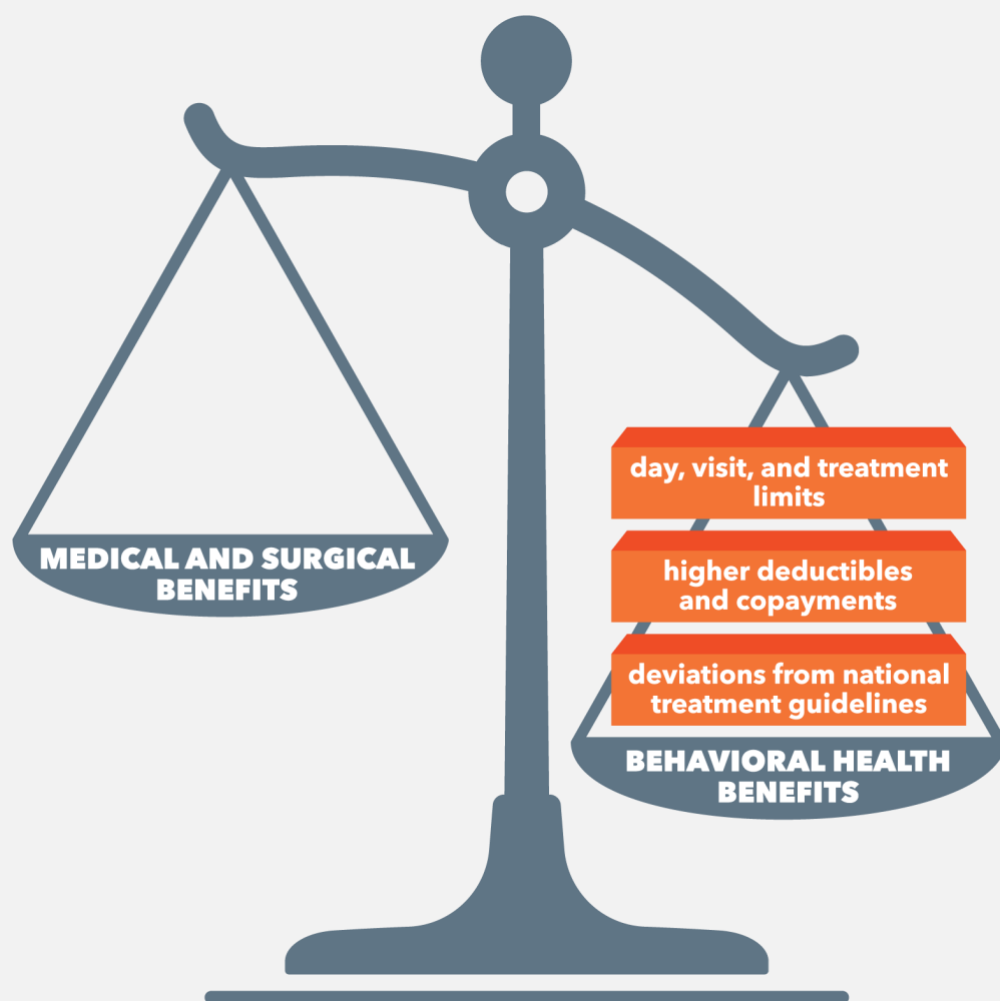


# A BEHAVIORAL HEALTH PARITY

## PLAYBOOK

**STRENGTHENING STATE LAWS AND PARTNERSHIPS**



**JANUARY 2023**

# A BEHAVIORAL HEALTH PARITY PLAYBOOK:

## STRENGTHENING STATE LAWS AND PARTNERSHIPS

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### RECOMMENDED CITATION

Stephenson, A.H., Hudock, W.J. (2022). *A Behavioral Health Parity Playbook: Strengthening State Laws and Partnerships*. Alexandria, VA: National Association of State Mental Health Program Directors.

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### ACKNOWLEDGEMENT

This report was authored by Arlene Hahn Stephenson, MAS, NHDP-BC, Senior Advisor, NASMHPD, and William J. Hudock, MA, with the assistance of Lisa Hadley, MD, JD, Sr. Medical Advisor.

This work was developed under the National Association of State Mental Health Program Director's contract/task order, HHSS2832017000241/75S20321F2001 and funded by the Substance Abuse and Mental Health Services Administration through the National Association of State Mental Health Program Directors.

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# PURPOSE AND USE

## PURPOSE

The Mental Health Parity and Addiction Equity Act sets a national floor for parity compliance. The Law provides detailed guidance and important protections that some state statutes have adopted and built upon to support and facilitate implementation of the law. Parity is widely defined as the process of creating equality or equivalency. A long-held goal of the behavioral health field has been to achieve equal health insurance coverage and managed care treatment as that which applies to medical and surgical (med/surg) health conditions. This Playbook briefly explains the laws and regulations that pertain to behavioral health parity, how enforcement of these laws and regulations takes place, and the roles that the state behavioral health agencies can play in achieving the goal of parity. This Playbook includes numerous references to government sources and other resources that can be used to obtain more information on specific topics.

## HOW TO USE THIS PLAYBOOK

The Playbook was developed to provide authoritative educational materials about parity and parity enforcement. It condenses and summarizes thousands of pages of material that have been published by federal and state agencies and provides examples of promising practices from states. Additionally, it references studies and articles on the topic. Unless otherwise noted, government sources have been used and referenced here to best ensure that information is based on available facts. Hyperlinks are used in this Playbook to direct the reader to additional information that may be helpful.

It is recommended that this Playbook be shared with appropriate staff in your agency. It also can be shared with others, as appropriate, to build a common understanding of how parity is defined and assessed, how compliance with its legal and regulatory requirements are determined, and most importantly how behavioral health leaders can work with other stakeholders to help achieve parity.

An “Abbreviation and Acronyms” list is in the [Appendix](#) of this Playbook.

## ADDITIONAL RESOURCES

Two addendums to this Playbook are also available: “Issue Brief: Behavioral Health Crisis Services Governed by the No Surprises Act and Federal Parity Law,” funded by the Mental Health Treatment and Research Institute of the Bowman Family Foundation, and “Crisis Care Parity Action Plan for State and Providers,” funded by the Sozosei Foundation.

# EXECUTIVE SUMMARY OF THIS PLAYBOOK

Attaining equality between behavioral health and med/surg benefits in insurance coverage and treatment is the goal of parity legislation, regulation, and enforcement. Insurance policies (employer provided, individual, or Medicaid) define:

- 1) benefits covered (services and goods financially reimbursed),
- 2) who is authorized to provide the service,
- 3) what determines the medical necessity to provide services,
- 4) the number and/or duration of services that will be reimbursed, and the specific treatment modalities that will be reimbursed (in some instances).

Insurance policies often include broad language and reference “managed care” processes, also referred to as “cost containment,” which are used to permit the insurer to provide oversight and to approve or deny reimbursement for specific treatments or use of specific providers. These “managed care” processes can ensure more effective and cost-effective treatment. However, they also can be used to deny needed treatment or to manage costs to the insurer at the expense of the beneficiary who may need treatment.

The tension between appropriately managing the costs of care and inappropriately managing cost applies both to med/surg and behavioral health care. Achieving parity will not eliminate this issue and it will not guarantee comprehensive care, but legislative and regulatory steps have been used to close this gap. The principal steps aimed at fostering more appropriate managing of benefits are federal and/or state insurance mandates that stipulate the services that require coverage. Additionally, there are laws and regulations that stipulate who is authorized to provide given services that have the potential to increase service capacity and choice for consumers. Lastly, laws and regulations that curtail the use of specific utilization and cost containment approaches by managed care companies may result in increased access to services. The health insurance benefits available to consumers reflect the combination of these approaches. Parity is just one important requirement.

The legal and regulatory underpinnings of health insurance policies are complex, which is one factor that makes achieving parity challenging. Some of these underpinnings are governed by federal law and others by state law. As such, different federal and state agencies have principal responsibility for enforcement. This web of laws, regulations, and enforcement mechanisms makes it difficult for insurers and managed care companies to administer their policies and programs. Federal agencies have been providing specific statutory, regulatory, and sub-regulatory guidance for the past decade. Much of that guidance is clear and consistent. The January 2022 U.S. Department of Labor (DOL) [Report to Congress](#) documented that all 58 health insurance issuers reviewed had failed to provide the required analyses for parity compliance outlined in these statutes and regulations.

An additional complexity in achieving the goal of parity is that it is difficult to compare the services provided to treat behavioral health conditions with the broad range of med/surg health treatments and conditions. Federal and state regulations and sub-regulatory guidance has helped to address this by providing specific examples of what does and does not constitute a parity violation. For some issues legislation has been proposed to provide the regulatory agencies with more power to fine and sanction managed care companies for violations. For now, it is often challenging, expensive, and time consuming for providers and consumers to know how to appeal or provide grievances or address potential violations of state and federal parity laws and regulations.

State Behavioral Health Agencies (SBHA) typically do not have lead responsibility in enforcement of parity laws and regulations. That responsibility is usually in the State Insurance Department, the State Medicaid Authority or the Attorney General. In many states the SBHAs serve a consultative or collaborative role in review of parity compliance and in its enforcement. This Playbook focuses on how to inform this consultative role as well as the role of the SBHA in supporting consumers, providers, advocates, and the insurers and managed care companies in achieving parity. It also addresses the consultative role that the SBHA can play with the State Medicaid Authority that contracts with managed care companies to provide benefits to state Medicaid beneficiaries.

# INTRODUCTION: WHAT IS PARITY AND WHY IS IT IMPORTANT?

Federal and state laws and regulations have been promulgated to achieve a simple result—that health insurance and managed care companies will structure and administer their policies so that coverage for behavioral health benefits is no more stringent or restrictive than those for med/surg benefits covered by the policy. The need for these laws and regulations reflects the historical fact that behavioral health benefits were administered separately using policy limitations, rules, and processes that often were more stringent and restrictive than those used for med/surg health insurance benefits. It should be noted that health insurance policies do not prohibit specific care from being delivered, but they do specify whether given services and/or providers will be reimbursed under the health insurance policy. Federal and/or state laws can mandate that specific coverage will be reimbursed and whether specifically trained, licensed, or certified practitioners are to be reimbursed. In the absence of laws that mandate coverage and limit restrictions, the parity laws are intended to ensure the no more restrictive or stringent rules. Two features of financing healthcare reimbursement are important to understand to gain insights into parity: health insurance policies and managed care. This section will explain both.

## HEALTH INSURANCE POLICIES

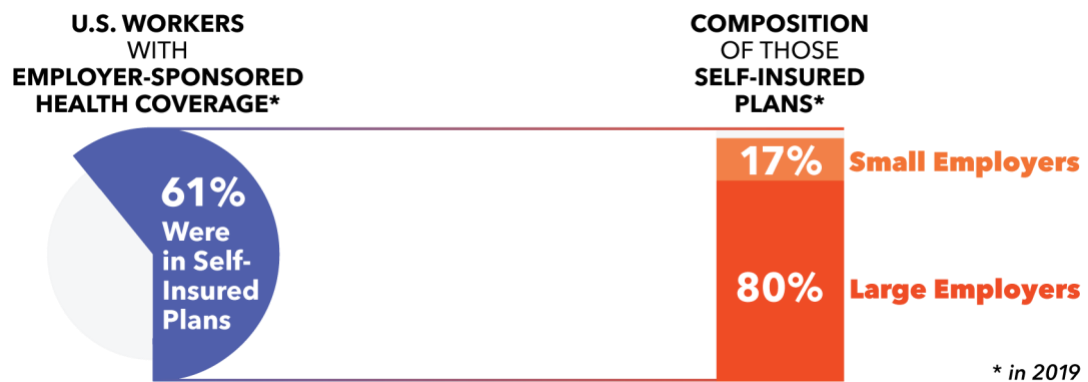
To comprehend parity laws and regulations it is important to first understand how health insurance policies are structured and how managed care processes are used to administer them. Following is a brief explanation:

Health insurance companies are licensed by the state in which they are doing business and are subject to the laws and regulations of that state. Insurance companies obtain separate licenses for each state in which they do business. State laws and regulations can stipulate minimum policy coverage, the provider qualifications of health services coverable under policies, and the consumer protections afforded under the policy. Insurance policies offered under these licenses can be purchased by individuals or employers. Policies written through these licenses are referred to as “fully insured.”

In 1974, a federal law, the Employee Retirement Income Security Act (ERISA), addressed both pension benefits and health insurance benefits offered by multi-state employer groups, and those employers who choose to “self-insure” their employee health insurance benefits rather than purchase them through a state licensed insurance company. Under ERISA, companies must adhere to minimum standards for health and other benefit plans established by private employers for their employees who receive health insurance benefit through the place of employment. These plans also are therefore subject to certain federal health insurance laws and regulations unless otherwise stipulated by federal law. This effectively means that state mandated benefits or other restrictions on insurance companies do not always apply. Most large and multi-state employers choose to



self-insure, although the vast majority still use insurance companies and managed care companies (generally referred to as “third-party administrators”) to administer their health benefit plans. In 2019, 61 percent of U.S. workers with employer-sponsored health coverage were in self-insured plans, with 17 percent working for small employers and 80 percent for large employers.<sup>1</sup>



Government-run health insurance programs such as Medicare, Medicaid, and Tricare (which covers members of the military, their dependents, and some retirees) are covered under separate laws. In some states government entities that purchase health insurance for their employees or for individuals who receive publicly paid health benefits outside of Medicaid may be covered by different laws and regulations. Some faith-based healthcare cost reimbursement programs also are covered by separate laws. This patchwork of licensing, laws, and regulations impacts how parity is defined, how it is regulated, and how it is enforced.

