Diagnostic and Statistical Manual of Disorders (DSM). See the Glossary for a list of key terms/definitions used in this report (Appendix A)

This policy analysis was designed to identify key elements of state legal codes relating to parity. By employing a systematic, replicable methodology of indexing and coding statutes, a comparative analysis of state parity laws is possible. Based on the results of the Statutory Coding Instrument (SCI), the states with the highest grades and points for their statutes are Illinois (A, 100), Tennessee (C, 79), Maine (C, 76), Alabama (C, 74), Virginia (C, 71), and New Hampshire (C, 71). However, the laws of most of these higher-scoring states have room for improvement.

The state statutes with the lowest grades and points are Wyoming (F, 10), Arizona (F, 26), Idaho (F, 36), Indiana (F, 38), Alaska (F, 43), and Nebraska (F, 43).

The key issues and recommendations for improvement based on frequent deficiencies found in our analysis of state statutes include:

Key Issue	Legislative Recommendation
How mental health & substance use disorders are defined	Mental health and substance use disorders (MH/SUD) must be seen as broad as physical health conditions. As such, states should define MH/SUD to include all disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) with no exclusions.
How mental health & substance use disorders are covered	Conditions that share the same characteristics should be treated in the same way. As such, co-pays and out-of-pocket costs, along with insurer medical management requirements must be the same for MH/SUD services as those for physical illnesses. States should require that insurance benefit management processes and treatment limitations, specifically both for quantitative treatment limitations (QTL) and non-quantitative treatment limitations, (NQTL) ensure parity in coverage.
How compliance with the parity law is monitored and enforced	States should strengthen enforcement and compliance activities by empowering regulatory agencies to enforce parity laws, including the Federal Parity Law, and require monitoring agencies to regularly report on steps taken to enforce compliance. In addition, states should mandate that all health benefit plans submit regular (e.g., annual) analyses demonstrating compliance with the relevant laws.

We cannot rely on legislative solutions alone, and other regulatory and enforcement actions must be taken to advance the goals of parity. In fact, among the many states assessed with a low score on the SCI, policymakers and advocates have leveraged regulatory and enforcement tools to help advance parity. Conversely, some states for which the statute was assessed as having a higher score are experiencing a high rate of parity violations, lack of enforcement by regulators, and poor access to care. This reflects the reality of how laws are enforced.

Particularly with the concurrent alcohol, opioid, and suicide epidemics ravaging states across the country, states must make parity enforcement a priority in order to increase access to critically needed treatment. Robust state parity enforcement will save not only lives but also benefit state budgets by encouraging commercial insurers to pay for treatment to which beneficiaries are entitled, reducing costly late interventions and cost shifts to payers such as Medicaid. The authors hope that the transparency of comparing state parity statutes will inform readers unfamiliar with the variations in state parity law and serve as a catalyst for action. A template for excellence in state mental health parity law has been established in this report, enabling states to significantly improve access to the mental health and substance use disorder treatments needed to improve the lives of millions of Americans who cannot access the mental health and substance use disorder treatment they need.



Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Parity Law) requires insurers to treat illnesses of the brain, such as depression or substance use disorders, the same way they treat illnesses of the body, such as diabetes or cancer. Large group health plans are required to cover mental health and substance use disorders (MH/SUD) in a way that is no more restrictive than coverage for physical or other medical conditions.

Under the Federal Parity Law, insurers may not impose higher co-pays, higher out-of-pocket costs, or different coverage limits on MH/SUD services when compared to services for the treatment of physical illnesses such as diabetes or hypertension. The Patient Protection and Affordable Care Act (ACA) of 2010 expanded these requirements to small group and individual health plans by mandating parity and mental health and addiction services as an essential health benefit. For parity to be achieved, state legislatures must do their part by enacting legislation that establishes clear pathways for parity monitoring, reporting, and enforcement activities.

This report is a result of research assessing the strength and quality of state statutes using a quantitative and systematic coding methodology that was applied to all 50 states.

Strong state parity laws are foundational to robust parity enforcement, because without such laws, there often is little transparency or accountability relating to health plans' parity compliance and regulator agencies' enforcement activities.

Every state in the country, except for Wyoming, has adopted one or more laws supporting parity (see www.paritytrack.org). While many state statutes and regulations were initially enacted in 2008 and 2010, immediately after enactment of the Federal Parity Act, many states also have updated their parity laws in recent years. In fact, state laws and regulations can be even more rigorous or have a broader scope than the protections of the Federal Parity Law. These laws also help state regulatory agencies promulgate additional guidance through administrative rulemaking and other forms of sub-regulatory guidance. This report is a result of research assessing the strength and quality of state statutes using a quantitative and systematic coding methodology that was applied to all 50 states.

State and Federal Shared Responsibility

With a few notable exceptions,³ most insurance plans are covered in some way by parity laws. Enforcement responsibilities under the Federal Parity Law vary based on the type of insurance plan. While the federal government provides overall direction on parity enforcement activities, states are primarily responsible for monitoring compliance for fully-insured group plans, individual and employer-funded plans of less than 51 insured employees, Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and in states that have expanded Medicaid under the ACA, to Alternative Benefit Plans. The federal government has "backup" jurisdiction in states that assert they cannot enforce or fail to substantially enforce the Federal Parity Law.⁴ **An estimated 26.6% of the U.S. Population or 87 million Americans are impacted directly by state insurance regulators.**^{5,6}

Within the federal government, enforcement is split among three different agencies depending on the type of health plan at issue. The US Department of Health and Human Services (HHS) oversees and has enforcement authority over the group and individual market as well as Qualified Health Plans in the exchanges. The US Department of Labor (DOL) and the Internal Revenue Service (IRS) generally have enforcement authority over self-insured private sector employment-based plans that are subject to the Employee Retirement Income Security Act (ERISA). In addition, the Office of Personnel Management is responsible for ensuring that the Federal Employees Health Benefit Program plans comply with parity.

³ Health insurance plans for which the Federal Parity Law does NOT apply include: Small employer plans created before March 23, 2010 (these were "grandfathered," and therefore exempt from the requirements of parity), plans sponsored by religious institutions and self-insured plans sponsored by state and local governments, retiree-only plans, TriCare, Medicare, Traditional Medicaid (fee for service, non-managed care). While states are prohibited from regulating some plans that are not covered by the Federal Parity Law (e.g. Medicare and TriCare), other plans (e.g. small employer plans and self-funded non-federal governmental plans), may be subject to parity protections by state law.

