



MENTAL HEALTH INSURANCE PARITY: STATE LEGISLATIVE AND ENFORCEMENT ACTIVITIES

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Abstract

- **Issue:** Treating mental health conditions and substance use disorders as equivalent to other health conditions in insurance plans (“mental health parity”) continues to be a priority policy concern at the federal and state levels. Measures approved by Congress and state legislatures have established methods for assessing mental health parity on a regular basis. But other issues that have long challenged the nation’s health care system, such as transforming payment and delivery of services, may need to be addressed to ensure parity becomes a reality.
- **Goal:** Provide mental health insurance parity policy options for state leaders.
- **Methods:** Review policy challenges, statutes, regulations, and enforcement efforts, and identify future policy avenues.
- **Key Findings:** States continue to address gaps in parity through legislation and through regulatory, enforcement, and compliance efforts. They are requiring 1) insurance companies to demonstrate compliance; 2) insurance departments to report on compliance; 3) coverage of a fuller range of mental illnesses and substance use disorders; and 4) greater transparency by insurance providers. They are attempting to correct the negative outcomes of insurance practices such as prior authorization for services, provider networks, and formulary design.
- **Conclusion:** States have led the way in addressing parity issues with legislation to 1) shape coverage; 2) provide a model for federal legislation; 3) facilitate implementation of federal laws; and 4) ensure insurance market compliance. Bigger challenges lie ahead when it comes not only to ensuring all individuals have access to quality services but also in equipping the overall health care system and other systems to address mental health needs. Numerous factors have generated various successful strategies and solutions with opportunities for expansion in government and practice.

Background and Introduction

Efforts to address mental health insurance parity can be traced back 60 years to former President John F. Kennedy's call for requiring the Federal Employees Health Benefits Program to cover psychiatric illnesses at a level equivalent to general medical care. The federal Mental Health Parity Act of 1996 required mental health parity only for annual and lifetime dollar limits. In response, states began passing piecemeal parity bills to expand parity by such efforts as mandating coverage of certain conditions, eligible populations, a number of inpatient days and outpatient visits, and annual dollar amounts. A decade after that federal bill, 37 states had parity laws of widely varying scope and efficacy in addressing discriminatory coverage practices.¹

The federal Mental Health Parity and Addiction Equity Act of 2008 provides a definitive legal standard that coverage for mental health and substance use disorder treatment cannot be

more restrictive than coverage for other medical treatment. The law applies to most commercial insurance plans, Medicaid managed care, and the Children's Health Insurance Program (CHIP) but not Medicare.² While the 2008 law largely eliminated many longstanding problems across mental health and substance use disorder coverage, problems with insurers' managed care practices have emerged in the years since.

Since the beginning of 2018, 17 states have passed legislation requiring insurers to demonstrate compliance on an annual basis. Medicaid managed care organizations were included in the legislation approved in six states and the District of Columbia. Just last year, Congress passed legislation that requires every health insurer in the country to perform compliance analyses.³

Managed Care

Health care delivery system organized to manage cost, utilization, and quality in which patients agree to visit only certain doctors and hospitals. A managed care organization (MCO) monitors the cost of treatment.

Medicaid Managed Care

Provides for the delivery of Medicaid health benefits and additional services through contracted agreements between state Medicaid agencies and MCOs that accept a set per member per month payment for these services.

Source: Medicaid.gov



Policy Challenges

Despite the focus of federal and state governments in recent years, there remain numerous policy challenges preventing the full realization of parity. The challenges detailed below are highlighted because they are the priority concerns of state leaders based on CSG research. Additional challenges are detailed in the Future of Mental Health Insurance Parity Policy section at the end of this brief.