## MANAGED CARE

The second element required to understand parity laws and regulations is managed care. Following is a brief explanation:

Managed care is a group of processes and restrictions that are used by an insurance company (sometimes administered through a separate managed care company) to cover services while controlling and managing costs. To do this, managed care may:

- limit the selection of eligible providers covered under the policy,
- stipulate the range of treatments that will be reimbursed,
- require prior authorization for specific treatment,
- review and approve treatment plans,
- authorize continued care, and
- specify post-discharge planning and appropriate follow-up care.

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<sup>1</sup> Sachdev, G., White, C., & Bai, G. (2019, October 7). Self-Insured Employers Are Using Price Transparency to Improve Contracting with Health Care Providers: The Indiana Experience. *Health Affairs Blog*. <https://www.healthaffairs.org/doi/10.1377/forefront.20191003.778513/full/>

The goal of managed care is to influence the quality and cost of care in ways that benefit the consumer and the payer. These “managed care” processes can ensure more effective and cost-effective treatment. However, without checks and balances they also can be used to deny needed treatment or to manage cost to the insurer at the expense of needed treatment. The tension between appropriately managing care and inappropriately managing cost applies both to med/surg and behavioral health care. Federal and state governments address the risk of denial of needed and appropriate care through a variety of approaches. The principal approach is federal and/or state insurance mandates that stipulate coverage that must be provided. There are also laws and regulations that stipulate who is authorized to provide given services that have the potential to increase service capacity and choice for consumers. Laws and regulations that limit the use of specific utilization and cost containment approaches have the potential to increase access to services. These approaches combine with parity laws/regulations to help tip the balance to maximize access to quality care.

# FEDERAL LAWS SUPPORTING PARITY

Mental health insurance parity has its roots in the 1961 requirement of President John F. Kennedy that the Federal Employees Health Benefits Program cover psychiatric illnesses at the same level as general medical care.<sup>2</sup> This was followed by more sweeping federal reforms, including the following laws.

## THE MENTAL HEALTH PARITY ACT OF 1996

The Mental Health Parity Act of 1996 (MHPA), spearheaded by Senators Paul Wellstone (D-MN) and Pete Domenici (R-NM), provided that large group health plans cannot impose annual lifetime dollar limits on mental health benefits that are lesser than any limits imposed on medical/surgical benefits.<sup>3</sup> The law was a major advance, but it did not cover issues such as treatment limits, cost sharing or managed care protocols, or types of facilities covered.

## PARITY FOR FEDERAL EMPLOYEES

In 1999, President Clinton directed the Office of Personnel Management to implement comprehensive mental health and substance use disorder (MH/SUD) parity in the Federal Employee Health Benefit Plan beginning in 2001 affecting 8.5 million insured lives.<sup>4</sup> The directive covered all diagnoses listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and all aspects of in-network MH/SUD benefits.

## THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) OF 2008

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), sponsored by Patrick J. Kennedy (D-RI), was aimed in part at addressing the gaps in the MHPA of 1996, and expanding parity laws even further. It amended ERISA, the Public Health Service

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<sup>2</sup> Barry, C.L., Huskamp, H.A., & Goldman, H.H., (2010, September). A Political History of Federal Mental Health and Addiction Insurance Parity. *Milbank Quarterly*, 88(3), 404–433.  
<https://doi.org/10.1111/j.1468-0009.2010.00605.x>

<sup>3</sup> The Mental Health Parity and Addiction Equity Act (MHPAEA). (n.d.). U.S. Department of Health and Human Services. Centers for Medicare and Medicaid Services, Consumer Information Insurance Oversight Office.  
<https://go.cms.gov/3RIFxxw>

<sup>4</sup> The State of Mental Health in America (2022), *Issue Brief: Parity*. MHA National.  
<https://www.mhanational.org/issues/issue-brief-parity>

Act (PHSA), and the Internal Revenue Code to require a group health plan that covers **over 50 employees and that provides both medical/surgical benefits and MH/SUD benefits** to ensure that:

- 1) The financial requirements (FRs), such as deductibles and copayments, applicable to MH/SUD benefits are no more restrictive than the predominant FRs applied to substantially all med/surg benefits covered by the plan;
- 2) There are no separate cost sharing requirements; and
- 3) There are no separate treatment limitations that are applicable only to MH/SUD benefits.

Collectively, the law refers to these treatment limitations and cost differentials as **Quantitative Treatment Limitations (QTLs) and Non-Quantitative Treatment Limitations (NQTLs)**. The law mandates **transparency and coverage parity** by requiring that the criteria for medical necessity

determinations and the reason for any denial of reimbursement or payment for services for MH/SUD benefits to be made available by the plan administrator. It also requires the plan to provide out-of-network coverage benefits for MH/SUD if the plan provides out-of-network coverage for med/surg benefits.

Additionally, MHPAEA prohibits unequal limits on the scope or duration of benefits for treatment when they are not expressed numerically. These types of restrictions are referred to as **Non-quantitative Treatment Limitations (NQTLs)**. Scope refers to types of treatment and treatment settings. Examples of NQTLs are prior authorization requirements, provider network admission standards, reimbursement rates, network adequacy, facility type and geographic restrictions, exclusions, and many more. Collectively, these are the utilization controls or managed care approaches that insurers and managed care companies use to control utilization, provider networks, and cost of care. MHPAEA requires that they be designed and implemented comparably and no more stringently for MH/SUD than they are for med/surg care.

A survey conducted before the MHPAEA law was enacted found that 74 percent of workers in employer-sponsored health plans with mental health benefits were subject to an annual outpatient visit limit, 64 percent were subject to an inpatient day limit, and 22 percent had higher cost sharing for mental health benefits than for general medical benefits.<sup>5</sup>

## Quantitative Treatment Limitations (QTLs)

are treatment limitations and cost sharing differentials

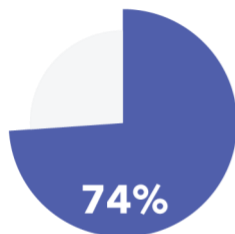
## Non-Quantitative Treatment Limitations (NQTLs)

are unequal limits on the scope or duration of benefits that are not expressed numerically

<sup>5</sup> Barry, C.L., Gabel, J.R., Frank, R.G., Hakins, S., Whitmore, H.H., & Pickreign, J.D. (2003). Design of Mental Health Insurance Coverage: Still Unequal after All These Years. *Health Affairs*, 22(5),127-37. <https://doi.org/10.1377/hlthaff.22.5.127>

The parity law seeks to eliminate these disparities as well as improve access to medically necessary MH/SUD care.

#### WORKERS IN EMPLOYER-SPONSORED HEALTH PLANS WITH MENTAL HEALTH BENEFITS\*



HAD AN  
OUTPATIENT  
VISIT ANNUAL LIMIT



HAD AN  
INPATIENT  
DAY LIMIT



HAD HIGHER COST SHARING  
FOR MENTAL HEALTH  
BENEFITS THAN FOR  
GENERAL MEDICAL BENEFITS

\* before the MHPAEA law was enacted

## THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

In 2010, Congress passed the Patient Protection and Affordable Care Act of 2010 ("PPACA," P.L. 111-148), also known as the Affordable Care Act (ACA). This law contains provisions that prohibit coverage exclusions for preexisting health conditions and for individuals with some high-risk conditions. It also expands the reach of federal mental health parity requirements to four main types of health plans:

- 1) Qualified Health Plans (QHPs), as established by the ACA, for fully insured small employer plans (up to 50 employees)
- 2) Medicaid managed care benchmark and benchmark-equivalent plans
- 3) Children's Health Insurance Plans (CHIP)
- 4) Plans offered through the individual market

The law grandfathered self-insured plans that were first established prior to March 23, 2010 and that had no significant changes in covered benefits, cost sharing or premium contributions. The federal parity requirements do not apply to these grandfathered plans. Today, however, most self-insured employer plans are governed and regulated by the Federal Parity law.

## STRENGTHENING BEHAVIORAL HEALTH PARITY ACT OF 2020

The Strengthening Behavioral Health Parity Act of 2020 (SBHPA) requires health insurance plans to demonstrate to the U.S. Department of Labor (DOL) or a state insurance commissioner how they are using appropriate standards of care when determining medical necessity and not violating MHPAEA requirements (including self-insured, employer-sponsored ERISA plans) that are not MHPAEA compliant. It also requires the Secretary of the DOL to send an annual report to Congress identifying any plans that are out of compliance. Prior to the passage of the SBHPA, third-party administrators used the ERISA law of 1974 to bypass state and federal mental health parity protections. ERISA contained a very broad preemption clause that prevented states from regulating these plans, and in 2016, the U.S. Supreme Court took it another step by allowing ERISA to be used by employer-sponsored health plans to avoid states' health care data transparency efforts.

## CONSOLIDATED APPROPRIATIONS ACT OF 2021

The Consolidated Appropriations Act of 2021 (CAA) requires applicable health plans to conduct a detailed comparative analysis of how their plans meet the NQTL requirements and plan limits. The DOL is reviewing these analyses as a standard item in their enforcement plan audits.<sup>6</sup> Within the CAA is the **No Surprises Act** that protects consumers from certain surprise medical bills in three circumstances:

- Emergency care either at an out-of-network facility or from an out-of-network provider
- Air ambulance emergency transport services (but not ground ambulance services)
- Non-emergency care at an in-network facility when treatment was provided by an out-of-network provider without knowingly electing that provider or consenting to be billed.

The Act filled gaps in state laws such as protections for post-stabilization services. Federal protections will take precedence over existing state surprise-billing laws unless state laws are more protective.

The numerous laws described in this section are aggregated in the following chart to clarify information on who is and is not required to comply with parity laws.

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<sup>6</sup> Health Care Reporting. (2021, August). Mental Health Parity & Addiction Equity and Employer Compliance, NQTL Analysis Service. <https://nqtlanalysis.com/comparative-analysis-mhpaea-compliance-8-18-2021>

## HEALTH INSURANCE PLANS OFFERING MH/SUD BENEFITS

ARE REQUIRED TO COMPLY WITH PARITY*	ARE NOT REQUIRED TO COMPLY WITH PARITY*
<ul style="list-style-type: none"> <li>Fully insured and self-insured large employer group plans with 51 or more employees (<i>unless grandfathered</i>)</li> <li>Individual and small employer group plans offered through state health exchanges</li> <li>Medicaid managed care organization or alternative benefit plans</li> <li>Medicaid CHIP plans</li> <li>Certain state and local government plans that have not opted out of federal parity laws**</li> <li>Church-sponsored plans**</li> </ul>	<ul style="list-style-type: none"> <li>Medicare plans</li> <li>Fee-for-service Medicaid (<i>not managed care</i>)</li> <li>Small employer plans (<i>≤50 employees, created before March 23, 2010, and without significant changes since, hence grandfathered</i>)</li> <li>Large employer groups that have not changed benefits since 2010 and with grandfathered non-compliant benefit plans</li> <li>Tricare plans (though TRICARE has made improvements to MH/SUD coverage)</li> <li>Retiree-only plans</li> <li>Federal Employee Health Benefits (though some have adopted parity voluntarily)</li> <li>Plans that have successfully requested an exemption from the federal parity law (i.e., where parity has caused costs to increase by a certain amount, and self-insured state and local governments)</li> </ul>

\* The State of NY laws may be different

\*\* Church and state and local government plans that are self-insured may opt-out

# STATE LAWS SUPPORTING PARITY

Regulating insurance is primarily a state responsibility and therefore results in considerable differences in health insurance regulation across states. This system of regulation began with the McCarran-Ferguson Act of 1945, which describes state regulation and taxation of the industry as being in “the public interest,” and is clear that it has preeminence over federal law,<sup>7</sup> unless in certain circumstances, such as litigation, an insurer moves to have the issue heard in federal court under ERISA. Each state still creates its own set of statutes and regulations and requires state-licensed insurance carriers to offer coverage for specified health care services, known as “benefit mandates.” The numbers of mandates vary greatly across the states.

In 1991, Texas and North Carolina became the first states to enact mental health parity legislation. However, the scope of the laws was limited and applied only to insurers covering state and local government employees. By 1996, when federal parity legislation was enacted, a total of seven states had passed laws that required certain specified state-regulated health plans to provide full-parity mental health coverage.<sup>8</sup> Because the federal MHPA of 1996 required mental health parity only for annual and lifetime dollar limits, states filled equity holes by passing bills that mandate coverage

of certain conditions, eligible populations, a specified number of inpatient days and outpatient visits, and annual dollar amounts. Some states have been reluctant to require mandated benefits, fearing increased insurance premiums and additional costs to employers. Commissions have been created by some states to study the cost-benefit of mandates prior to legislating them. For example, Maryland formed an Interdepartmental Committee on Mandated Health Insurance Benefits (1990–1993) to review and inform on the cost-benefit of proposed mandated benefits.