⁴ Alabama, Oklahoma, Missouri, Texas and Wyoming have asserted that their state insurance commissioner lacks the authority under the current state laws to enforce the Federal Parity Law (Source: SAMHSA.gov)

⁵ Henry J. Kaiser Family Foundation. (2016). *Health Insurance Coverage of the Total Population*. [Data file]. Retrieved from <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁶ Henry J. Kaiser Family Foundation. (2016). Figure 10.1. Percentage of Covered Workers in a Self-Funded Plan, by Firm Size. Retrieved from <https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/#figure101>

The Importance of State Statutes

State statutory codes provide critical protections related to coverage for mental health and substance use disorders. While the Federal Parity Law provides some protections, state statutes bridge important gaps and facilitate implementation of the Federal Parity Law. For example, state statutes can mandate or expand the scope of coverage for a mental health or substance use disorder or can require regulatory agencies to carry out market conduct examinations and submit reports demonstrating adequate enforcement. Embedding strong parity protections in state statutes establishes the minimum criteria for regulatory agencies to enforce, while also building in transparency and accountability to make enforcement less reliant on political will alone and to encourage continuity across administrations.

Given the significance of state statutory codes in helping make parity a reality, it is important to identify and understand variations in state statutes. Characterizing the relative strengths and weaknesses of each state helps inform policymakers, advocates, and other stakeholders as they identify priorities for their legislative sessions. This policy analysis was designed to identify key elements of state legal codes relating to parity.

By employing a systematic, replicable methodology of indexing and coding statutes, a comparative analysis of states is possible. Furthermore, the resulting database enables future research studies designed to evaluate the impact of state laws on mental health and substance use disorders or other public health outcomes of interest. To supplement each report, state specific report cards were developed to tailor recommendations.

State-specific report cards can be downloaded at: ParityTrack.org/anniversary.

The Statutory Coding Instrument

Legal epidemiology is the scientific study of law as a factor in the cause, distribution, and prevention of disease and injury.⁷ This is an emerging field that blends the practice of developing and implementing health laws with the scientific evaluation of how laws can affect health. Understanding how state parity laws impact important public health outcomes (such as access to mental health care or suicide prevalence) first requires the use of rigorous methods to measure the characteristics and prevalence of laws of interest.⁸

The Kennedy-Satcher Center for Mental Health Equity in the Satcher Health Leadership Institute at Morehouse School of Medicine (KSCMHE) and The Kennedy Forum formed a multidisciplinary research team to develop the Statutory Coding Instrument (SCI). The SCI assesses state-level mental health parity statutes (written laws that were passed by state legislatures and signed by the governor) using systematic methods. A systematic evaluation of state administrative codes, other sources of law, and agency activities such as state enforcement activities and Medicaid requires a separate coding methodology, thus is beyond the scope of this report.

The research was conducted in two Phases. In Phase I, a panel of experts was convened by a research team associated with The Kennedy Forum to consider and assign value to the practical impact of specific legal provisions. These subject matter experts included individuals from leading national advocacy organizations, academic institutions, state insurance regulators, and the insurance industry to review and comment on the coding criteria.

This panel informed the development of 10 questions that were used to code the state statutes. To ensure broad consensus, the questions were also reviewed by The Kennedy-Satcher Center for Mental Health Equity at Morehouse School of Medicine National Advisory Board and the Parity Leadership Workgroup, a coalition of organizations actively engaged in state and national parity implementation efforts. The research team incorporated feedback to improve the ability to apply a coding methodology that could be replicated. Table 1 lists the SCI item questions. The full instrument with rationale for point allocations is included in Appendix B.

⁷ Burris, S., Ashe, M., Levin, D., Penn, M., & Larkin, M. (2016). A Transdisciplinary Approach to Public Health Law: The Emerging Practice of Legal Epidemiology, *Ann. Rev. Pub. Health*, 37,135.

⁸ Presley D., Reinstein, T., & Burris, S. (2015, Feb.). Technical Standards for Policy Surveillance and Legal Datasets: Report of a Delphi Process. In Resources for Policy Surveillance. Retrieved from http://publichealthlawresearch.org/sites/default/files/uploaded_images/CombinedYear1Report_Feb2015.pdf.

An evidence-based approach to weighting the components of the SCI would reflect the relative impact on outcomes for each of the SCI items. Each question item was weighted equally and assigned a total of 10 points to avoid making unsupported assumptions about the impact of SCI items on outcomes.

Table 1. Statutory Coding Instrument Items (full instrument included in Appendix B)

1.	Is there statutory language stating that coverage provided for MH/SUD services must be on the same terms and conditions as it is for other medical coverage?
2.	Is there statutory language mandating that health insurance/benefit plans cover or offer to cover some or all MH/SUD treatment services?
3.	To which types of health insurance/benefit plans do the relevant parity sections of state law apply?
4.	Are different types of plans required to cover MH/SUD services in the same way?
5.	How are mental health conditions and/or substance use disorders defined in state statutes?
6.	Does a state statute expressly require coverage of any of the following MH/SUD benefits in any type of plan (outpatient visits, inpatient days, residential mental health or substance use disorder treatment, Medication Assisted Treatment (MAT), emergency medication without prior authorization)?
7.	Does a state statute specify that non-quantitative treatment limitations (NQTL), including but not limited to utilization review and prior authorization, must be comparable to and applied no more stringently than other medical care?
8.	Does a state statute require, authorize, or prevent the state insurance department or other relevant state agency to enforce the Federal Parity Law and any relevant federal law, or to issue regulations regarding the Federal Parity Law or any other relevant federal law?
9.	Does a state statute require the state insurance department or any other relevant state agency to submit reports about its actions monitoring parity compliance?
10.	Does a state statute require health insurance/benefit plans to submit reports demonstrating how they comply with the Federal Parity Law and/or any state parity statutes or regulations?