- **Non-compliance of insurance and Medicaid managed care plans:**

As state insurance departments significantly ramped up implementation and enforcement of parity in 2017, nearly every examination and analysis found significant problems.⁴ Around the same time, state Medicaid programs also

were undergoing invigorated compliance activities, with New York leading the way. The problems identified included issues around prior authorization for services and utilization review, provider network design, formulary design (i.e. which medicines can be prescribed when), and coverage and reimbursement.⁵ While states have assessed fines for such violations, the jury is still out on whether compliance will improve. Moreover, there are wide variations in parity and inconsistent levels of enforcement from one state to the next. Differing levels of competition among insurers from one state to another and disparities in consumer-friendliness within state insurance divisions are among the factors shaping the inconsistent approaches.⁶

Nonquantitative Treatment Limitations

Non-numerical limits on the scope or duration of benefits for treatment, such as prior authorization requirements.

Prior Authorization

A health plan cost-control process by which physicians and other health care providers must obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage.

Utilization Review

A provider analysis of patient records to determine if complete and appropriate treatment and services occurred.

Utilization Management

A process of responding to the utilization review results and developing plans and procedures for improving the outcome of reviews.

Sources: American Medical Association, Behavioral Health & Medical Review Experts, Centers for Medicare & Medicaid Services



- **A lack of transparency and accountability:** In enforcement efforts, states have sought greater transparency from insurers in areas like utilization management policies and procedures and standards for setting reimbursement rates. States also have sought to have consumers benefit from the greater transparency.

State Solution to Transparency and Accountability

In Pennsylvania, an insurance company agreed to pay \$800,000 to fund a public outreach campaign to educate consumers about their benefits (see chart below). But health plans can be an impenetrable, jargon-heavy universe for many patients, and it remains to be seen how well transparency and accountability efforts will take hold across the insurance landscape.

- **Misalignment between law enforcement and behavioral health care:** States may need to focus on improving the outcome of encounters between individuals with mental health or substance use problems and law enforcement. The challenges have been the lack of alternatives to calling 911 to report a mental health or substance use crisis, 911 personnel not being adequately trained to deal with such crises, and a lack of training for law enforcement personnel called to the scene. As a result, some crises have resulted in tragic confrontations, commitments to psychiatric facilities that may not be in the individual's best interest, and incarcerations that may not be necessary.

Mentally ill victims accounted for **1 in 5** fatal police shootings in 2019.⁷

State Solutions to Misalignment of Law Enforcement and Behavioral Health Care

Mental Health America and other advocacy organizations have recommended improved training for law enforcement and other first responders and linking mobile crisis response teams to psychiatric urgent care centers. In July 2020, the Federal Communications Commission adopted rules to establish 988 as a new, nationwide phone number for individuals in crisis to connect with suicide prevention and mental health crisis counselors. The National Suicide Prevention Lifeline (1-800-273-TALK) is accessible now with the transition to 988 happening by July 16, 2022. It includes 170 local- and state-funded crisis centers nationwide. But sufficient local crisis center capacity to address expected increases in call volume could become a challenge for states. States like Alabama, Indiana, Nevada, Utah, Virginia, and Washington have led the way with capacity-focused 988 legislation, with other states poised to follow suit.

Sources: Mental Health America, Federal Communications Commission, Substance Abuse and Mental Health Services Administration

Existing State Legislation and Trends

In recent years, state legislative efforts have focused on requiring insurance companies to demonstrate compliance, insurance departments to report on compliance, coverage of more mental illnesses and substance use disorders, and greater transparency by insurance providers.