A decade after MHPAEA became effective, 37 states had parity laws of widely varying scope and efficacy in addressing discriminatory coverage practices. It is important to note that most of these early laws excluded parity for substance use disorders. Now, all states have state laws and regulations pertaining to some aspect of parity, however, each is different in terms of what is covered.

**All states have state laws and regulations pertaining to parity, however, each is different in terms of what is covered, and full parity is still not available across all states.**

<sup>7</sup> Webel, B. (2016, December 30). *Insurance Regulation: Background, Overview, and Legislation in the 114th Congress* (CRS Report No. R44046). Congressional Research Service. <https://www.everycrsreport.com/reports/R44046.html>

<sup>8</sup> Sundararaman, R., & Redhead, C.S. (2008, June 19). *Mental Health Parity: Federal and State Action and Economic Impact* (CRS Report No. RL31657). [EveryCSCRRReport.com](https://www.everycrsreport.com/reports/RL31657.html). <https://www.everycrsreport.com/reports/RL31657.html>



Between 2018 and 2021, the District of Columbia (DC) and 16 states passed legislation requiring insurers to demonstrate compliance annually—Arizona, Colorado, Connecticut, Delaware, Illinois, Indiana, Kentucky, Maryland, Montana, New Jersey, Nevada, Oklahoma, Oregon, Pennsylvania, Tennessee, and West Virginia.<sup>9</sup> Medicaid managed care organizations (MCO) were included in the legislation approved in six states and Washington, DC.

## A LOOK AT FOUR STATES ILLUSTRATES DIFFERENCES IN PARITY APPROACHES AND IMPLEMENTATION

### 1. MARYLAND

Maryland's mental health parity law of 2010 prohibits discrimination against an individual with a "mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder" by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply for the diagnosis and treatment of physical illnesses. Maryland developed regulations adopting concrete criteria for requiring network adequacy using quantitative standards (e.g., distance, travel time to provider, number of days it takes to schedule an appointment). Maryland has a long history of mandating behavioral health benefits and parity related laws. This has included advancing requirements for MH/SUD benefits such as:

**2005**—Coverage of medically necessary residential crisis services

**2011**—Insurers to disclose more information about appeals, grievances, and independent review organization (IRO) processes including a process for advice when a medical necessity complaint is filed, and parity benefits for some small employer health plans

**2013**—Insurers to make notice of coverage required by MHPAEA and state law; complaints processes; and a mandated benefit for transitioning between carriers related to out-of-network coverage

**2015**—State benchmark plans with essential benefits to comply with MHPAEA/related laws

**2017**—Coverage for one opioid overdose reversal medication without pre-authorization and a comprehensive list of MH/SUD services including telehealth; and prohibits denying behavioral health care service provided at a public school or through a school-based health center

**2019**—Requirement for short-term limited duration insurance to include MH/SUD

The Maryland Insurance Administration (MIA) is the lead for parity-related policy. Their Insurance Commissioner reported during a Mental Health Parity Regulations Hearing in November 2020 that their investigations have demonstrated that carriers' compliance reporting is needed to more effectively root out system-wide practices that limit access to MH/SUD care.

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<sup>9</sup> Kirby, J. & Slone, S. (2021, September). *Mental Health Insurance Parity: State Legislative and Enforcement Activities*. The Council of State Governments.  
[https://www.csg.org/wp-content/uploads/sites/7/2021/09/Mental\\_Health\\_Parity.pdf](https://www.csg.org/wp-content/uploads/sites/7/2021/09/Mental_Health_Parity.pdf).

In 2021, MIA issued detailed regulations governing carrier parity reporting requirements, consistent with MHPAEA.

In a letter to the State Legislature each year, MIA reports on compliance with MHPAEA and related MH/SUD parity laws. The first two surveys examined carriers' internal processes and policies for MHPAEA compliance and how the processes and policies are developed. The focus of the third survey is to evaluate whether carriers apply those processes and policies consistently and uniformly. In October 2021, Maryland submitted the annual Medicaid and CHIP MHPAEA report on compliance for the CHIP to CMS.

In addition to the regulatory aspect of parity, the Insurance Commissioner's Office sponsors initiatives in collaboration with advocacy groups to heighten the public's awareness of the role they play in regulating parity. Materials are available to provide consumers with assistance on their benefits and healthcare rights, and access to healthcare, particularly MH/SUD services.

The Commissioner's Office has collaborated with the University of Maryland School of Law to develop a resources guide related to MH/SUD that is available to consumers and providers as well as a Mental Health Parity and Addiction Equity Act Resource Guide for consumers. Maryland also established a program to use law students to help consumers to pursue denials of parity claims. An example of the success of this effort was that as a result of a coordinated communication effort led by law students and joined by multiple stakeholders (MIA, advocates, consumers, etc.), a managed care company changed its policy and now covers all methadone maintenance treatment, as an in-network service, regardless of whether it is provided in- or out-of-network. This achieved a voluntary resolution of the issue by the managed care company themselves.<sup>10</sup>

**The State of Washington's parity law designates behavioral health emergency services providers, including facilities and mobile crisis teams, as "emergency service providers," making them equivalent for the purpose of parity to ambulances, emergency departments, and urgent care centers.**

## 2. WASHINGTON

The original State of Washington Parity Law provided that persons eligible for medical care service benefits are eligible for mental health services to the extent that they meet the client definitions and priorities established by chapter 71.24 RCW. The new State of Washington Balance Billing Protection Act protects consumers from charges for out-of-network health care services by addressing coverage of emergency services and aligning the Act and the Federal No Surprises Act. Sections 2 and 3 of this legislation amend current law, including provisions related to

<sup>10</sup> Substance Abuse and Mental Health Services Administration. (2016). *Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States*. <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4983.pdf>

coverage of emergency services, to clarify the role of behavioral health crisis services providers in meeting the needs of individuals enrolled in fully insured individual and group health plans when they experience a behavioral health emergency. This provision has received considerable attention nationwide. In 2020, Washington State issued a behavioral health market scan for auditing MHPAEA NQTL compliance by carriers in its state.

The following explanation was provided by Washington State Insurance Commissioner Mike Kreidler, to the Alabama Insurance Commissioner, Jim L. Ridling, in a letter dated June 21, 2022:

“Washington state law defines an emergency medical condition to encompass ‘a medical, MH/SUD condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress...’ according to a prudent layperson standard, which is consistent with CMS’s interpretation of the Emergency Medical Treatment and Labor Act (EMTALA) statute. The new law designates ‘behavioral health emergency services providers’ as providers of emergency services. Under the act, ‘behavioral health emergency services providers’ include facilities licensed to provide behavioral health crisis services, such as evaluation and treatment facilities, crisis triage facilities, medical withdrawal management services facilities, and mobile rapid response crisis team services. These behavioral health emergency services providers are equivalent to the full range of emergency and crisis services for med/surg conditions including hospital emergency rooms, ambulance (mobile outreach), and urgent care centers.

“This clarification in the Washington State law regarding emergency behavioral health services providers brings Washington state law into alignment with provisions of the federal MHPAEA and the federal No Surprises Act. Ultimately, a federal solution to this issue would be best so that enrollees in self-funded group health plans could have the same access to behavioral health crisis services as enrollees in fully insured health plans issued in Washington state. My office has made this request to members of Washington state’s Congressional delegation, as well as the DOL and CMS/Center for Consumer Information and Insurance Oversight (CCIIO).”<sup>11</sup>

Washington laws require individual, small employer fully-insured, large employer fully-insured, and public employee plans to cover all mental health services and substance use disorders in the DSM that are part of an “approved treatment plan,” with the exception of V codes. Approved treatment plan is defined as a “discrete program of chemical dependency treatment provided by a treatment program certified by the department of social and health services.” Plans are exempted from covering residential treatment and the law forbids plans from requiring prior authorization for inpatient care if the patient is involuntarily committed.

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<sup>11</sup> Kreidler, M., (2022, June 21). [Letter from Washington State Insurance Commissioner to the Alabama Insurance Commissioner Jim L. Ridling]. <https://www.insurance.wa.gov/sites/default/files/documents/commissioner-kreidler-letter-to-insurance-regulators-behavioral-health-protections.pdf>

Additional laws enacted include:

**2011**—Individuals eligible for medical care services benefits are eligible for mental health services if they meet the client definitions and priorities

**2011**—Medicaid plan coverage of universal autism screening for children in accordance with the Bright Futures guidelines

**2011**—A requirement for health plans/insurers to file a joint justification analysis for FRs and QTLs

**2016**—A telemedicine payment parity and training requirement: creation of a state Office of Behavioral Health Consumer Advocacy for parity compliance; and a uniform reporting/complaint investigation system to inform and train patients and certify and certify consumer advocates

### 3. LOUISIANA

In 2013 the Louisiana Department of Insurance (LDI) issued a [bulletin](#) about the Department's authority to enforce the [Federal Parity Law](#) and the ACA. It informed plans that LDI would be monitoring all relevant plans for compliance, that non-compliant plans would be asked to comply, and continued non-compliance would result in an LDI referral to CMS for further disciplinary action. Any pattern of violations would result in a discussion between LDI and CMS regarding performing market conduct examinations<sup>12</sup>. An assessment of compliance would take place whenever LDI performs a market conduct examination. The [2022 MHPAEA Report to Congress](#) explains the bifurcated regulatory approach indicating that Louisiana is one of six states (Alabama, Florida, Louisiana, Montana, and Wisconsin) that have entered collaborative MHPAEA enforcement agreements with CMS. These states perform state regulatory and oversight functions with respect to MHPAEA; however, if the state finds a potential violation and is unable to obtain compliance by an issuer, the state will refer the matter to CMS for possible enforcement action. In FY2020, CMS was responsible for enforcement of MHPAEA with regard to issuers in Missouri, Oklahoma, Texas, and Wyoming.

A [2020 bulletin](#) regarding parity reporting requirements was sent by LDI to inform all health insurance carriers and MCOs that beginning January 31, 2021, issuers would be required annually to report:

- a) a description of the process used to develop and select medical necessity criteria for MH/SUD as compared to med/surg benefits,
- b) identification of NQTLs that are applied to MH/SUD and med/surg benefits, and
- c) the results of the analyses including findings and conclusions.

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<sup>12</sup> Parity Track (2017, December). Louisiana Regulations: Parity Report. The Kennedy Forum. <https://www.paritytrack.org/reports/louisiana/regulations/>

Other mandated benefits and parity related laws include:

**2008**—Meaningful coverage for autism under state regulated plans

**2013**—Applications for temporary exemption from the ACA still require compliance with the Federal Parity Law (small employer fully-insured plans excluded)

**2016**—Minimum Essential Health Benefit plans must be in accordance with MHPAEA and provide the new adult group with a benchmark benefit or equivalent that includes the EHBs provided in insurance exchanges, including MD/SUDs, behavioral health treatment

#### 4. INDIANA

Indiana parity laws require that plans cannot use treatment limitations and Financial Requirements (FRs) if similar treatment limitations and FRs are not used for other medical coverage. These sections of the law apply to large employer fully-insured plans, individual plans, and State employee plans. Those that provide MH/SUD coverage are required to submit an annual report and analysis that includes:

- A description of the processes used to develop or select medical necessity criteria for coverage of MH/SUD and med/surg services and the results of a comparative analysis demonstrating parity compliance with medical necessity criteria requirements.
- Identification of all NQTLs applied to MH/SUD and med/surg benefits and the results of a comparative analysis demonstrating parity compliance with NQTL requirements (2020).

In addition, the Department of Insurance was required to submit a one-time report (by March 1, 2021) to the General Assembly concerning rules and procedures to ensure parity compliance. This includes the Department's methodology for determining compliance, the results of targeted market conduct examinations (12 months), and any educational or corrective action the Department has taken to ensure the insurers' compliance with parity.<sup>13</sup>

Other mandated benefits and parity related laws include:

**2009**—A requirement for the CHIP program to cover behavioral health, inpatient care, residential treatment, and community mental health rehabilitation services, and outpatient care

**2015**—Reimbursement for mental health drugs

**2016**—A requirement for Medicaid MCOs to report compliance with the coverage; the Healthy Indiana Plan (HIP) to cover MH/SUDs without treatment limitations or FRs if there are no similar limitations or requirements for med/surg conditions; "suboxone" reimbursement eligibility in an opioid treatment program; and Medicaid reimbursement for

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<sup>13</sup> Weber, E. (2020, December). Legal Action Center. Spotlight on Mental Health and Substance Use Disorder Parity Compliance Standards: An Analysis of State Compliance Reporting Requirements. <https://www.lac.org/resource/spotlight-on-mental-health-and-substance-use-disorder-parity-compliance-standards>

services provided by advanced practice nurses employed by a community mental health center

**2020**—Key aspects of the MHPAEA including a Medicaid reimbursement for outpatient MH/SUD treatment services; HMOs and insurer annual reports demonstrating compliance with MHPAEA including an analysis for each NQTL in each classification of care consistent with the six-step process; Medicaid coverage of clinical social workers, mental health counselors, clinical addiction counselors and marriage and family therapists who are licensed; annual reports by insurers to the Department of Insurance and by the Department of Insurance to the general assembly concerning its implementation of rules and procedures to ensure parity compliance

In 2016 the Indiana Department of Insurance received an Indiana Health Insurance Enforcement and Consumer Protections Grant Award for:

- coordinating meetings with other state agencies and special interest groups to identify barriers to coverage for MH/SUDs;
- collaborating to create solutions for such barriers, identifying future issues and find proactive measures to prevent future issues;
- developing and implementing checklists to use for policy form language reviews in order to review for parity in MH/SUD and med/surg benefits with a focus on QTLs, NQTLs, amounts for deductibles, copays and coinsurance, requirements for prior authorization, and step therapy; and
- upgrading its current MHPAEA template to an automated process to facilitate a more uniform and comprehensive review of forms.<sup>14</sup>

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<sup>14</sup> Indiana Health Insurance Enforcement and Consumer Protections Grant Award. (2015, June). Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/in-cpg>

# THE INTERSECTION OF FEDERAL AND STATE PARITY LAWS

MHPAEA specifically states that it does not preempt state parity laws that include stricter requirements. As such, the federal law and regulations create a national floor of benefit protection

but not a ceiling. States are free to enact and enforce stricter requirements. As illustrated in the previous section, some states have chosen to mandate specific benefits, in excess of parity laws, to address perceived inadequacies of specific treatment availability. An example of this is Applied Behavior Analysis (ABA) for people with autism. To date, 13 states have enacted specific minimum coverage requirements for this specific therapy, irrespective of whether similar limits apply to med/surg benefits.