In Phase II, a list of relevant state statutes was developed using numerous resources: ParityTrack.org (publicly available),⁹ the National Conference of State Legislatures (NCSL) Mental Health Benefits analysis (publicly available, last updated December 30, 2015)¹⁰ and a 50-state survey conducted by Thomson Reuters (October 2017, available by subscription only)¹¹. More than 150 state statutes were identified through these sources.

To confirm the initial list of statutes and ensure updated analysis, the legal database WestlawNext was used to collect the existing statutes, with the last search conducted on August 20, 2018. Where external review of the research findings identified additional source documents, coding was revised to incorporate those sources.

The coding of state statutes was conducted by two attorneys and supervised by an attorney with experience conducting legal epidemiology studies.¹² To establish consistent interpretation of state statutes when applying the SCI, seven states were independently coded by two attorneys. The supervisor and coders held consensus meetings to identify coding discrepancies within the sample of duplicate states, to clarify coding interpretations and to reach consensus for all seven duplicate states.

Subsequently, each coder independently assessed 29 states by reviewing the relevant statutes, applying the SCI, and entering the scores in a spreadsheet to generate a total score for each state.

The supervising attorney reviewed the scores and source documents for all 50 states upon coding completion. The statutory source document and specific provision used to justify the points assigned for each coding question was documented and is available upon request to the corresponding author.

After the secondary review, states were assigned a grade on a scale of A through F based on their numeric score. Scores were converted into grades via the following rubric:

A = 90-100

B = 80-89

C = 70-79

D = 60-69

F = 0-59

⁹ The Kennedy Forum. (2016). *Parity Implementation National Survey*. Retrieved from <https://www.paritytrack.org/parity-reports/state-reports/>.

¹⁰ National Conference of State Legislatures (2015, Dec. 30). Mental Health Benefits: State Laws Mandating or Regulating. Retrieved from <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx>.

¹¹ Thomson Reuters. (2017, Oct.). Mental Health and Substance Abuse Parity and Coverage Requirements (Statutes). Available by subscription only.

¹² Douglas M.D., Benevides T.W., & Carretta H. (2017). Analyzing State Autism Private Insurance Mandates for Allied Health Services: A Pilot Study. *OTJR (Thorofare N J)*, 37(4), 218-226. doi: 10.1177/1539449217730355.

State Statutory Scores and Grades

Based on the results of the Statutory Coding Instrument (SCI), the states with the highest grades and points for their statutes are Illinois (A, 100), Tennessee (C, 79), Maine (C, 76), Alabama (C, 74), Virginia (C, 71), and New Hampshire (C, 71). However, the laws of most of these higher-scoring states have room for improvement.

The state statutes with the lowest grades and points are Wyoming (F, 10), Arizona (F, 26), Idaho (F, 36), Indiana (F, 38), Alaska (F, 43), and Nebraska (F, 43). Wyoming is noteworthy for being the only state not to address mental health parity in its statutory code.

Figure 2 provides a map of the United States that has been color coded according to grades. It should be noted that 43 states received a grade of D or F, with only seven states receiving a satisfactory grade of "C" or higher. Table 2 lists the SCI score for each state.

Figure 2: Map of the United States, Color Coded by Statutory Grades

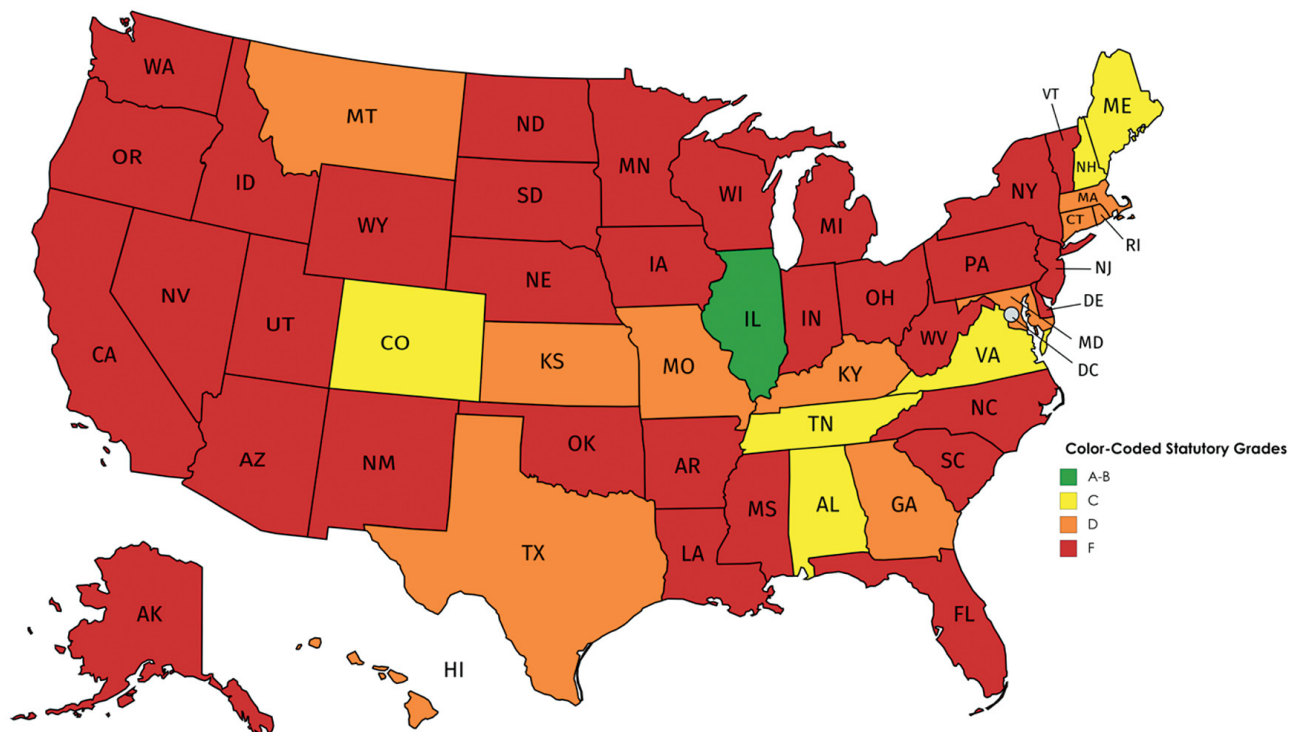


Table 2. List of States and State Parity Statutory Score on the Statutory Coding Instrument