State	Bill/Statute Number	Summary	Significance
Arizona	Senate Bill 1523/Chapter 4 (2020)	Requires insurance companies to conduct and file an analysis with the state Department of Insurance demonstrating compliance with federal parity laws. The department will review the reports for potential violations and give insurers an opportunity to address those issues. The legislation creates a mental health parity advisory committee.	The legislation, known as Jake’s Law for an individual who died by suicide in 2016, also funds expanded access to behavioral health services in schools and established a suicide mortality review team. ⁸
California	Senate Bill 855/Chapter 151 (2020)	<p>Requires:</p> <ul style="list-style-type: none"> • Coverage of full range of mental illnesses and substance use disorders • Coverage of “medically necessary treatment” and “medical necessity” determinations be consistent with generally accepted standards of care • Health plans and insurers to use specified clinical criteria and guidelines for level of care determinations and prohibits the application of additional, different, or conflicting criteria. <p>Prohibits:</p> <ul style="list-style-type: none"> • Limiting benefits or coverage for mental health and substance use disorders to short term or acute treatment • Denying medically necessary services on the basis that they should be or could be covered by a public entitlement program. <p>Provides for:</p> <ul style="list-style-type: none"> • Administrative or civil penalties by the Department of Managed Health Care in the Department of Insurance 	The legislation addresses concerns identified in the 2019 federal court ruling: <i>Wit vs. United Behavioral Health</i> . Prior California law did not apply to all mental health conditions or to substance use disorders. Treatment was required for just nine serious mental illnesses. Prior law also was ambiguous about the definition of “medically necessary treatment” and level of care criteria. The 2020 legislation requires health plans and insurers to monitor clinical review criteria and utilization review decision making and to sponsor education programs for staff, contractors, providers, and beneficiaries. ⁹ The Kennedy Forum based a model state parity bill on the California legislation and named it for former Minnesota Congressman Jim Ramstad, one of the co-sponsors of the 2008 federal bill. ¹⁰ Since 2018, the District of Columbia and 17 states have passed the model legislation: Arizona, Colorado, Connecticut, Delaware, Illinois, Indiana, Kentucky, Maryland, Montana, New Jersey, Nevada, Oklahoma, Oregon, Pennsylvania, Tennessee, and West Virginia. ¹¹



State	Bill/Statute Number	Summary	Significance
Colorado	House Bill 19-1269 (2019)	Creates certain coverage requirements for insurers, including parity-compliant mental health and substance use disorder coverage for preventive services screening and minimum coverage requirements for preventive and screening services and treatment services. The law also requires the state insurance commissioner to submit an annual parity compliance report to the legislature and creates additional requirements for all Medicaid plans to be compliant with federal parity law.	The legislature decided not to support \$68 million annually to place the same requirements on the state's Medicaid program as on private insurers, which some fear could create a gap that may make it difficult for Medicaid patients to get optimal care. Individuals with dual-diagnoses or co-occurring conditions (e.g., a mental health condition like bipolar disorder and a physical ailment such as deafness) often are shuttled among health care providers who might specialize in one or the other. Coverage denials can complicate matters further. The new law requires private insurers to treat any mental health need that appears as part of a dual-diagnosis and which is included in any of three recognized diagnostic manuals. But for Medicaid, language about co-occurring conditions only applies to "covered treatments for covered behavioral health diagnoses." ¹²
Georgia	Senate Bill 80 (2021)	Requires insurers to disclose their criteria for prior authorization requirements in a timely fashion when making adverse decisions and publish aggregate statistics on their websites covering approval/denial rates, reasons for the denials, whether the denial was appealed, the outcome of appeals, and time between submission and response.	Some experts have argued for the need to eliminate prior authorizations for inpatient psychiatric care. ¹³