**Federal parity laws create a national floor of benefit protection but not a ceiling.**

**States are free to enact and enforce stricter requirements.**

# STATE MEDICAID PLANS AND PARITY

State Medicaid Plans are not totally exempt from federal parity laws. Three statutes apply parity rules to Medicaid:

- The 1997 **Balanced Budget Act** applies federal parity rules to Medicaid MCOs and plan services provided on a fee-for-service (FFS) basis to MCO enrollees.
- In 2009, section 502 of the **Children's Health Insurance Reauthorization Act (CHIPRA)** was amended to apply MHPAEA parity requirements to all CHIP plans that provide both med/surg and MH/SUD benefits.
- The 2010 **Affordable Care Act (ACA)** applies the FRs, QTLs, and NQTLs of federal parity law to Medicaid Alternative Benefit Plans (ABPs). This includes ABPs services provided by Prepaid Inpatient Health Plans (PIHPs) and by Prepaid Ambulatory Health Plans (PAHPs) to MCO enrollees.<sup>15</sup>

The Center for Medicaid and State Operations sent a State Health Official letter on November 4, 2009 to guide states on the implementation of:

- 1) MH/SUD parity requirements on all CHIP Programs;
- 2) parity requirements for State Medicaid programs under title XIX of the Act;<sup>16</sup> and
- 3) MHPAEA requirements only applying to Medicaid contracts with MCOs or PIHPs.

An additional statement regarding this was made on April 7, 2015, in a rule in the Federal Register.

These Medicaid plans were also required to comply with the parity evaluation requirements by October 2017. These apply to FRs, QTLs, and Aggregate Lifetime and Annual Dollar Limits. States that have posted their compliance plan reports online include California, Colorado, Iowa, New Hampshire, and Tennessee.

The November 4, 2009 CMS letter provides an exemption for states from being found in violation if the state requires legislative action in order to be in compliance with the requirements, a legislative session has yet to take place, and the Department of Health and Human Services (DHHS) Secretary has been notified and concurs that legislation is needed.

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<sup>15</sup> Musumeci, M. (2015, June). Behavioral Health Parity and Medicaid. Kaiser Family Foundation Issue Brief. <https://www.kff.org/report-section/behavioral-health-parity-and-medicaid-issue-brief/>

<sup>16</sup> Mann, C. (2009, November 4). [Provide guidance on implementation of section 502 of Children's Health Insurance Program Reauthorization Act of 2009 to State Health Officials]. <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf>



In 2016 the CMS clarified for Medicaid and CHIP (final rule effective 2017) that states' managed care plans are required to analyze limits on MH/SUD treatment benefits in accordance with the ACA requirements. The requirement applies to all behavioral health benefits for beneficiaries enrolled in an MCO. These benefits are subject to a parity analysis in five areas—aggregate lifetime limits, FRs, QTLs, NQTLs, and availability of information. The parity analysis may be conducted by the state

or the MCO, and CMS will review the provisions in the MCO contract. A full analysis is not required for certain ABPs and CHIP plans. CMS has developed a tool to guide Medicaid programs, Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.

**Medicaid and  
CHIP parity  
analyses may be  
conducted  
by the state or the MCO.**

CMS has noted that states did not use CMS-provided templates for parity analyses, leading to variation across states. Also, the analyses for compliance with NQTLs was the most difficult task for states and plans. Overall, the states and MCOs have not made major changes to their behavioral health benefits based on the reviews conducted.<sup>17</sup>

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<sup>17</sup> McMullen, E.K. (2021, January). *Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP*. Medicaid and CHIP Payment and Access Commission. <https://www.macpac.gov/wp-content/uploads/2021/01/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>

# CRITERIA FOR ASSESSING PARITY COMPLIANCE

The MHPAEA interim final regulations established six classifications of benefits:

- 1) in-network inpatient,
- 2) out-of-network inpatient,
- 3) in-network outpatient,
- 4) out-of-network outpatient,
- 5) emergency services, and
- 6) pharmacy.

The final regulations provided that the parity requirements be applied on a classification-by-classification basis. This categorization was retained in the final regulations. The remainder of this section explains relevant parts of the federal regulations applicable to plans and issuers.

## FR, QTL, AND NQTL PARITY COMPLIANCE STANDARDS

REQUIRED	APPLICABILITY	COMPARABLE APPLICATION
A FR <sup>i</sup> or QTL <sup>ii</sup> imposed on MH/SUD (Quantitative Parity Analysis)	Any classification, can be no more restrictive than the predominant <sup>iii</sup> FR or QTL	Substantially all <sup>iv</sup> med/surg in same classification
An NQTL applied with respect to MH/SUD benefits	Any classification, must be comparable and applied no more stringently	Med/surg benefits in the same classification

<sup>i</sup> deductibles

<sup>ii</sup> annual or lifetime day or visit limits

<sup>iii</sup> greater than one-half of med/surg benefits

<sup>iv</sup> two-third standard

## PARITY COMPLIANCE CRITERIA

ACTION	REQUIREMENT	CRITERIA
Insurer/plan provides in-network benefits through multiple tiers of in-network providers ( <i>such as an in-network tier of preferred providers with more generous cost sharing to participants than a separate in-network tier of participating providers</i> ).	The plan may divide its benefits on an in-network basis into sub-classifications that reflect those network tiers.	Tiering must be based on reasonable factors and regardless of whether provider is MH/SUD or med/surg after the sub-classifications are established. Insurer/plan may not impose any FR or QTL on MH/SUD benefits in any sub-classification that is more restrictive than the predominant FR or QTL that applies to substantially all med/surg benefits in the sub-classification.
Sub-classifications may be added to the <u>six classifications mentioned previously</u> .	All care provided must be categorized into the six classifications. Sub-classifications must apply both to med/surg and behavioral health benefits. It is not permissible to have a sub-classification that only applies to med/surg or behavioral health benefits.	E.g., a sub-classification for office visits is permitted within the categories of outpatient care, but parity must be maintained within that sub-classification.
Plans and issuers may take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply.	All criteria used in applying an NQTL to MH/SUD benefits are comparable to, and not applied more stringently than, those with respect to med/surg benefits.	Disparate results <b>alone</b> do not mean that the NQTLs in use do not comply with these requirements. However, disparate results are a “warning sign” or “red flag” that warrants additional scrutiny to ensure compliance with parity.
The plan or issuer must provide the claimant with the rationale for any adverse benefit determination as well as any new or additional evidence in connection to a claim.	If issuing an adverse benefit determination on review based on a new or additional rationale, the claimant must be: <ul style="list-style-type: none"> <li>provided, free of charge, with the rationale.</li> <li>provided the determination in a timeframe that permits the consumer to appeal the decision quickly so that ongoing care continuity is achieved.</li> </ul>	Includes documents of a comparable nature with information on medical necessity criteria for MH/SUD and other factors used to apply an NQTL with respect to med/surg benefits and MH/SUD benefits under the plan.

Three points that are important to remember:

- 1) **MHPAEA does NOT require NQTLs to be the same as for Med/Surg benefits.** It requires that the processes, strategies, evidentiary standards, and other factors used to determine and define those NQTLs to be comparable, and no more stringent for MH/SUD benefits than they are for med/surg benefits covered by the plan both as written and in operation.
- 2) **Identical outcomes are NOT required.** Disparate results **alone** do not mean that the NQTL in use does not comply with MHPAEA. That said, disparate results are a warning sign or red flag warranting closer scrutiny.
- 3) **MHPAEA does NOT require that MH/SUD benefits be provided.** State and federal benefit mandates identify what is required. However, if MH/SUD benefits are provided, they may not be limited, applied less comprehensively, or managed more stringently for behavioral health than for med/surg benefits. Parity laws apply to all populations equally. It is not appropriate for health plans to use subclassifications as a basis for altering comparison criteria.

The following example illustrates this point:

Under MHPAEA Final Rules, restrictions or exclusions based on “facility-type” that limit the scope of coverage for services are expressly listed as NQTLs.

The MHPAEA Final Rules provide an example of a non-comparable facility-type restriction or exclusion that violates the NQTL rule under MHPAEA. In Example 9 of the Final Rule, the salient facts are that a plan automatically excluded coverage for inpatient substance use treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For med/surg conditions, the plan provided coverage for inpatient treatment outside of a hospital upon authorization that the inpatient treatment was medically appropriate. The Final Rules conclude that the plan’s exclusion of SUD inpatient treatment in any setting outside of a hospital violated MHPAEA, as it was not comparable to the coverage of med/surg inpatient treatment outside of a hospital, as long as it was authorized.

In addition, any separate NQTL (such as facility-type exclusion or restriction) that applies only to behavioral health benefits within any particular classification of benefits does not comply with MHPAEA. The MHPAEA Self-Compliance Tool provides an example of a plan that classifies medical skilled nursing facilities and behavioral residential treatment facilities as inpatient benefits and covers room and board for all med/surg inpatient care. The plan imposed a restriction on behavioral health residential care, which was an impermissible limitation only on behavioral health benefits and therefore violated MHPAEA. Thus, any restriction on coverage for behavioral health emergency and crisis services where there exists coverage for medical emergency and urgent care services would be in violation of MHPAEA.

# ENFORCEMENT OF PARITY LAWS AND REGULATIONS

Because responsibility for regulation of insurance is shared between the federal and state governments, enforcement responsibility is similarly shared. The following chart illustrates the responsible government agency and corresponding enforcement responsibility.

## PARITY ENFORCEMENT RESPONSIBILITY BY GOVERNMENT AGENCY

AGENCY	PARITY ENFORCEMENT RESPONSIBILITY
<b>Federal Department of Labor, EBSA</b>	<ul style="list-style-type: none"><li>▪ Self-insured and fully insured private sector employer-sponsored Group Health plans.</li><li>▪ Non-federal governmental group health plans, such as plans for employees of state and local governments<sup>18</sup></li><li>▪ MHPAEA with respect to health insurance issuers selling products in the individual and fully insured group markets in states that believe they do not have the authority to or are otherwise not enforcing MHPAEA</li></ul>
<b>Centers for Medicare and Medicaid Services (CMS)</b>	<ul style="list-style-type: none"><li>▪ Medicaid Managed Care plans and for CHIP plans</li><li>▪ Plans sold through the ACA marketplaces in states which will not enforce MHPAEA</li></ul>
<b>U.S. Department of Treasury (USDT), through the Internal Revenue Service (IRS)</b>	Ensures tax treatment of health insurers and self-insured entities appropriately account for costs associated with compliance with the law
<b>State responsibility</b>	<ul style="list-style-type: none"><li>▪ Employment-related group health plans (insured or self-funded)</li><li>▪ Small employer plans</li><li>▪ Individual insurance market</li><li>▪ State Medicaid contracts—while CMS has lead responsibility the state can do much to impact parity by ensuring that the metrics of contractual compliance ensure that parity is achieved</li></ul>

<sup>18</sup> Consumer Information and Insurance Oversight Office. (n.d.). *Self-Funded, Non-Federal Governmental Plans*. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/non\\_federal\\_governmental\\_plans\\_04072011](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/non_federal_governmental_plans_04072011)

## ROLE OF SBHAs TO UPHOLD PARITY

To address their parity enforcement responsibility, many states have enacted laws and regulations that require health plans to report specific data in specified formats to ease the process of analysis. The burden of compliance heavily rests on the State Insurance Departments for private insurance plans and health benefit exchanges, and on other state agencies, either health departments or Medicaid agencies for Medicaid plans. States are identifying new partners and new state laws needed, and the new relationships with health plans necessitating increased communication and oversight. The SBHAs are an important partner in this regard. It is important to recognize that the requirements of enacting parity and the administrative burdens to comply with the law add cost and limit flexibility for health insurers and managed care companies. As such, compliance largely is mandated rather than voluntary. The goals of accountability and transparency fall heavily on government to accomplish.

In recent years, state legislative efforts have focused on coverage of more MH/SUDs, but also on requiring insurance companies to demonstrate compliance and greater transparency. The following chart provides a list of states and links to parity-related legislation passed within the last five years (Council of State Governments).