State (score)	State (score)	State (score)	State (score)	State (score)
Alabama (74)	Hawaii (67)	Massachusetts (61)	New Mexico (47)	South Dakota (55)
Alaska (43)	Idaho (36)	Michigan (54)	New York (53)	Tennessee (79)
Arizona (26)	Illinois (100)	Minnesota (51)	North Carolina (49)	Texas (68)
Arkansas (59)	Indiana (38)	Mississippi (57)	North Dakota (48)	Utah (58)
California (51)	Iowa (50)	Missouri (63)	Ohio (51)	Vermont (53)
Colorado (70)	Kansas (65)	Montana (66)	Oklahoma (55)	Virginia (71)
Connecticut (60)	Kentucky (66)	Nebraska (43)	Oregon (47)	Washington (51)
Delaware (57)	Louisiana (51)	Nevada (54)	Pennsylvania (55)	West Virginia (55)
Florida (53)	Maine (76)	New Hampshire (71)	Rhode Island (67)	Wisconsin (52)
Georgia (60)	Maryland (68)	New Jersey (54)	South Carolina (50)	Wyoming (10)

Limitations

The scope of the quantitative analysis included state statutes only. Applying a quantitative instrument to statutes that are qualitative in nature leaves room for interpretation as the SCI was applied. Our consensus method was used to mitigate discrepancies in applying the instrument. This process also revealed that some statutes are written in ways that do not clearly align with the SCI items. For example, some states scored high for their requirements around coverage of mental health conditions, but low for coverage of substance use disorders. The SCI did not distinguish state statutes to this level of granularity.

In addition, the analysis only evaluated Medicaid if the state parity statute included it explicitly.

Since 65 million Americans were enrolled in Medicaid managed care,¹³ which is required to comply with the Federal Parity Law, development of a Medicaid coding instrument is needed.

As the items included in the SCI may not capture every domain of state statutes that are important to achieving parity outcomes, monitoring state laws on a regular basis can identify trends for inclusion into future iterations of the SCI. Legislative updates are regularly posted to *ParityTrack.org*. Appendix C includes a narrative summary of trends in recent proposed legislation.

¹³ Henry J. Kaiser Family Foundation. (2016). *Total Medicaid Managed Care Enrollment* [Data file]. Retrieved from <https://www.kff.org/medicaid/state-indicator/total-medicare-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

The Importance of Regulatory, Compliance, and Enforcement Efforts

Beyond enacting state statutes, state insurance personnel and other state regulators, including state attorneys general in some jurisdictions, are responsible for enforcing health insurance laws. To help guarantee that the Federal Parity Law and relevant state laws are properly implemented, state regulatory agencies can issue more detailed guidance including regulations, bulletins, opinion letters and frequently asked questions to clarify areas of the law. These departments can also use these documents to provide information to help enrollees, family members, and advocates understand their rights.

As a result, these departments are accountable for ensuring that plans sold in the state are compliant with all relevant laws and for investigating any potential violations through detailed and thorough market conduct examinations. Additionally, state attorneys general typically have the authority to enforce state parity law, and they can investigate potentially fraudulent and illegal conduct related to consumer products, including health insurance plans. If violations of parity laws are found, attorneys general can use their enforcement powers to issue fines and compel health plans to come into compliance.

Consumer parity complaints are an important facilitator of compliance and enforcement activities, yet consumers cannot be expected to submit complaints explicitly characterized as violations of parity. They do not have the information necessary to know whether limitations on their mental health or substance use disorder coverage are more restrictive than for physical health coverage. Consumers often lodge complaints and appeals with health insurers and regulators when they receive coverage denials or less reimbursement than expected. Despite this challenge, by carefully analyzing all mental health and substance use disorder complaints and appeals, regulators can identify potential parity violations.

Among other options, consumers should register their complaints of denials of care at www.parityregistry.org and leverage the state-by-state resource page to obtain helpful information on filing complaints.

Enforcement best practices include **prospective compliance verifications and retrospective review following a consumer complaint**. These best practices require plans to submit detailed parity compliance analyses and verify that these submissions in fact demonstrate compliance.

It is particularly vital for the analyses and verification to occur prior to plans being offered to consumers in order to prevent parity violations and ensure consumers receive the equitable coverage to which they are entitled. Retrospective parity reviews of plans' actual MH/SUD coverage practices are also critical to effective parity enforcement to identify emerging noncompliance activities before they become a mainstream practice.

Promising Practices

In 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) published an Issue Brief “Approaches to Implementing Mental Health Parity and Addiction Equity Act: Best Practices from the States”¹⁴ resulting from interviews with seven states (California, Connecticut, Maryland, Massachusetts, New York, Oregon, and Rhode Island). The report identified five primary components that they considered critical for the successful implementation and monitoring of parity:

- Open channels of communication
- Standardization of materials
- Creation of templates, workbooks, and other tools
- Implementation of **market conduct examinations** and **network adequacy assessments**
- Collaboration with multiple state and federal agencies, health insurance carriers, and stakeholder groups

In our review of source documents, the qualitative environmental scan, and consultation with experts, several promising practices were identified as important steps in ensuring that individuals have access to quality care. What follows is not an exhaustive list, but these exemplars can help improve readers’ understanding of how these practices could work to supplement state laws, and help make parity a reality.

Market conduct examinations are carried out by state insurance regulators in order to assess if health insurers’ operations, practices, plans, and policies are compliant with federal and state laws and regulations in order to determine the insurer’s authority to issue insurance within the state.

Network adequacy assessments are typically conducted by regulators to determine if the providers contracted by the plan or policy to provide medical and/or mental health and substance use disorder services are at capacity sufficient to serve the beneficiary population, as determined by federal and state requirements.

¹⁴ Substance Abuse and Mental Health Services Administration. (2016). *Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States* (HHS Publication No. SMA-16-4983). Rockville, MD: U.S. Government Printing Office.

California: In-Depth Prospective Compliance Review

California's Department of Managed Health Care (DMHC) requires insurers to submit information to determine if they complied with the Federal Parity Law. The DMHC designed worksheets for plans to show 1) that they cover all behavioral health benefits required under state law and 2) that they calculate financial requirements in compliance with the parity final rules.^{15,16,17} Insurers were also required to submit their policies and procedures for utilization management and other non-quantitative treatment limitations. These requirements allowed DMHC to compare the policies governing behavioral health services with those governing medical services to identify potential parity violations. DMHC is working with the plans to revise their policies so that the plans can come into compliance.