Existing State Legislation and Trends *(continued)*

State	Bill/Statute Number	Summary	Significance
Illinois	Senate Bill 1707 (2018)	<p>Requires:</p> <ul style="list-style-type: none"> • Health plans to submit parity compliance analyses to the departments of Insurance and Healthcare and Family Services for review and to share online with the public • The agencies to conduct market examinations/parity compliance audits and report their enforcement activities annually • The Illinois Auditor General to review implementation of the state parity law and report back to the General Assembly <p>Prohibits:</p> <ul style="list-style-type: none"> • All prior authorization and step-therapy requirements for treatment of substance use disorders • Exclusions of prescription coverage and related support services for substance use disorders on the grounds they are court ordered 	<p>A loophole in previous Illinois law allowed school district health plans to discriminate against mental health and addiction coverage because the plans were exempted from parity requirements.¹⁴ Upon its passage, Senate Bill 1707 was deemed the strongest mental health parity law in the country by The Kennedy Forum.¹⁵ A 50-state report card on parity statutes released the same year gave Illinois a score of 100. It was the only state to receive a grade higher than 79 as 32 states received a failing grade.¹⁶</p>
New York	Senate Bill 4356/Insurance Chapter 28, Article 3, Section 343 (2020)	<p>Requires: Insurers providing managed care products to submit a report every two years to the Superintendent of Insurance that demonstrates a plan's compliance with state and federal parity requirements using records of actual coverage over the two-year period. These records can include rates of prior and concurrent authorization requests, adverse determinations, and in-network paid claims of mental health and substance use disorder claims; cost-sharing requirements of mental health and substance use disorder benefits compared to that of medical/surgical benefits; and in-network participant information</p>	<p>Prior to passage of Senate Bill 4356, the New York Attorney General's Office received numerous complaints that fell into three categories:</p> <ul style="list-style-type: none"> • Plans were conducting frequent and stringent utilization review for behavioral health treatment, resulting in unwarranted medical necessity denials • Plans were excluding coverage of residential treatment for behavioral health conditions, while covering skilled nursing care • Plans charged consumers higher copayments for behavioral health treatment than for primary care medical visits.¹⁷
Pennsylvania	House Bill 1439/Act 89 and House Bill 1696/Act 92 (2020)	<p>Requires health insurers to assess each policy they offer and document how it complies with mental health and substance use parity requirements.</p>	<p>Prior to the passage of the House Bill 1439 and House Bill 1696, the state's Insurance Department revealed significant parity compliance concerns through health insurance market conduct examinations.¹⁸</p>

State	Bill/Statute Number	Summary	Significance
Texas	House Bill 2595 (2021)	Creates a parity complaint portal with basic tracking and reporting features to ensure an enrollee's complaint can be filed and followed up on and requires annual reporting of parity metrics.	House Bill 2595 also establishes October as Mental Health Awareness Month and requires the development and distribution of educational materials on the topic. ¹⁹
Washington	House Bill 1086/Chapter 202 (2021)	Creates a state Office of Behavioral Health Consumer Advocacy to promote patient and compliance with applicable federal and state law. The new agency, to be created by January 2022, will promote access to services, establish a statewide uniform reporting system, and set up a system to investigate complaints and inform patients about their rights. The agency also will train and certify consumer advocates.	Creation of the Office was a legislative priority for the Washington branch of the National Alliance on Mental Illness. ²⁰

Recent State Regulatory, Enforcement, and Compliance Efforts

Recent state regulatory, enforcement, and compliance efforts have focused on trying to correct insurance market practices around prior authorization for services and utilization review, provider network design, formulary design, and coverage and reimbursement. Compliance examinations have resulted in substantial fines in some cases as well as other resolutions.

State	Agency/ Agencies	Action	Significance
Connecticut	Insurance Department (2020/2021)	Issued \$575,000 in fines against four health plan subsidiaries as well as \$500,000 in payments to fund education programs.	A market conduct report found several problem areas involving non-quantitative treatment limitations and a lack of documentation demonstrating parity compliance, claims denial rates, pre-authorizations, applied utilization review management, and other metrics. ²¹
Delaware	Office of the Insurance Commissioner (2020)	Announced completion of the first round of mental health parity examinations involving major health insurers resulting in \$597,000 in parity violations. The violations included improper pre-authorization requirements for substance use disorders, unfair formulary tiers, inappropriate medication restrictions, and improper utilization management/claims processes.	Senate Bill 230, passed in 2018, required companies to submit an initial analysis of mental and behavioral health coverage in 2019. A high number of violations was expected since it was the Department of Insurance's first assessment. ²²