### RECENT STATE LEGISLATION ON COMPLIANCE AND TRANSPARENCY

STATE	BILL/STATUTE NUMBER
<a href="#">Arizona</a>	<a href="#">SB1523 (2020)</a>
<a href="#">California</a>	<a href="#">Senate Bill No. 855 (2020)</a>
<a href="#">Colorado</a>	<a href="#">HB1269 (2019)</a>
<a href="#">Georgia</a>	<ul style="list-style-type: none"><li>▪ <a href="#">SB80 (2021)</a></li><li>▪ <a href="#">HB1013 (2022)</a></li></ul>
<a href="#">Illinois</a>	<a href="#">SB1707 (2018)</a>
<a href="#">New York</a>	<a href="#">SB4356 (2020)</a>
<a href="#">Oregon</a>	<a href="#">ID 1-2022</a>
<a href="#">Pennsylvania</a>	<ul style="list-style-type: none"><li>▪ <a href="#">2020 Act 89—PA General Assembly (state.pa.us)</a></li><li>▪ <a href="#">House Bill 1696</a></li></ul>
<a href="#">Texas</a>	<a href="#">HB2595 (2021)</a>
<a href="#">Washington, DC</a>	<a href="#">HB1086 (2021)</a>

## RECENT STATE ENFORCEMENT AND COMPLIANCE EFFORTS

Enforcement and compliance efforts in recent years have focused on prior authorization, utilization review, provider network and formulary design, and coverage and reimbursement resulting in substantial fines and other resolutions.<sup>19</sup> Some states have had great success, as shown in the following table.

### STATE PARITY ENFORCEMENT AND RESOLUTIONS

STATE	ACTIONS
<b>Connecticut</b> (2020/2021)	Issued <u>\$575,000 in fines</u> against four health plan subsidiaries and required \$500,000 in payments to fund education programs.
<b>Delaware</b> (2020/2021)	Their first parity examination of major health insurers resulted in <u>\$597,000 in parity violations</u> , including improper pre-authorization requirements for SUDs and utilization management/claims processes, unfair formulary tiers, inappropriate medication restrictions.
<b>Illinois</b> (2020)	Over <u>\$2 million in fines</u> against five major insurance companies for violating the 2008 federal parity law.
<b>Maine</b> (2001)	Requires plans to complete a checklist of coverages they must provide or must offer and indicate where these sections are found in the plans
<b>Massachusetts</b> (2020)	Settlements with five health insurance companies and two managed behavioral health companies resulted in <u>over \$900,000 in fines</u> .
<b>New Hampshire</b> (2020)	Market exams beginning in 2017 identified problems with the offering of and reimbursement for MH/SUD treatments by two of the state's insurers, reimbursing at lower rates than they do for other medical treatments, but stopped short of accusing them of violating the Federal Parity Law.
<b>New York</b> (2018)	<u>\$3 million in fines</u> against seven health plans for violating state and federal parity requirements.
<b>New York</b> (2020)	<u>Required health insurers to develop and implement compliance programs</u> by December 29, 2020, and annually attest that such programs are in place; insurers to designate an experienced individual, such as the parity compliance officer, to assess, monitor, and manage parity compliance through related written policies and procedures; regulations identify specific improper practices under law.

<sup>19</sup> Kirby, J. & Slone, S. (2021, September). *Mental Health Insurance Parity: State Legislative and Enforcement Activities*. The Council of State Governments.  
[https://www.csg.org/wp-content/uploads/sites/7/2021/09/Mental\\_Health\\_Parity.pdf](https://www.csg.org/wp-content/uploads/sites/7/2021/09/Mental_Health_Parity.pdf)

<b>Oregon</b> (2017)	<u>Over \$550,000 in fines</u> against four health plans for parity violations related to categorical denial of mental health treatments.
<b>Pennsylvania</b> (2019)	<u>\$1 million fine</u> against United Healthcare for claims wrongly denied, overpayments of out-of-pocket expenses, and to cover interest on delayed claims; \$800,000 for a public outreach campaign to educate consumers.
<b>Rhode Island</b> (2018 & 2022)	Completed a market conduct examination of Blue Cross/Blue Shield in 2018 resulting in the company agreeing to pay <u>\$5 million</u> ; in lieu of a traditional fine, funds were directed to the RI Foundation for prevention and intervention. <sup>20</sup> And, in 2022, United Healthcare was fined <u>\$100,000</u> .

<sup>20</sup> *Mental Health and Substance Use Disorder Insurance Coverage and Model Legislation*. (n.d.). American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/advocacy/state-affairs/model-parity-legislation>



# PARITY ENFORCEMENT: PROGRESS ACHIEVED TO DATE

While the MHPAEA codified parity in federal law and many states have enacted separate laws, advancing the concept of parity implementation has proved difficult. Insurers largely have done a good job of complying with the clearer requirements of **QTLs**. However, implementation progress on **NQTL** compliance has been far less successful. Specific issues have been raised and addressed, but variations of the same issues arise again.<sup>21</sup>

## WHY PARITY ENFORCEMENT IS DIFFICULT

Parity of NQTLs involves comparisons of treatment approaches, provider qualifications, scope of practice limits, and episodes of care that are often different between behavioral health and med/surg conditions. While federal regulations articulate quantifiable standards for measuring whether QTLs follow the laws' requirements, NQTLs involve qualitative and process comparisons, in addition to operational measurable ones. Parity compliance with NQTLs requires that the factors, evidentiary standards, and strategies used to design and implement the NQTL for behavioral health treatment services be comparable to and no more stringently applied than they are for med/surg benefits. A 2020 MHPAEA Self-Compliance Tool including a multi-step process in a [compliance guide for NQTL requirements](#) illustrates how the comparison is to be done. The Self-Compliance Tool is to be updated every two (2) years. The need for this compliance guide was clearly articulated in a [2019 report](#) developed by the actuarial firm Milliman that looked at the status of mental health parity based on insurance information from claims data for more than 37 million employees and dependents from all 50 states. It included the following findings:

- 1) From 2013 to 2017, the disparity between how often behavioral health inpatient facilities are utilized out of network relative to medical/surgical inpatient facilities has increased from 2.8 times more likely to 5.2 times more likely, an 85% increase in disparities over five years
- 2) Average in-network reimbursement rates for behavioral health office visits are lower than for med/surg office visits (each as a percentage of Medicare-allowed amounts), and this disparity has increased between 2015 and 2017. As of 2017, primary care reimbursements were 23.5% higher than behavioral health reimbursements, which is an increase from 20.8% higher in 2015. In 2017, 17.2% of behavioral health office visits were to an out-of-network provider compared to 3.2 % for primary care providers and 4.3% for medical/surgical specialists.
- 3) In 2017, disparities in reimbursement rates for primary care office visits were more than 50 percent higher than those for behavioral health office visits in eleven states.

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<sup>21</sup> Ibid.

The **general challenges** states are facing per the Council of State Government's research are:

- **Non-compliance of Insurance and Medicaid Managed Care Plans.** Prior authorization for services and utilization review, provider network design, which medicines can be prescribed when, and coverage and reimbursement.
- **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.<sup>22</sup>

The **policy challenges** states are facing per the American Medical Association, Behavioral Health & Medical Review Experts, and the CMS are:

- **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.<sup>23</sup>

The Self-Compliance Tool seeks to address this. In addition, DOL has issued numerous sub-regulatory communications over the years to address specific issues related to MHPAEA compliance. Most are in the form of FAQs and show how a given action by a health insurer or MCO would or would not be compliant with the law and regulations. Despite these increasingly clear regulations, many states and DOL/DHHS have not provided proactive enforcement. Hence, providers and consumers continue to complain that actions taken by insurers and MCOs are not in compliance with the law.

The federal approach to MHPAEA compliance was altered as a result of the CAA amendment to MHPAEA which codifies the requirement of group health plans and issuers to prepare and, upon request, submit comparative analysis of NQTLs that are used. Some states have provided self-compliance tools to aid in addressing this requirement. Under this requirement, plans must set forth the factors, and evidentiary standards and comparative analyses to demonstrate the comparability and no more stringency, as written and in operation, of NQTLs used for MH/SUD benefits as compared to med/surg benefits.

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<sup>22</sup> Ibid.

<sup>23</sup> Musumeci, M. (2015, June). Behavioral Health Parity and Medicaid. Kaiser Family Foundation Issue Brief. <https://www.kff.org/report-section/behavioral-health-parity-and-medicaid-issue-brief/>

The desirability of this codified approach to compliance has been demonstrated through many analyses and reports that have been written over the last decade. For example, the DOL, DHHS, and DOT in their required biennial report submission to Congress, [MHPAEA Report to Congress 2022: Realizing Parity, Reducing Stigma, and Raising Awareness](#), as well as the report required on NQTLs comparative analyses both noted that limits on the scope or duration of benefits for treatment, such as prior authorization requirements, were a major obstacle to parity. The Employee Benefits Security Administration (EBSA), an agency within the U.S. DOL, issued 80 insufficiency letters covering more than 170 NQTLs, and 30 initial determination letters that identified 48 impermissible NQTLs. They also issued a [Fact Sheet, FY21 MHPAEA Enforcement Overview: Ensuring Parity](#), that summarizes EBSA's and CMS's investigations and public inquiries, including complaints related to MHPAEA during FY2021.

## **EBSA'S 2021 REQUEST LIST FOR COMPARATIVE ANALYSIS OF NQTLs**

*in Descending Order of Frequency*

- Preauthorization or precertification requirements
- Network provider admission standards
- Concurrent care review
- Limitations on ABA or treatment for autism spectrum disorder
- Out-of-network reimbursement rates
- Treatment plan requirements
- Limitations on MAT for opioid use disorder
- Provider qualification or billing restrictions
- Limitations on residential care or partial hospitalization programs
- Nutritional counseling limitations
- Speech therapy restrictions
- Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress
- Virtual or telephonic visit restrictions
- Fail-first or step therapy requirements

NQTLs for which EBSA requested a comparative analysis, listed in the CAA, added the new requirement to document NQTL parity analyses. However, for the most part the comparative analyses submitted did not meet the criteria for how the NQTL is applied to MH/SUD versus med/surg benefits. The plan/issuer needs to explain how the NQTL is operationally comparable and not more stringently applied, and change their documents, policies, and more to come into compliance. One requirement is to identify consumers who were affected by the NQTL to re-adjudicate claims and/or denials. In their corrective action plan submissions, plans and issuers include analyses of operational data metrics to demonstrate the relative stringency of the NQTL. The major categories into which NQTLs fall are:

- Preauthorization and Pre-service Notification Requirements
- Fail-First Protocols
- Probability Improvement
- Written Plan Required

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## MOST COMMON NQTL PARITY VIOLATIONS<sup>24</sup>

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- Limitation or exclusion of applied behavioral analysis (ABA) therapy or other services to treat autism spectrum disorder (see *Example 1* in “Three Examples of Differing NQTL Enforcement”)
  - Billing requirements—such as licensed MH/SUD providers [inability to bill directly per insurer or health plan requirement, but] can bill the plan only through specific types of other providers
  - Limitations or exclusions of MAT for opioid use disorder (OUD) (see *Example 2* in “Three Examples of Differing NQTL Enforcement”)
  - [Non-comparable and more stringent use of] preauthorization or precertification requirements (see *Example 3* in “Three Examples of Differing NQTL Enforcement”)
  - Limitation or exclusion of nutritional counseling for MH/SUD conditions
  - Provider experience requirements beyond licensure
  - Care manager or specific supervision requirements for [specified] MH/SUD [services]
  - Limitation or exclusion of residential care or partial hospitalization to treat MH/SUD conditions
  - “Effective treatment” requirements applicable only to SUD benefits
  - [Non-comparable and more stringent] treatment plan requirements
  - Employee Assistance Program referral requirements
  - Exclusion of care for chronic MH/SUD conditions
  - Exclusion of speech therapy to treat MH/SUD conditions
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<sup>24</sup> Grindler, K.F. (2022, June). *DOL Signals Heightened Enforcement of NQTL Requirements*. Verrill Benefits Law Updates. <https://www.verrill-law.com/benefits-law-update/dol-signals-heightened-enforcement-of-non-quantitative-treatment-limitation-requirements>

In addition to plans and insurers, EBSA has the authority to enforce MHPAEA with respect to self-insured employers and indirectly the third-party administrators (TPAs) to self-insured plans, covered by ERISA and collaborate with state insurance departments to investigate fully insured carriers.

The submissions by insurers and plans lacked both a sufficiently detailed explanation of how an NQTL was applied to MH/SUD versus med/surg benefits, and the documentation showing review of the NQTL's operational application. For example, a plan or issuer might test denial rates, reasons for denial, utilization rates, frequency of reviews, lengths of reviews, lengths of stays authorized, frequency of elevation to a peer-to-peer review, or review turnaround times. For an NQTL related to network admission standards, demonstration of comparability as applied might include comparisons of rates for acceptance/denial or withdrawal for MH/SUD and med/surg providers, application processing time, network reimbursement rates, latitude granted rate negotiators, or the role of network adequacy metrics.