Montana: Additional Guidance Detailing Potential Violations

The Montana Commissioner of Securities and Insurance released a bulletin focusing on non-quantitative treatment limitations. The memorandum contains examples of "red flags" that indicate a potential parity violation. All of the red flags are taken from de-identified consumer complaints to the department. Examples include fail-first protocols, blanket exclusions of treatment regardless of medical necessity, frequent concurrent reviews for inpatient care, refusal to reimburse for outpatient care because "progress" has not been achieved, requirement that treatment plans be submitted every 90 days, and no out-of-state coverage for behavioral health.

New York: Optimizing Regulatory Enforcement through Investigations and Fines

The New York Attorney General's Office has reached settlements with numerous insurers after conducting investigations into their behavioral health claims practices. These investigations revealed insurers were using protocols that either were not in place for other medical care or were applied more stringently to behavioral health benefits than other covered services. These protocols involved use of fail-first policies, more onerous prior authorization procedures, more frequent and rigorous utilization review, and categorical exclusions of residential treatment and neuropsychological testing.

¹⁵ California Department of Managed Health Care. (n.d.). *Mental Health Parity and Addiction Equity Act*. Retrieved from <https://www.dmhca.gov/aboutthedmhca/lawsregulations/mentalhealthparityandaddictionequityactof2008mhpaee.aspx>.

¹⁶ California Department of Managed Health Care. (2014, Aug. 21). *Instructions for the Federal Mental Health Parity and Addiction Equity Act Compliance Filing*. Retrieved from https://www.dmhca.gov/Portals/0/LawsAndRegulations/MentalHealth/Workbook_including_Index_and_Tables_1_through_4.pdf.

¹⁷ California Department of Managed Health Care. (2014, Aug. 21). *Federal Mental Health Parity and Addiction Equity Filing*. Retrieved from https://www.dmhca.gov/Portals/0/LawsAndRegulations/MentalHealth/Table_5-Non_Quantitative_Treatment_Limitations.pdf.

The Attorney General's Office levied over \$3 million in penalties and ordered reprocessing of claims that resulted in payment of millions of dollars in previously-withheld reimbursement to enrollees and providers. **Nearly half of denials re-reviewed as part of settlements were overturned on appeal.**¹⁸ The health plans involved in these investigations are also monitored to ensure parity compliance is reached and maintained.

Oregon: Regulations with Greater Specificity than Federal Rule

The Oregon Department of Consumer and Business Services issued regulations that go beyond the specificity of the final rules of the Federal Parity Law in several ways. The regulations prohibit insurers from excluding coverage solely because an entire course of treatment was not completed or because the treatment was court-ordered. Additionally, the regulations disallow insurers from categorically excluding a form of treatment for a mental health condition.

Pennsylvania: Consumer Guide

The Pennsylvania Insurance Department released a comprehensive consumer guide to behavioral health. The report is divided into different types of insurance. It then specifies the rights consumers are entitled to under each insurance plan. The final section provides resources for individuals if they need further assistance. Other states have also developed these tailored tools.

Texas: Collecting and Publishing Health Insurer Data

The Texas Department of Insurance released a report in August 2018 comparing data on how insurance plans in the state covered MH/SUD versus medical and surgical care. Required by House Bill 10, passed in 2017, the report examined data relating to prior authorization utilization, claims denials, appeals, and external reviews. The Texas Health and Human Services Commission released a similar report on Medicaid managed care organization data. While such public data reporting should occur on a regular basis, these one-time Texas reports increased transparency on metrics that are related to parity and can give insights on where the greatest problems are in MH/SUD coverage.

¹⁸ Ollove, M. (2015, May 7). Despite Laws, Mental Health Still Getting Short Shift. *Pew, Stateline*. Retrieved from <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/07/despite-laws-mental-health-still-getting-short-shift>.

Conclusions

This Report presents a framework to evaluate state parity statutes that advance the public policy goals underpinning the Federal Parity Law. Key issues and recommendations for legislative actions based on *frequent deficiencies* found in our analysis of state statutes include:

Key Issue	Legislative Recommendation
How mental health & substance use disorders are defined	Mental health and substance use disorders (MH/SUD) must be seen as broad as physical health conditions. As such, states should define MH/SUD to include all disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) with no exclusions.
How mental health & substance use disorders are covered	Conditions that share the same characteristics should be treated in the same way. As such, co-pays and out-of-pocket costs, along with insurer medical management requirements must be the same for MH/SUD services as those for physical illnesses. States should require that insurance benefit management processes and treatment limitations, specifically both for quantitative treatment limitations (QTL) and non-quantitative treatment limitations, (NQTL) ensure parity in coverage.
How compliance with the parity law is monitored and enforced	States should strengthen enforcement and compliance activities by empowering regulatory agencies to enforce parity laws, including the Federal Parity Law, and require monitoring agencies to regularly report on steps taken to enforce compliance. In addition, states should mandate that all health benefit plans submit regular (e.g., annual) analyses demonstrating compliance with the relevant laws.

For many individuals directly impacted by mental illness or substance use disorders, the promise of parity remains elusive. They are denied care when they need it most and have few resources to advocate on their own behalf. These individuals cannot rely on legislative solutions alone, and fortunately, other actions can be taken that advance the goals of parity. In fact, in many states whose parity statute were assessed as having a low score on the SCI, policymakers and advocates have leveraged other tools to help advance parity. Conversely, some states whose statutes were assessed as having a higher score are experiencing a high rate of parity violations and poor access to care. This reflects the reality of how laws are enforced.

Particularly with the concurrent alcohol, opioid, and suicide epidemics ravaging states across the country, states must make parity enforcement a priority in order to increase access to critically needed treatment. Robust state parity enforcement will save not only lives but also benefit state budgets by encouraging commercial insurers to pay for treatment to which beneficiaries are entitled, reducing costly late interventions and cost shifts to payers such as Medicaid.