Recent State Regulatory, Enforcement, and Compliance Efforts *(continued)*

State	Agency/ Agencies	Action	Significance
Illinois	Department of Insurance (2020)	Announced fines totaling over \$2 million against five major insurance companies for violating the 2008 federal parity law.	The department pledged to launch parity examinations in 2018, ²³ when the state's widely praised parity legislation was passed.
Maine	Bureau of Insurance	Requires plans under its jurisdiction to complete a checklist of coverages they must provide or must offer to provide and indicate where these sections can be found in the plans.	One of the checklists concerns compliance with parity and autism sections of state insurance law. A Frequently Asked Questions section on the bureau's website contains information about mandated benefits. The bureau also has created a timeline listing the history of mandated benefits. ²⁴
Massachusetts	Office of the Attorney General (2020)	Reached settlements with five health insurance companies and two companies that manage behavioral health coverage for insurers that resulted in more than \$900,000 in fines.	The Attorney General's investigation focused on the need for the companies to improve their mental health and substance use disorder provider network and provider directories, the establishment of behavioral health care provider reimbursement rates, and the disclosure of utilization management policies and procedures. ²⁵
New Hampshire	Insurance Department (2020)	Market conduct exams started in 2017 found problems with the offering of and reimbursement for mental health and substance use disorder treatments at two of the state's insurers. The department found the health plans were reimbursing providers for mental health services at lower rates than they do for other medical treatments, but stopped short of accusing them of violating the Federal Parity Law.	No fines were assessed but the carriers received a warning and an obligation to develop documentation on their procedures and standards for setting reimbursement rates. ²⁶
New York	Departments of Financial Services and Health (2020)	Promulgated regulations authorized in the state budget (and Senate Bill 4356 above) requiring health insurers to develop and implement mental health and substance use disorder parity compliance programs by Dec. 29, 2020 and annually attest that such programs are in place. The regulations require insurers to designate an experienced individual, such as the parity compliance officer, to be responsible for assessing, monitoring, and managing parity compliance and to have written policies and procedures describing how their compliance is assessed, monitored, and managed. The regulations also identify specific practices defined to be improper under law. ²⁷	Part of a wave of states increasing the rigor with which they scrutinize non-quantitative treatment limitations for behavioral health conditions. ²⁸

State	Agency/ Agencies	Action	Significance
New York	State Office of the Attorney General (2018)	Assessed \$3 million in fines against seven health plans for violating federal and state parity requirements. ²⁹	Four of the eight settlements with the fined health plans required implementation of reforms in administration of behavioral health benefits, including medical management practices, coverage of residential treatment, co-pays for outpatient treatment, and regular submission of compliance reports. Two settlements focused on coverage of particular services. Two settlements addressed improper imposition of pre-authorization requirements for Medication-Assisted Treatment for patients with substance use disorders. ³⁰
Oregon	Department of Consumer and Business Services (2017)	Issued over \$550,000 in fines against four health plans for parity violations related to categorical denial of mental health treatments including Applied Behavior Analysis (ABA) therapy.	ABA therapy is used often for children with autism spectrum disorder or other developmental conditions. ³¹
Pennsylvania	Department of Insurance (2019)	Assessed a \$1 million fine against United Healthcare to cover restitution to consumers whose claims were wrongly denied and who overpaid out-of-pocket expenses as well as to cover interest on delayed claims. The company also agreed to pay \$800,000 to fund a public outreach campaign to educate consumers about their benefits. ³²	A market conduct examination report found extensive noncompliance with mental health parity and prompt pay laws, as well as concerns with the company's coverage for services relating to autism spectrum disorders and substance use disorders. The state's Insurance Commissioner expressed disappointment with the violations since they negatively affected some of the most vulnerable populations the company serves. ³³
Rhode Island	Office of the Health Insurance Commissioner	Completed a market conduct examination of Blue Cross/Blue Shield of Rhode Island in 2018 that resulted in the company agreeing to pay \$5 million to expand mental health services. The money, in lieu of a traditional fine, was directed into a fund at the RI Foundation, which is used for prevention of mental health problems and intervention.	The state's investigation found the insurer to be out of compliance with federal and state parity laws and that their method of approving coverage was "clinically inappropriate." Requirements for prior authorization of prescription drugs to treat mental health conditions led to, or caused a potential to, impede or delay care, according to the examination. The insurer reviewed in-patient care for mental health and substance use disorders more frequently than for physical health cases. Sometimes a less costly drug was used to treat certain mental health conditions when the more expensive drug would be clinically preferred. ³⁴

Future of Mental Health Insurance Parity Policy

Despite progress in recent years, more remains to be done in ensuring mental health parity and holding insurance providers accountable. In addition, some states are starting to think beyond parity to reshaping the delivery of behavioral health to better serve those who seek access to it.