An additional weakness identified for the plans and issuers that did provide information on how an NQTL is applied in operation was that they did not provide the "contextual" information needed to evaluate the claims metrics provided—a description of the methodology, source data, and calculations used to generate the numbers being compared. The requirement is that if any disparities in the application of an NQTL to MH/SUD and med/surg benefits exists, then the plan/issuer should explain how the NQTL is operationally comparable and not more stringently applied. State mental health administrators should focus primarily on the NQTLs as this is the source of most non-compliance with MHPAEA.

Three examples with different types of responses to application disparities are shown in the following subsection.

## THREE EXAMPLES OF DIFFERING NQTL ENFORCEMENT

### EXAMPLE 1

**ABA Therapy Exclusion:** A plan denied all claims for Applied Behavioral Analysis (ABA) therapy to treat children with autism spectrum disorder using the rationale that the treatment is experimental or investigative.

**DOL response:** A medical management standard limiting or excluding benefits based on whether a treatment is experimental or investigative is an NQTL under MHPAEA. It imposes this exclusion more stringently on MH/SUD benefits, as the plan denies *all* claims for ABA therapy, despite professionally recognized treatment guidelines and sufficient randomized controlled trials to support the use of the therapy to treat children. The plan's exclusion of ABA therapy as experimental does not comply with MHPAEA.

### EXAMPLE 2

**Removal of Exclusion on Medication-Assisted Treatment (MAT) for Opioid Use Disorder:** The plan set a dosage limit for buprenorphine to treat opioid use disorders.

**DOL response:** If the plan deviates from nationally recognized treatment guidelines for buprenorphine/naloxone to treat OUD based on Pharmacy & Therapeutics (P&T) Committee's reports but does not deviate from such guidelines with respect to covering prescription drugs to treat med/surg benefits based on the recommendations of the P&T Committee, then this deviation should be evaluated for compliance with MHPAEA's NQTL requirements. For example, by determining (1) whether the expertise of the members of the P&T Committee in MH/SUD conditions is comparable to their expertise in med/surg conditions, and (2) by determining whether the Committee's evaluation of nationally recognized treatment guidelines in setting dosage limits for medications for both MH/SUD and med/surg conditions is comparable.

### EXAMPLE 3

#### Removal of Blanket Pre-certification Requirement for MH/SUD Benefits.

**DOL Response:** A large, self-funded Taft-Hartley health plan had a plan provision requiring pre-certification of all MH/SUD outpatient services, but only a select list of med/surg outpatient services. The plan did not have a comparative analysis for this nor any other NQTL and did not have an explanation for the precertification provision. The plan had not taken steps to comply with the CAA requirements until after having received EBSA's initial request. At that point it searched for an advisor to conduct a parity analysis. As a result of the review process, the plan amended its written plan document to no longer require precertification for all MH/SUD services. They worked to a resolution with EBSA's Philadelphia Regional Office confirming operations, obtaining a comparative analysis for the current precertification requirements, and reviewing the claims process to assess whether any participants were affected by the non-compliant provision.

Ten years after the enactment of MHPAEA, the impact of access limits on behavioral health has been significant. Behavioral health patients were four times more likely to go out-of-network to get care, raising the costs for services. Out-of-network providers provided 32 percent of behavioral outpatient care in 2015 compared to six percent of med/surg care in the same setting. In addition, behavioral health providers were paid, on average, more than 20 percent less than primary care services and 17 percent less than the average paid for specialist services.<sup>25</sup>

It is important to remember that parity does not require achieving equal results from interventions provided. It is possible that an insurer or managed care company can achieve different results even if they have utilized equal processes, strategies, evidentiary standards, and factors used in applying an NQTL to MH/SUD benefits and med/surg benefits, and that they have been comparably and no more stringently applied both in writing and in operation.

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<sup>25</sup> Melek, S., Perlman, D., Davenport, S., Matthews, K., & Mager, M., (2017, November). *Impact of Mental Health Parity and Addiction Act*. Milliman White Paper. <https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/impact-mental-health-parity-act.ashx>

## STATE POLICYMAKERS' ROLES IN PARITY ENFORCEMENT

Because state policymakers have an important role in parity enforcement and in strengthening it, understanding MH/SUD parity and how to implement it while complying with federal and state

**State laws can strengthen federal parity protections but not weaken them.**

parity laws may seem very complex. However, the final rules clarify the state and Federal government relationship: **"MHPAEA requirements are not to be 'construed to supersede any provision of State law' which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of MHPAEA and other applicable provisions. To the extent the State law mandates that an issuer provide some coverage for any MH/SUD, benefits for that condition or disorder must be provided in parity with med/surg benefits under MHPAEA."**

**Simply put, state laws can strengthen parity protections but not**

**weaken them.** States and the federal government share enforcement authority, depending on the type of plan, and DHHS, DOL, the USDT IRS Division, and state insurance commissioners may have primary or secondary authority. Having planned for the state role, the DHHS, DOL, and USDT have produced numerous resources regarding the implementation of the MHPAEA in conjunction with other federal laws. One such document, *The Essential Aspects of Parity: A Training Tool for Policymakers*, serves as a targeted reference document for state insurance regulators and behavioral health staff to develop a better understanding of parity and undertake efforts to improve compliance with parity laws.

Ensuring that group health plans and health insurance issuers comply with parity rules requires a thorough understanding of fundamental concepts that include:

- **benefits classifications and sub-classifications**—the MHPAEA regulations divide benefits into the six classifications as noted above;
- **types of parity requirements**—FRs, dollar limits, QTLs, and NQTLs;
- **relevant tests for determining compliance**—the Two-Part Test (to determine compliance with FRs and QTL compliance), cumulative FRs and cumulative QTLs, dollar limits, NQTLs that otherwise limit the scope or duration of benefits, strategy for determining which benefits in this classification should be subject to the limit, the process for implementing the limit and other restrictions, and evidentiary standards; and
- **disclosure provisions and when they apply**—information about medical necessity criteria used to determine coverage, specific information about why a claim was denied, and comparative analyses for NQTLs imposed on a plan.

States' compliance and enforcement activities can successfully integrate the requirements of MHPAEA and related laws.

# THE ROLES OF THE STATE BEHAVIORAL HEALTH AGENCY IN ACHIEVING PARITY

SBHAs play an important part in achieving the goal of parity in three ways:

- 1) **Consulting and partnering** with the state insurance department to understand the information provided by insurers and managed care companies to demonstrate compliance with parity law requirements. Behavioral health expertise is critical in assessing whether the information provided makes sense, is comprehensive and definitive.
- 2) **Working with insurers and managed care companies** to address capacity and network adequacy issues. While government behavioral health agencies typically focus on addressing the needs of public sector clients, the availability of licensed clinicians and support personnel easily can move from serving public sector to private sector clients and vice versa. Achieving a comprehensive approach to this issue that addresses the needs of the public and private sector is critical.
- 3) **Working with providers, consumers, and advocates** to clarify what parity is, how it is assessed, how it is enforced and to help to clarify how potential non-compliance issues should be identified and addressed in a timely fashion. A 2014 Harris poll conducted by the American Psychological Association found that more than 90 percent of Americans were unfamiliar with the mental health parity law.<sup>26</sup> This lack of awareness and some misinformation about the law are issues that SBHAs can help to address.

## AMERICANS' FAMILIARITY WITH THE MENTAL HEALTH PARITY LAW\*



\* according to a 2014 Harris poll conducted by the American Psychological Association

<sup>26</sup> Only 4 percent of Americans know about mental health parity, 45(7). (2014, July/August). American Psychological Association. <https://www.apa.org/monitor/2014/07-08/upfront-health-parity>



# STATE OPERATIONAL READINESS FOR PARITY ENFORCEMENT

## IMPLEMENTING PARITY ENFORCEMENT

A wise place to start the journey of learning or improving federal parity requirements is a review of the Substance Abuse and Mental Health Services (SAMHSA) tool, *The Essential Aspects of Parity: A Training Tool for Policymakers*. Also, SAMHSA conducted a survey of states (2016) to identify best practices in implementing enforcement. States identified the five primary components, listed below, that they considered critical for the successful implementation and monitoring of parity.

### 1) OPEN CHANNELS OF COMMUNICATION

The states supported an interactive relationship through calls and in-person meetings with the carriers to work as quickly as possible to achieve compliance. This strategy fosters understanding of the parity rule, determines if carriers were providing appropriate coverage to consumers, and resolves potential non-compliance issues and violations by helping carriers better understand the law. Some states had structured meetings with carriers.

### 2) STANDARDIZATION OF MATERIALS AND

### 3) CREATION OF TEMPLATES, WORKBOOKS, AND OTHER TOOLS

The use of standardized language and terms was critical and can be supported through states' use of templates, workbooks, and other tools such as The "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements designed by the Kennedy Forum to ensure parity compliance both in the form filing process and for operational use by the carriers. These tools served multiple purposes and in some cases were required by state law.

The most common examples are:

- checklists, templates, and workbooks;
- analysis of complaints from consumers and providers;
- guides and bulletins; compliance surveys;
- market conduct examinations to investigate consumer complaints or issues;
- and network adequacy assessments.

States also include materials to educate carriers and consumers and materials to facilitate data submission from carriers during the form filing process. Prior to implementing policy provisions, carriers are required to file their policy forms with the state and, in most cases, receive a prior approval. Having these tools helped the states in ensuring a uniform process

while facilitating parity compliance among all carriers. Several states reported seeing the number of parity issues decrease over time, including reported non-compliance rates, reflecting the outcomes of better carrier compliance, and a reduction in consumer complaints.

#### 4) IMPLEMENTATION OF MARKET CONDUCT EXAMS AND NETWORK ADEQUACY ASSESSMENTS



**States found  
market conduct  
exams  
to be the most important  
method of broadly  
increasing compliance.**

Market conduct exams were determined to be the most important way of broadly increasing compliance, especially when they included examinations of processes and procedures through direct follow-up with carriers from whom they needed clarification. For example, network adequacy assessments are critical to ensuring access to behavioral health services in all geographic areas of a state. Access improvements might be limited due to lack of provider availability in some parts of the state. Inadequate capacity cannot be overcome through parity compliance, but it is appropriate to ensure that health plans are taking appropriate steps to broaden their networks as much as possible. Parity requires that adequacy be achieved by using criteria and processes for network inclusion that are no more restrictive than those used for med/surg providers, and that the processes used to determine reimbursement rate standards are no more restrictive.

Below is a discussion about meeting the challenges in light of workforce shortages, yet it is important to realize that parity requirements supersede those issues.

#### 5) COLLABORATION WITH MULTIPLE AGENCIES AND STAKEHOLDER GROUPS

States identified that successful implementation of all these strategies required collaboration with agencies and groups such as state health and behavioral health departments, consumers, consumer advocacy groups, providers, and other state agencies such as the State Insurance Department, the State Medicaid Authority or the Attorney General. The states supported an interactive relationship through calls and in-person meetings with the carriers to work as quickly as possible to achieve compliance with federal parity standards and requirements.

**Federal agencies.** By working first with federal agencies, the state ensures the accuracy of subsequent information provided to carriers, consumers, providers, and other advocates through materials such as bulletins and toolkits.

**State agencies.** Collaborating with other state agencies enables state insurance commissioners to design requirements for essential health benefits that are consistent with parity requirements. State insurance commissioners also partner with various advocacy groups to develop educational products on parity for consumers and providers.

**Consumers.** Consumer education, which is essential in ensuring that consumers receive the benefits of the law, can be facilitated through online and printed products, as well as live presentations. A consumer report card can allow consumers to make comparisons when selecting their health insurance plans.

The **overarching strategy** that was described by states included:

- early and ongoing communication with carriers to foster understanding of the parity rule,
- determining that carriers were providing appropriate coverage for consumers, and
- resolving potential non-compliance issues and violations by helping carriers better understand the law.

The information in the preceding section was compiled and released in a SAMHSA report: *Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States*. Appendix A of the report provides links to resources for states and insurance commissioners interested in reviewing processes and procedures used by other states.

## SELF-ASSESSMENT

On a biennial basis, the U.S. DOL issues a self-compliance tool to help state regulators, group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, and other parties determine whether a group health plan or health insurance issuer complies with the MHPAEA and additional related requirements under the ERISA that apply to group health plans. *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)* references the extensive list of NQTLs and sets out a four-step process for assessing Parity Act compliance providing multiple examples and notes to assist with commonly applied NQTLs, including:

- reimbursement rate setting,
- practices to address provider network shortages,
- coverage of intermediate levels of care,
- restrictions on reimbursement for room and board,
- prior authorization requirements for OUD medications,
- medical necessity review requirements imposed on a frequent basis,
- training and state licensure requirements for network credentialing, and
- exclusion of coverage for various testing procedures related to mental health conditions.<sup>27</sup>

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<sup>27</sup> Center for Substance Abuse Treatment. (2016). *Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States*. (SMA-16-4983). Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4983.pdf>

# SUPPORTING PARITY WITH AVAILABLE RESOURCES

State Insurance Departments, Medicaid Agencies, and Behavioral Health Agencies all struggle with having a sufficient number of staff, and fully trained staff, to support enforcement of state and federal parity laws. In most instances states respond to complaints rather than do prospective analysis due to staffing constraints. The requirement that health plans, upon request, submit their data and analysis has decreased the enforcement burden for state staff, but there still is a need to critically assess what is being submitted and to make judgments concerning whether a parity violation has taken place. SBHA staff likely bring the most expertise concerning how to interpret the complaint and the treatment aspects of health plan submissions while state insurance department and Medicaid staff best can assess contractual issues. Partnerships between the state agency staff is the best practice. By collaborating it is likely that the findings will be better quality, will be addressed more promptly, and will help the SBHA with their role in communicating results to consumers, providers, and advocates.