The authors hope that the transparency of comparing state parity statutes will inform readers unfamiliar with the variations in state parity law and serve as a catalyst for action. A template for excellence in state mental health parity statutes has been established in this report, enabling states to significantly improve access to care needed to improve the lives of millions of Americans who cannot access the mental health and substance use disorder treatment they need.

Please send any questions, feedback, or comments the corresponding author.



Appendix A: Glossary of Terms

Behavioral Health: An all-encompassing term for both mental health and substance use disorders. This includes the full spectrum of conditions covered in the American Psychiatric Association's Diagnostic and Statistical Manual of Disorders (DSM). *NOTE: To avoid confusion, throughout this report we use the phrase "mental health and substance misuse/abuse conditions" or "mental health and substance use disorders"*

Centers for Consumer Information and Insurance Oversight (CCIIO): A federal department within the Centers for Medicare and Medicaid Services (CMS) that is charged with helping implement many ACA reforms.

County and Municipal Employee Health Plan: A health plan for non-federal government employees, including school districts.

Diagnostic and Statistical Manual of Mental Disorders (DSM): A manual published by the American Psychiatric Association that offers common language and standards criteria health professionals use in the diagnosis of behavioral health conditions. The most recent version is the DSM-V, but many laws and regulations still refer to the DSM-IV, which was in use from 1994-2013.

Financial Requirements: A requirement where enrollees must pay a certain amount before their health insurance coverage begins. Examples include deductibles, copayments, coinsurance, and out-of-pocket expenses.

Fully-Insured Plan: Health plans that employers purchase from an insurance company to provide their employees with health benefits. These health plans are regulated by state insurance departments.

Individual Plan: Health plans that individuals can purchase for themselves. Individuals who purchase these plans normally do not receive health insurance through their employer. These health plans are regulated by state insurance departments.

Inpatient Care: Treatment delivered to an individual in a hospital or a sub-acute treatment facility.

International Classification of Disease (ICD): A document created by the World Health Organization that is the international standard for the diagnosis of medical conditions. It contains a section on behavioral health disorders.

Large Group Plan: Generally, these are health plans with 51 or more employees. However, in some states, this number was changed to 101 or more after January 1, 2016. These plans are regulated either by a state department of insurance or the federal Department of Labor.

Medicare: The federal health insurance program for people who are 65 or older, some people below age 65 with disabilities, and individuals with end-stage renal disease. The Medicare program does not have to comply with the Federal Parity Law.

Medicaid: A joint federal and state program that provides health insurance for low-income families and individuals.

Medication Assisted Treatment (MAT): An evidence-based treatment that combines behavioral therapy with medication to treat substance use disorders. The three medications used in the treatment of substance use disorder are buprenorphine, methadone, naltrexone.

Mental Health Parity and Addiction Equity Act (the Federal Parity Law): Signed into law in 2008, the Federal Parity Law requires many insurance plans that offer behavioral health coverage to provide these benefits under the same terms and conditions as other health benefits. This law does not require health insurance plans to offer behavioral health services.

Non-Quantitative Treatment Limitations (NQTL): A medical management practice that cannot be quantified. Examples include geographic restrictions, prior authorization requirements, medical necessity review, and fail-first protocols.

Outpatient Care: Treatment delivered to an individual where they can go home after care without being admitted to a hospital or a residential treatment facility.

Patient Protection and Affordable Care Act (ACA): The national health reform law that was signed into law in 2010. The ACA requires that behavioral health services are an essential health benefit and therefore must be covered by health benefit plans sold in the individual market.

Public Health Service Act: A United States federal law that contains many provisions, including important components of the federal laws that govern mental health parity.

Quantitative Treatment Limitations: A medical management practice that is measurable. Examples include outpatient visit limits and inpatient day limits.

Residential Treatment: Treatment delivered in a setting where the patient is in the treatment facility 24 hours a day for a designated number of days.

Self-Insured Plan: A health plan where an employer covers their employees' health insurance utilization with the employer's own money rather than purchasing a health plan from an insurance company. These plans are regulated by the Department of Labor except for non-federal governmental plans, which are regulated by the states and CCIO.

Small Group Plan: Generally, a health plan with 50 or fewer employees. However, in some states, this number was changed to 100 or fewer after January 1, 2016.

State Departments of Insurance: Any state agency/department that implements and enforces state and federal law governing behavioral health coverage.

Appendix B: Statutory Coding Instrument

Coders scored state statutes and regulations using a point-based system. The highest possible score was 100, with the total value for each question ranging from 0-10 points. The 10 questions below were used to determine point assignments. For each question, justification for the importance of asking the question and limited examples are provided.

1. Is there statutory language stating that coverage provided for behavioral health services must be on the same terms and conditions as it is for other medical coverage? (10 points available; only one answer may be selected)

- a. Yes (10 points)
- b. Yes, but explicitly allows certain things to be different (e.g., medical management, geographic restrictions, etc.) (5 points)
- c. No (0 points)

This question addresses the foundation of parity. Some states make it clear that the language, “same terms and conditions” or “no more restrictive,” encompasses all aspects of benefit design and delivery. Some states have “same terms and conditions” language but then have exceptions in place such as numerical impositions (e.g. allowing health plans to only cover 28 days of residential treatment) or language exempting medical management practices from the “same terms and conditions” requirement. Several states have no language to the effect of “same terms and conditions.”

For coding purposes, states received the full 10 points if any state statute related to behavioral health insurance benefits included a parity clause, defined as requiring comparable coverage for behavioral health treatment and physical health or medical treatment. Only two states received 5 points for this question (Florida and Arizona) and Wyoming is the only state that received 0 points.

2. Is there statutory language mandating that health insurance/benefit plans cover or offer to cover some or all behavioral health treatment services? (10 points available; only one answer may be selected)

- a. Behavioral health treatment services are a mandated benefit for health insurance/benefit plans (10 points)
- b. Behavioral health treatment services are not a mandated benefit for health insurance/benefit plans (0 points)

This question distinguishes between state laws where coverage for behavioral health services is optional and state laws that require coverage of behavioral health services. This distinction is similar to MHPAEA, which does not mandate coverage (parity is required only if a plan covers behavioral health treatment) and the ACA requirement that behavioral health services are an essential health benefit and therefore must be covered by health benefit plans sold in the individual market.