- **Requirements for Insurers:** Five states (**Delaware, Illinois, New Jersey, New York, and Tennessee**) have passed legislation³⁵ that requires insurers to submit to regulators the type of parity analyses now required of them under the 2020 federal law. In most cases, these laws were passed with no opposition from the insurance industry.³⁶ Other states are expected to follow suit. The American Psychiatric Association has drafted model legislation for each state.³⁷
- **Medicaid Managed Care:** Since the 2020 federal law does not apply to Medicaid managed care, states may want to make sure Medicaid managed care organizations are completing compliance analyses alongside their private insurance counterparts.³⁸
- **Generally Accepted Standards of Care:** States are pursuing legislation related to generally accepted standards of care for mental health and substance use disorders. The standards are based in part on the findings in *Wit v. United Behavioral Health*, the 2019 class action lawsuit brought against the country's largest behavioral health insurer. The decision by a U.S. District Judge for the Northern District of California enunciated eight general standards of care, including:
 1. Effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms
 2. Effective treatment requires treatment of co-occurring mental health and substance use disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders when determining the appropriate level of care
 3. Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective
 4. When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care
 5. Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration
 6. The appropriate duration of treatment for mental health and substance use disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment
 7. The unique needs of children and adolescents must be taken into account when making decisions regarding the level of care involving their treatment for mental health or substance use disorders
 8. The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient³⁹

- A variety of other sources also offer generally accepted standards of care based on credible scientific evidence and the input of behavioral health experts.⁴⁰
- **Mental Health Redesign:** Some argue that parity enforcement must be just part of assessing coverage in the larger context of a redesign of the mental health care system. Government should ultimately seek to eliminate policies that artificially carve out or separate mental health and addiction benefits, delivery of services, or financing from overall health care, advocates say.⁴¹
- **Integration of Physical and Mental Health Care:** Ultimately the integration of physical and mental health care will need to occur across primary, hospital inpatient, emergency, and community mental health care. Innovative solutions to addressing the financing of health care will be needed in order to remove mental health, addiction services, and

primary care from existing silos. Hospitals may need to become more like centralized units of care, encompassing emergency departments, short-term psychiatric treatment facilities, and other components. But hospital emergency departments today are seldom equipped to handle mental health crises. Moreover, the integration of physical and mental health may cry out for connecting health care to other sectors of society and other stakeholders including the education system, employers, and the judicial system.⁴² A 2021 Bipartisan Policy Center report suggested the key to addressing the nation's mental health and addiction crisis lies in an integration with primary care, which could be achieved by transforming payment and delivery to advance value-based care; expanding and training an integrated workforce; and promoting technology and telehealth.⁴³





Conclusions

States should look to build on 60 years of work by continuing their efforts to enhance and enforce behavioral health parity while at the same time seeking to improve the accessibility, affordability, quality, and ubiquity of services available for all patients.

How This Study Was Conducted

The Council of State Governments (CSG) convened an advisory group of 19 members, including state legislators from six states, state executive branch health officials from eight other states, and five subject-matter experts. Mental health insurance parity was discussed at two virtual meetings — an introductory session March 4, 2021, and a deeper dive July 23, 2021.

Prior to the second meeting, the advisory group was presented with a summary compiled by CSG researchers bringing together academic research on mental health insurance parity along with scans of state policies and programs.

The authors drew upon the research summary, input from meeting participants, and additional research in writing this brief.

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