SBHAs' support of parity compliance should be woven into the fabric of the agency's functions because most states cannot afford dedicated staffing for it. Since many agency staff field consumer issues and/or deal with advocates, they need to be well versed on parity, compliance, and how consumers and providers can appeal adverse judgments by insurers. The passage of parity laws has focused this role, but the function is not a new one. What is new is the heightened need to collaborate with the state insurance department and/or the state Medicaid agency. Doing so need not be overly time-consuming, but it is critical to achieving the most appropriate outcome. It is likely preferable to assign more experienced staff to this interdepartmental function since their perspective and judgment are more fully developed.

# EMERGING ISSUES ON PARITY: A FOCUS ON CRISIS SERVICES

While MHPAEA has been in effect for over 14 years, many issues and applications of the parity laws have not yet been adjudicated in court or resolved by regulation and enforcement. As is true of most legal and regulatory issues, the application of MHPAEA and of state parity laws evolves over time. The following illustrates this point.

Crisis Receiving and Stabilization Centers and Mobile Crisis Teams address behavioral health emergencies. As such, one easily can conclude that their services would be categorized as emergency services for evaluating whether a parity violation has occurred.

However, many models are in use across, and even within, the states for providing crisis services and therefore it is difficult to definitively assess categorically how to conduct the parity compliance analyses. States will need to develop a plan for how analyses can be conducted across, for example, multiple MCT models. It may need to be conducted separately for each jurisdiction and potentially for the design used by each provider. As time passes, services models may become more uniform, however, in the interim the challenge will be for states, payers and the Federal government to develop definitions that are acceptable to all parties. But until then states will need to look to creative solutions for conducting analyses under complicated circumstances, and to look to federal and state laws for the support they need to resolve issues.

# LEGISLATION TO SUPPORT PARITY

Most would agree that the similarities between behavioral health crises and medical emergencies are clear. Thus, it is puzzling why definitions for medical emergencies are readily available, but those for behavioral health crises are not. States have turned to legislation to address this issue, but definitions can also be created through regulations and contracts if permitted by law. As states create legislation to establish their 988 and crisis services systems, some are concurrently seeking to establish and link definitions in statute to nurture fulfillment of the goals of parity in order to provide sustainable sources of funding for their crisis systems.

Washington State's approach was described [earlier in this document](#). California's [AB 988](#) is their "988 bill" but also includes language that resolved the behavioral health crisis definition dilemma and moved parity forward by linking crises to medical necessity.

## CALIFORNIA

"Behavioral health crisis services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

Following is a summary of language added to the Section 1374.724 of the Health and Safety Code:

- 1) Coverage of MH/SUD treatment includes medically necessary treatment of a MH/SUD, including, but not limited to, behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team, regardless of whether the service is provided by an in-network or out-of-network provider.
- 2) A health care service plan shall not require prior authorization.
  - a) A health care service plan shall reimburse a 988 center, mobile crisis team, or other provider of behavioral health crisis services for medically necessary treatment of a MH/SUD.
  - b) The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider. This amount shall be referred to as the "in-network cost-sharing amount." An out-of-network provider shall not bill or collect an amount from the enrollee for services except for the in-network cost-sharing amount.
- 3) The definition of "behavioral health crisis services" ... shall apply for purposes of this section.
- 4) This section does not excuse a health care service plan from complying with Section 1374.72 or any other requirement of this chapter.

- 5) This section does not apply to Medi-Cal managed care contracts and a health care service plan for enrolled Medi-Cal beneficiaries.

Also, the same language in these five points was added to Section 10144.57 of the Insurance Code, along with two additional requirements:

- This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.
- The Commissioner may promulgate regulations subject to ... to implement this section, and ... of this code. This subdivision shall not be construed to impair or restrict the Commissioner's rulemaking authority pursuant to another provision of this code or the Administrative Procedure Act.

## MODEL BILL TEMPLATES TO ENHANCE STATE LEGISLATION/REGULATION

Whether a particular state has or has not passed 988 legislation, model bills are available to assist policymakers in amending or creating new laws to move the state closer to a goal of parity. The following model bills were developed by advocacy organizations and not by the federal government, and therefore, although they are helpful, it is important to understand that they are not definitive.

### KENNEDY FORUM MODELS

- **State Parity Legislation Model**

The purpose of the [Kennedy Forum Model Legislation](#) is to facilitate implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) and strengthen parity provisions within state law. Each section of this model legislation targets critical areas that must be addressed to ensure that coverage for mental health conditions and substance use disorders is equal to coverage for other medical conditions.

- **State Parity Legislation Model Incorporating Medical Necessity Language**

A model bill spearheaded by the Kennedy Forum is based on California's Senate Bill 855 which took effect January 1, 2021. The [Kennedy Forum Model Bill](#) would require that all insurers follow generally accepted standards of behavioral health care when making medical necessity decisions and use criteria consistent with these standards.

### APA STATE MODEL

The **American Psychiatric Association** had a legislative goal of model parity legislation and has developed it to be **specifically adapted for each state**, amending the appropriate sections of state code or creating new sections in the right titles or chapters, using correct terminology for each state, formatted as bills are drafted in the state, and offering four versions.

## DEFINITIONS

Definitions are critical to coding and billing, but collectively states lack consistent definitions on what constitutes a behavioral health crisis and how crisis services are covered by insurance. The Medicaid and CHIP Payment and Access Commission's [MACPAC Report to Congress on Medicaid and CHIP, June 2021](#) provides analyses of definitions in all 50 states and the District of Columbia and revealed that state definitions of mental health services are not standardized and how widely they vary. Having spent considerable time reviewing definitions across the states, they provided a table of definitions (page 75 of the [MACPAC Report](#)) and explain that the definitions are MACPAC's categorization of state-level coverage and approximate the closest service descriptions. States can use this information to clearly define the crisis service array that will best achieve their goals and then use these service definitions to create billing codes for use in Medicaid and benefit mandates.

## CODING

Standardized Coding of crisis services can provide significant support for reimbursement for these important services from all insurers. Coding and funding approaches must evolve to successfully implement comprehensive crisis systems throughout the nation.<sup>28</sup> SAMHSA has provided relevant coding guidance in their report, [National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#). They suggest appropriate billing codes for crisis related services—call centers, mobile crisis teams, and crisis receiving and stabilization services.

### SAMHSA'S RECOMMENDED CRISIS SERVICE CODES

SERVICE	RECOMMENDED CODING OPTION APPROACH
<b>Crisis Line</b>	<b>H0030:</b> Behavioral Health Hotline Service and contract as a safety net resource to augment funding
<b>Mobile Crisis Response</b>	<b>H2011:</b> Crisis Intervention Service per 15 minutes <i>Note: The HT modifier can be utilized in combination with this code to denote a multi-disciplinary team if codes are used for multiple crisis delivery modalities.</i>
<b>Crisis Stabilization Facility (nonhospital)</b>	<b>S9484:</b> Crisis Intervention Mental Health Services per Hour <b>S9485:</b> Crisis Intervention Mental Health Services per Diem <i>Note: The TG modifier can be utilized to denote a complex level of care if these codes are utilized for multiple crisis delivery modalities.</i>

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<sup>28</sup> Galdys R., Covington D. & Hepburn, B. (2022). *Sustainable Funding for Mental Health Crisis Services Healthcare Crisis Service Coding Guidelines to Support Standardized Billing and Access to Coverage from All Insurers*. CrisisNow. <https://crisisnow.com/wp-content/uploads/2022/01/Sustainable-Funding-Crisis-Coding-Billing-2022.pdf>



Providers can use billing codes to define their service delivery and to guide their billing practices. Insurers and Managed Care companies then will need to determine whether these emergency services are administered at parity with med/surg emergency services.

## PROS AND CONS OF LEGISLATION

States have pursued legislation to achieve parity because so many Americans have faced greater barriers in accessing services for MH/SUD benefits than for med/surg benefits. This was a result of higher cost sharing imposed as well as more restrictive limitations on MH/SUD treatment services.<sup>29</sup> A state's first approach should be to work with the federal laws, use standardized billing templates and appeals letters, and avenues through state and federal regulators. However, there may be reasons to be more restrictive and develop new methodologies for compliance analysis. The state may have to accept that the federal law needs to become the floor rather than the ceiling. An incremental approach to parity improvement may begin with partnerships with interested stakeholders, or small regulatory or statutory changes. Clear communication of expectations within the agency's department, with carriers, and with other state agencies, state organizations, and multiple stakeholders may also be fruitful. However, if the required improvements lend themselves to a major change, coordination with the Insurance Department and Attorney General will help guide the right approach before reconstruction of current statutes or legislation is considered.

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<sup>29</sup> Goodell S. (2014, April 3). *Health Policy Brief: Mental Health Parity*, Health Affairs. <https://doi.org/10.1377/hpb20140403.871424>

# PARTNERSHIPS TO FURTHER PARITY

Recognizing their unique position as primary regulators of insurance and overseers of public health more generally, states are invaluable partners in increasing access to treatment for mental illness and substance use disorders. They also have considerable experience in creating partnerships for the greater good. This Playbook can help states understand the role they can play in enforcing existing state and Federal Parity laws and regulations. Many states have relied on the regulations issued by DOL, DHHS, and the IRS for decades. State behavioral health leaders can look to Federal Parity guidance and Federal agencies to assist them in understanding and ensuring full use of MHPAEA in addition to any additional state protections. This section provides information on partnerships that have been formed to further parity while stepping in to help, collaborating, etc.

## EBSA PARTNERSHIP EFFORTS

The EBSA has primary enforcement authority over employer-sponsored group health plans and insurers, but states are the primary enforcers for health insurance issuers per the McCarron Ferguson Act, thus making them strong partners. Many group health plan requirements included in ERISA create a federal floor, but states may be more protective of consumers in carrying out their obligations that relate to health insurance issuers under parallel provisions in the [Public Health Service Act](#).

**EBSA's Kansas City Regional Office** cooperates with other governmental organizations in the area in response to the opioid crisis within the midwestern states. They also participated in a workshop with stakeholders, including behavioral health professional associations and advocacy groups on MHPAEA compliance. This workshop focused on increasing awareness of EBSA's enforcement capabilities and developing leads for future investigation.

**EBSA's Cincinnati Regional Office** has met frequently with providers and consumer advocates to foster relationships with the community and to target and evaluate NQTLs being imposed by large behavioral health providers/issuers. The EBSA's Cincinnati Regional Office also works closely with local law enforcement agencies, as well as the Department of Justice, the Federal Bureau of Investigation, the Drug Enforcement Administration, DHHS, and state Medicaid Fraud Control Units on investigations and strategies relating to opioid investigations.

Their **Philadelphia Regional Office** regularly attends and participates in the DHHS Region 3 Federal Opioid Taskforce and participates in frequent meetings with the Pennsylvania Insurance Department to coordinate enforcement efforts.

EBSA, along with DHHS, joins regular conference calls with state regulators through the National Association of Insurance Commissioners (NAIC) to address discrete issues that arise between quarterly meetings. EBSA staff provides individual technical assistance to state regulators, as requested, including:

- Consumer publications to help individuals understand their legal rights

- Support for state insurance regulation by hosting several policy academies
- Webcasts, in-person seminars, and nationwide compliance outreach events for the regulated community
- Participant assistance and public awareness events that educated workers and other stakeholders about rights and benefits safeguarded under MHPAEA
- The 2020 MHPAEA Self-Compliance Tool updates, including the “best practice” four-step comparative analysis for each plan NQTL
- New [MHPAEA FAQs Part 45](#)
- FAQs about MH/SUD Parity Implementation and the Consolidated Appropriations Act, 2021, Part 45
- Guidance on warning signs based on past investigations
- Regular and ongoing dialogue with the NAIC and attendance at quarterly national NAIC meetings
- Releasing “Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits” (SAMHSA) which helps covered employees understand their right to access MH/SUD benefits.<sup>30</sup>

## STAKEHOLDER PARTNERSHIP EFFORTS

The best mental health parity results are achieved not only through enforcement of MHPAEA, but through discussions among stakeholders. In a [2020 Report to Congress](#) Secretary Eugene Scalia for the U.S. Department of Labor stated that such collaborative efforts were exemplified in meetings with a variety of stakeholders, including plans, issuers, providers, and consumer advocates. Following are several lessons learned from these activities.

- When there are gaps in the understanding of the regulated community, and where consumers feel that barriers remain, stakeholders are in the best position to provide this information, as they are the entities tasked with navigating parity compliance.
- Consumer advocacy groups, as well as provider organizations, are uniquely positioned to communicate the challenges that consumers still face.
- Meetings with a variety of stakeholder groups, including industry representatives, provider associations, and consumer advocacy organizations add to knowledge and solve problem areas.
- Roundtable discussions bring the regulated community together with provider and consumer organizations to exchange perspectives on proposed guidance and on parity implementation and enforcement. One roundtable was attended by approximately sixty external stakeholders

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<sup>30</sup> Ross, R.J., Shen, W.W., & Isserman, N.D. (2021, July 26). *Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services*. (CRS Report No. R46856). Congressional Research Service. <https://crsreports.congress.gov/product/pdf/R/R46856>

representing employers, the insurance industry, managed behavioral health organizations, and medical providers.