For coding purposes, states received 10 points if the statute mandated that any health benefit plans cover behavioral health treatments and/or if the statute mandated that behavioral health coverage is offered to the policyholder. States received 0 points if coverage of behavioral health treatments was optional to the health benefit plan.

Example (10 points, mandated benefit): Missouri, Mo. Ann. St. § 376.1550, 1(1): "A health benefit plan shall provide coverage for treatment of a mental health condition..."

Example (10 points, offer): Florida, Fla. Stat. Ann. § 627.668(1): "Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting group health insurance or providing prepaid health care in this state shall make available to the policyholder as part of the application, for an appropriate additional premium under a group hospital and medical expense-incurred insurance policy, under a group prepaid health care contract, and under a group hospital and medical service plan contract, the benefits or level of benefits specified in subsection (2) for the necessary care and treatment of mental and nervous disorders..."

Example (0 points): Nebraska, Neb. Rev. St. § 44-793(1): "...[A]ny health insurance plan delivered, issued, or renewed in this state (a) if coverage is provided for treatment of mental health conditions..."

3. To which types of health insurance/benefit plans do the relevant parity sections of state law apply? (10 points available; points awarded for each answer selected)

- a. Large group plans (2 points)
- b. Small group plans (2 points)
- c. Individual plans (2 points)
- d. State and/or county/municipal employee plans (2 points)
- e. Medicaid plans (2 points)

This question ultimately determines how many people within a state have insurance that includes parity. Some states limit their parity statutes to large group health plans, while others require all health benefit plans to cover behavioral health services and to do so in a comparable way to which medical treatment is covered.

For coding purposes, if a state statute did not specifically include or exclude specific types of plans and included a broad definition of “health benefit plan” large group, small group, individual and state employee health benefit plans would be included and the state would receive 8 points. States only received 2 points for Medicaid plans if the statute specifically included Medicaid. Only 2 states’ statutes explicitly included Medicaid (Illinois & Missouri).

4. Are different types of plans (refer to Question 3) required to cover behavioral health services in the same way? (10 points available; only one answer may be selected)

- a. Yes (10 points)
- b. No (0 points)

Uniformity in the requirements of state codes is essential to eliminating confusion and guaranteeing equal protections for all individuals insured. Additionally, disparate requirements for different plan types can increase the administrative burden for plans when designing benefits.

For coding purposes, states received 10 points if identical provisions applied to the health plans recognized in Question 3. For example, states whose parity statutes only applied to large and small group plans would receive 10 points if the parity provisions were identical for both large and small group plans.

5. How are mental health conditions and/or substance use disorders defined in state statutes? (10 points available; only one answer may be selected)

- a. Includes all disorders listed in Diagnostic and Statistical Manual of Mental Disorders (DSM) or behavioral health disorders in International Classification of Diseases (ICD) (10 points)
- b. Includes all disorders in DSM or behavioral health disorders in ICD with select exclusions (e.g., caffeine, nicotine, marital problems) (8 points)
- c. In a list that itemizes a limited number of behavioral health conditions OR includes everything in DSM/ICD with select major exclusions (e.g., depression, substance use disorders) (4 points)
- d. Includes a specific definition, but without explicit reference to DSM or ICD (2 points)
- e. Not defined (0 points)

It is important that state codes define mental illnesses and substance use disorders in a way that is consistent with modern science, especially since the Federal Parity Law leaves the definition to the states. The gold standard and most inclusive definition is to defer to the DSM or ICD without exception.

6. Does a state statute expressly require coverage of any of the following behavioral health and/or substance use disorder benefits in any type of plan? (10 points available; select all answers that apply)

- a. Outpatient visits (2 points)
- b. Inpatient days (2 points)
- c. Residential mental health or substance use disorder treatment (2 points)
- d. Medication Assisted Treatment (MAT) (2 points)
- e. Emergency medication without prior authorization (2 points)

This question seeks to reward states that explicitly require coverage of specific services that are often excluded when not explicitly mentioned, like residential mental health or substance use disorder treatment and emergency medication without prior authorization. It also distinguishes states that seek to confront the opioid epidemic through coverage of MAT. It is important to point out that states that do not expressly require coverage of these services in their statutes may still require coverage. However, since specific benefits are not expressly stated, plans in these states may have more leeway to deny coverage due to lack of specificity for certain benefits. In states where plans denied coverage for residential treatment, the statute remedied this problem by explicitly requiring coverage for residential treatment.

7. Does a state statute specify that non-quantitative treatment limitations (NQTL), including but not limited to utilization review and prior authorization, must be comparable to and applied no more stringently than other medical care? (10 points available; only one answer may be selected)

- a. The statute explicitly uses the umbrella term NQTL in defining treatment limitation or otherwise and requires that NQTL are no more restrictive than those for physical/other medical benefits **OR** the statute refers to the MHPAEA (42 USC 300gg-5; 300gg-26; 29 USC 1185a) and/or the regulations (45 CFR 146.136; 29 CFR 2590.712) and requires health plans to comply* (10 points)
- b. The statute does not explicitly use the umbrella term NQTL in defining treatment limitation or otherwise but requires that specified NQTLs are no more restrictive than those for physical/other medical benefits (8 points)
- c. The statute does not explicitly use the umbrella term NQTL in defining treatment limitation, but generally requires that any treatment limitations must be comparable to those imposed on physical or other medical benefits (5 points)
- d. The statute is silent as to NQTL or other treatment limitations (3 points)
- e. The statute allows for treatment limitations that are different from those for physical/other medical benefits (0 points)

This is one of the most important areas for parity given that plans continue to struggle with the non-quantitative treatment limitation requirements of the Federal Parity Law, which does not explicitly use the term “non-quantitative treatment limitation.” Non-quantitative treatment limitations are methods plans employ to limit access to treatment that are not quantifiable (e.g. medical necessity reviews, prior authorization requirements, step therapy protocols). The design and application of non-quantitative treatment limitations can be opaque, which is why additional protections beyond the Federal Parity Law can require greater transparency.

For coding purposes, coders referred to the “NQTL Warning Signs” document published by the U.S. Department of Labor and Department of Health and Human Services to identify NQTL provisions that are not explicitly named NQTL (available at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>). Much recent activity around NQTLs is occurring at the administrative agency level, but these activities were not included in this coding scheme.