- Provider and consumer groups stressed that they often had difficulty receiving requested documents from plans and issuers and provided examples of what they felt was inadequate disclosure. It was determined that there were challenges associated with fulfilling consumer disclosure requests and a more streamlined disclosure process was suggested.
- One partnership group developed three tools: Frequently Asked Questions (FAQs) about “Mental Health and Substance Use Disorder Parity Implementation” and the 21st Century Cures Act addressing medical management standards, network admission standards, and factors used in provider reimbursement methodologies; examples of sources of information that may serve as evidentiary standards; and a revised draft MHPAEA disclosure template and requested comments. Stakeholder perspectives shared at the roundtable resulted in refinements to the proposed guidance (including, where necessary, deleting language that commenters had identified as confusing or unclear).<sup>31</sup>

## NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) PARTNERSHIP GROUP EFFORTS

The NAIC has created a Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group with 33 states as members. This will help bring uniformity of understanding of the laws and their application. For 2022 they identified the following actions:

- 1) Monitor, report and analyze developments, and make recommendations regarding NAIC strategy and policy with respect to those developments.
- 2) Monitor, facilitate, and coordinate best practices with the states, the DOL, and DHHS.
- 3) Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts under the ACA that relate to MHPAEA.
- 4) Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the NAIC Market Regulation Handbook.
- 5) Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

In addition, the NAIC has set forth the Special (EX) Committee on Race and Insurance, which acts as the NAIC’s coordinating body to examine issues related to race, diversity and inclusion as it pertains to insurance. This has led to the adoption of charges for the Working Group to develop model educational material for state departments of insurance (DOIs), research disparities in and interplay between mental health parity and access to culturally competent care for people of color and/or

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<sup>31</sup> 2020 Report to Congress Parity Partnerships: Working Together. (2020). U.S. Department of Labor. <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf>

historically underrepresented groups and hear presentations from providers on Issues regarding parity.<sup>32</sup>

## PENNSYLVANIA MENTAL HEALTH PARTNERSHIPS EFFORT

Pennsylvania's state-based partnership group has developed a [Mental Health Partnerships website](#) that provides a one-page description of the responsibilities of each arm of government with regard to parity; an infographic "Are you having problems like..." for consumers and others; and another section "Parity in the Nation" offering information on regulation, legislation and litigation. Other resources of interest are:

- The DOL's List of Non-Quantitative Treatment Limitation "Red Flags": [\*Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations \(NQTLs\) that Require Additional Analysis to Determine Mental Health Parity Compliance\*](#)
- [The Pennsylvania Insurance Department's FAQ on Parity](#)
- [Pennsylvania Consumer Services Online](#)

## A MODEL FOR JOINT STAKEHOLDER EFFORTS

The "Parity at 10" campaign was a three-year campaign with a goal of uniting local and national advocates in ten states to pursue full enforcement of the Parity Act, to establish effective models for robust enforcement, and disseminate those models across the country.

The campaign recommended that states should use a pre-market enforcement process for the commercial insurance market and Medicaid, including pre-market plan review with specific data submission requirements for plans, and post-market conduct exams to achieve improved enforcement. But they also recommended a strong [Parity Complaint Process](#) because state insurance regulators rely heavily on consumer complaints to identify the scope and nature of insurance violations. "Parity at 10" developed the [\*State Attorney General Parity Act Enforcement Toolkit\*](#) to help states address parity complaints. They suggested that states should offer a stand-alone Parity Complaint Process because many parity violations will not involve an adverse decision.

## BEST PRACTICES

The elements of a strong consumer and provider **Parity Complaint Process** are components of a broad process that can foster the realization of parity. Each state must assess its current consumer assistance process, **identify strengths to be leveraged and gaps in capacity**, and develop a plan to adopt a comprehensive and consumer-friendly process. The practices and elements vary in resource requirements, but each can be modified based on available resources.

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<sup>32</sup> *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group*. (2022). National Association of Insurance Commissioners. [https://content.naic.org/cmte\\_b\\_mhpaea\\_wg.htm](https://content.naic.org/cmte_b_mhpaea_wg.htm)

Best practices would include an assessment of a state's current **consumer assistance process**, identification of strengths to be leveraged and gaps in capacity, with the goal of updating and strengthening the process as well as making it more consumer friendly. It should also include a **Parity Complaint Form** with guided questions to help determine whether the facts in each case point to a potential violation. An improved form would provide examples of common insurance barriers and ask specific questions.

In addition to a consumer assistance process, regulators should accept complaints from providers that **identify systemic problems** that their patients experience. This is important as for some parity violations, such as those involving reimbursement rate determinations and network design, where providers are the only stakeholder group with knowledge of insurer practices. Providers should be encouraged to **report systemic problems** via a hotline or email box and file formal complaints rather than patient-specific complaints.

## Best Practices for a Parity Complaint Process

- **Assess consumer assistance or ombudsman process/roles**
- **Identify strengths and gaps**
- **Establish a consumer assistance or ombudsman office**
- **Include a parity complaint form**
- **Identify/report systemic issues**
- **Improve outreach/education**
- **Improve data collection and analysis**

In establishing a **consumer assistance or ombudsman office**, stakeholders could establish, fund, and maintain a comprehensive assistance program that either offers direct assistance, including legal representation or one that provides a warm handoff to a partner organization that would assist. The factors that states should consider are the funding source, the need for statutory establishment, scope of assistance, and the relationship to government entities. If placed within a government agency, the customer assistance or ombudsman office must be structured so that it can operate independently of any other government entity that regulates insurance, and it will need to establish a referral pathway for consumers who need legal representation to resolve a dispute.

States might use legislation to **define the role of the customer service or ombudsman office and provide a government budget and staff**. This provides the ability to define the scope of the assistance to be provided, include a reporting requirement, and facilitate data sharing that would benefit other state entities to identify systemic problems. One disadvantage of state statute is that it could limit the flexibility of the office to handle concerns that were unforeseen at the time of enactment.

States would benefit from **improving outreach and education effort about parity laws and basic insurance rights**, so consumers understand their rights and available assistance. The education process should include coordinated outreach efforts across all

stakeholder groups, consumer friendly education materials, and outreach and education information at critical times. For example, Connecticut, Maryland, Massachusetts, and New York

require insurers to identify the health insurance assistance program in each adverse decision letter. This notice is the primary way that consumers in those states learn about them and can access their services.

State agencies should collect and report specific claims, complaint, and adverse decision data to identify potential parity violations. **Improved data collection and analysis** may be one of the most meaningful ways to improve the enforcement process. The data must be sorted into the relevant Parity Act classifications of benefits and related to specific NQTLs. These data should be reported by each carrier and should be supported by claims data. Consumer assistance staff and state agencies that work to enforce parity and should track complaints with the same data and coordinate responses to the extent permitted by law.

An example of a model was provided in the September 2018 report submitted by the Texas Department of Insurance, *Study of Mental Health Parity to Better Understand Consumer Experiences with Accessing Care*. Another model is available from the Bowman Family Foundation on the use of quantitative templates by three states, *Updated Issue Brief: Maryland Issues Final NQTL Data Reporting Forms (Templates) State Regulators' Use of Required Quantitative Data Templates to Assess NQTL Parity Compliance*.

## CONCLUSION:

# WE CAN ALL IMPACT CHANGE TO HELP REALIZE PARITY

Although parity is required by federal and state laws, in too many cases the laws are not being followed or enforced to the extent the laws require. Well-designed and strong state parity enforcement will have a positive impact on state budgets by strengthening requirements for insurers to pay for treatment for which subscribers have paid a premium, reducing expensive late interventions or cost shifts to other payers. Assisting state and federal regulators in implementing and enforcing existing parity laws is one of the actions that we all have available to quickly expand coverage for existing behavioral health programs, such as behavioral health crisis services. This is a critical step to save lives and help promote recovery at a time when crisis services are being expanded and increasingly utilized. Roles that all stakeholders have can vary, but below are some of the highlights reviewed in this report.

**Individuals.** Individuals can use state, federal, insurer, and advocate resources to learn about their rights and how to appeal denials to insurance plans. They can speak with their employer's human resources office, share their experiences on social networks, and communicate with their elected officials.

**Advocates.** Advocates can assist individuals by providing education on parity-related rights. They can also help educate and question insurers, employers, and elected officials about systemic improvements, ongoing problems, and additional actions needed to achieve the goals of parity and comprehensive effective care.

**Employers.** Employers can, on a regular basis, ask their employees if they are experiencing any problems related to their insurance plan, such as claims denials. They can also request a copy of the mental health comparative analysis, required by the DOL, which compares behavioral health benefits to med/surg ones.

**Behavioral health providers.** Providers can be informed about the best methods for billing, aggressively and uniformly appealing denials, and in being knowledgeable about parity laws in order to help their patients when violations occur.

**Payers.** Insurance companies, managed care companies, and third-party administrators must follow the law, but proactively can do more to achieve both the intent of parity laws as well as the goal of cost-effective care. Often, providing needed benefits even if not required by law can be cost effective for the insurance companies because untreated or under-treated behavioral health conditions can lead to higher aggregate cost of healthcare.



**Federal agencies.** Federal agencies can continue to develop and update tools to assist states and individuals, e.g., the following resources are posted on [SAMHSA's website](#):

- 1) *Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits*, is a pamphlet explaining mental health parity, detailing what it means to the consumer, and listing the protections the parity law provides.
- 2) *Understanding Parity: A Guide to Resources for Families and Caregivers*, provides an overview of parity geared toward parents, family members, or caregivers with information and tools to help them obtain behavioral health services for children or family members in their care.
- 3) *The Essential Aspects of Parity: A Training Tool for Policymakers*, provides state regulators and behavioral health staff an overview of MH/SUD parity and how to implement and comply with the federal parity law regarding employee-sponsored health plans and group and individual health insurance.

**Regulators.** Federal and state regulators can effectively monitor insurers and health plans to ensure the law is followed, to take actions necessary, and to continue to create methodologies to identify patterns of noncompliance. They can work together by reaching out to stakeholders to tackle problems together, and effectively design and use enforcement actions. This can also include reaching out to individuals who can provide insight regarding what they need and what they are experiencing.

**Legislators.** Legislators can listen to constituents about problems they have encountered, work with advocates and federal/state agencies, and write new bills and/or be active in supporting laws to improve parity protections and enforcement.

**State Behavioral Health Agencies.** Education is one of the major roles that the state SBHAs can play. They can also work with sister agencies such as Medicaid, Office of the Attorney General, and Insurance Departments to meet regularly, discuss methodologies that support regulation, and determine how they can best support each other in this effort.



**"Access to mental health services is one of the most important and most neglected civil rights issues facing the Nation.**

**For too long, persons living with mental disorders have suffered from discriminatory treatment at all levels of society."**

**—Representative Patrick Kennedy (D-RI),  
one of the chief architects of the parity law, arguing for its passage**

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*Congressional Record. S1864-5. Daily edition, February 12, 153. 2007.*

# APPENDIX

## ABBREVIATIONS AND ACRONYMS

**ABA**—Applied Behavior Analysis

**ABP**—Alternative Benefit Plan

**ACA**—Affordable Care Act

**APA**—American Psychiatric Association

**ASO**—Administrative Services Only

**CHIP**—Children’s Health Insurance Plan

**CAA**—Consolidated Appropriations Act of 2021

**CCIIO**—Center for Consumer Information and Insurance Oversight

**CHIPRA**—Children’s Health Insurance Reauthorization Act

**CMS**—Centers for Medicare and Medicaid Services

**DHHS**—Department of Health and Human Services

**DOI**—Departments of Insurance

**DOL**—U.S. Department of Labor

**DSM**—Diagnostic and Statistical Manual of Mental Disorders

**EBSA**—Employee Benefits Security Administration

**EMTALA**—Emergency Treatment and Labor Act

**ERISA**—Employee Retirement Income Security Act

**FAQ**—Frequently Asked Question

**FFS**—Fee-For-Service

**LDI**—Louisiana Department of Insurance

**MAT**—Medication Assisted Treatment

**MCO**—Managed Care Organization

**Med/Surg**—Medical and Surgical

**MHPA**—Mental Health Parity Act of 1996

**MHPAEA**—Mental Health Parity and Addiction Equity Act

**MH/SUD**—Mental Health and Substance Use Disorder

**MIA**—Maryland Insurance Administration

**NQTL**—Non-Quantitative Treatment Limitation

**ODU**—Opioid Use Disorder

**PAHP**—Prepaid Ambulatory Health Plan

**PIHP**—Prepaid Inpatient Health Plan

**PHSA**—Public Health Service Act

**PPACA**—Patient Protection and Affordable Care Act

**P&T**—Pharmacy & Therapeutics

**QTL**—Quantitative Treatment Limitation

**SUD**—Substance Use Disorder

**QHP**—Qualified Health Plan

**SBHPA**—Strengthening Behavioral Health Parity Act

**SBHA**—State Behavioral Health Agency

**U.S.**—United States

**USDT**—U.S. Department of the Treasury