**States that refer to the MHPAEA (42 USC 300gg-5; 300gg-26; 29 USC 1185a) and/or the regulations (45 CFR 146.136; 29 CFR 2590.712) but includes conflicting language in the state statute that allows for different treatment limitations were scored as 0 (impacts Arizona, Delaware, North Carolina).*

- 8. Does a state statute require, authorize, or prevent the state insurance department or other relevant state agency to enforce the Federal Parity Law and any relevant federal law, or to issue regulations regarding the Federal Parity Law or any other relevant federal law? (10 points available; only one answer may be selected)**
- a. State statute requires the state insurance department or other relevant state agency to enforce the Federal Parity Law (10 points)
 - b. State statute authorizes the state insurance department or other relevant state agency to enforce the Federal Parity Law (8 points)
 - c. State statute is silent as to whether the state insurance department or other relevant state agency may enforce the Federal Parity Law (5 points)
 - d. State statute prevents the state insurance department or other relevant state agency to enforce the Federal Parity Law (0 points)

State insurance commissioners (aka superintendent, health authority) are intrinsically and/or by statute required and/or authorized to perform general duties. However, state statutes expressly requiring or authorizing these officials to enforce the Federal Parity Law or other federal laws indicates that the state legislature places value in enforcing this law and expects the state agency to proactively enforce it. This does not mean that state agencies are not enforcing the federal laws even when the state parity law is silent. Some states either cannot or will not enforce the Federal Parity Law unless it is encoded in state law.

For coding purposes, parity statutes and statutes setting forth the Insurance Commissioner's general duties and authority were used as the source documents for this question.

9. Does a state statute require the state insurance department or any other relevant state agency to submit reports about its actions monitoring parity compliance? (10 points available; only one answer may be selected)

- a. Yes, on a recurring basis (10 points)
- b. Yes, but not on a recurring basis (5 points)
- c. No (0 points)

One of the most significant barriers to full implementation of the Federal Parity Law and state parity provisions has been inaction by state regulatory bodies. Authorizing or requiring a regulatory body to implement parity is a good step, but requiring that the agency file a report about its actions enhances accountability and spurs action.

10. Does a state statute require health insurance/benefit plans to submit reports demonstrating how they comply with the Federal Parity Law and/or any state parity statutes or regulations? (10 points available; only one answer may be selected)

- a. Yes, on a recurring basis (10 points)
- b. Yes, but not on a recurring basis (5 points)
- c. No (0 points)

It is difficult to know if health plans comply with the Federal Parity Law without data that demonstrates the insurers' methods for compliance. This is particularly true in terms of whether the design and application of non-quantitative treatment limitations comply with the Federal Parity Law.

Appendix C: Parity Track and Proposed Legislation

Parity Track

ParityTrack.org is a collaborative online forum that aggregates and elevates parity work taking place across the country. It was developed to address the need for accountability among all actors responsible for parity compliance. This effort includes the following activities:

- **Tracking parity legislative, regulatory, and legal activities** in all 50 states and at the federal level to monitor implementation throughout the country
- **Developing model resources**, such as legislation and compliance tools, that state and federal policymakers can use to ensure full compliance
- **Creating comprehensive and detailed issue briefs** on parity and related topics to increase knowledge of behavioral health insurance laws
- **Collecting consumer and provider stories** involving behavioral health care restrictions or denials that can be used to illustrate the harm associated with parity violations

Environmental scans identify proposed legislation and regulatory and enforcement activities using LexisNexis, LexisNexis StateNet, Thomson Reuters Westlaw, and expert opinion. The findings are housed on ParityTrack.org, which is a central resource for up-to-date parity information related to mental health and substance use disorders including legislation, regulation, and litigation. The primary purpose of Parity Track is to help consumers understand their rights under the Federal Parity Law and state parity laws.

Proposed Legislation

After a review of bills included on Parity Track that were introduced throughout the most recent state legislative sessions, several trends emerged during analysis. State lawmakers are considering parity related measures that loosely fall into three broad categories:

- **Expanded mandated benefits**
- **Managed care technique restrictions, and**
- **Required enforcement and compliance procedures**

Expanded mandated benefits. The Federal Parity Law does not *require* health plans to offer coverage for behavioral health treatment but does require many plans offering these benefits to ensure they are equivalent to the benefits provided for physical health. Proposed legislation that mandates the offering or coverage of benefits is building upon the Federal Parity Law by increasing the accessibility of mental health and substance use disorder services. A handful of bills do so broadly by extending certain sections or all of state parity statutes to apply to additional types of plans or policies, such as individual plans or short-term limited duration plans. Others do so by strengthening current state parity statutes by creating further requirements, such as requiring coverage or reimbursement of certain mental health and substance use disorder treatment, screenings, or telemedicine benefits. For instance, proposed bills are requiring Medicaid reimbursement eligibility for certain providers or requiring certain provider types' services be offered or covered by commercial plans and policies. These bills concern licensed marital and family counselors, licensed rehabilitation counselors, certified substance use disorder counselors, and certified addiction recovery coaches.

Expanding access by restricting managed care techniques. Additionally, proposed legislation is focusing on restricting managed care techniques for both Medicaid and commercial plans and policies. Curbing authorization requirements is increasingly common, such as limiting prerequisite or authorization criteria solely to a qualifying physician's determination of medical necessity or prescription for a treatment or service. Other legislation prohibits prior authorization requirements entirely for identified substance use disorder services, including MAT products and outpatient treatment and diagnosis.

Required enforcement and compliance. Bills mandating specific required compliance and enforcement procedures are being introduced in multiple states. Many of these bills incorporate language from The Kennedy Forum Model State Parity Legislation.¹⁹ This model bill reinforces parity provisions within the relevant sections of state laws by adding reporting requirements for insurers and regulators. Tailored versions of the model bill and related compliance and enforcement measures have been introduced across the nation to best suit a state's needs and political climates. Illinois scored 100 on the SCI and is an example of a state that recently adopted language from The Kennedy Forum Model Legislation.

Rewritten, new, and past bills are expected to be introduced during the upcoming legislative sessions. Visit *ParityTrack.org* for the most up to date information.

¹⁹ <https://www.paritytrack.org/resources/model-resources/>

Notes



