LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY ACT

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MODEL MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY ACT

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SECTION I. SHORT TITLE.

This Act may be referred to as the "Model Mental Health and Substance Use Disorder Parity Act," "the Act," or "Model Act."

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings.—The [legislature][1] finds that:

(1) In 2023, 105,227 people died of a drug overdose in the United States,[2] and in 2022, 49,449 people died by suicide, 46 percent of whom had a known, untreated mental illness;[3,4]

(2) An estimated 21.5 million adults in the United States have a co-occurring disorder, the coexistence of a mental illness and substance use disorder;[5]

(3) Access to health insurance increases the likelihood that people with mental health or substance use disorders will seek treatment;[6]

(4) Historically, barriers in health insurance coverage, such as higher financial costs and quantitative or nonquantitative treatment limitations for mental health and substance use disorder benefits, have made it more difficult to access mental health and substance use disorder care than to access similar medical/surgical care for physical ailments;[7]

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[1] This Act contains certain bracketed words and phrases (*e.g.*, "[legislature]"). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

[2] F.B. Ahmad, et al., *Provisional Drug Overdose Death Counts*, NAT'L CTR. FOR HEALTH STAT., CTRS. FOR DISEASE CONTROL & PREVENTION (last reviewed April 17, 2024), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[3] *Suicide Data and Statistics*, NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION (last reviewed Nov. 29, 2023), https://www.cdc.gov/suicide/suicide-data-statistics.html.

[4] Deborah M. Stone, et al., *Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015*, MORBIDITY & MORTALITY WEEKLY REP. (June 8, 2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm?s_cid=mm6722a1.

[5] *Co-Occurring Disorders and Other Health Conditions*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN. (March 29, 2024), https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders.

[6] *See* Kenneth A. Feder, et al., *Health insurance coverage is associated with access to substance use treatment among individuals with injection drug use: Evidence from a 12-year prospective study*, 96 J. OF SUBSTANCE ABUSE TREATMENT (January 2019), https://www.sciencedirect.com/science/article/pii/S0740547218303465, Norah Mulvaney-Day, et al., *Mental Health Parity and Addiction Equity Act and the Use of Outpatient Behavioral Health Services in the United States, 2005-2016*, 109(S3) Am. J. Public Health (June 2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6595520/.

[7] *See* JoAnn Volk, et al., *A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators*, GEORGETOWN U. HEALTH POLICY INST., CTR. ON HEALTH INSURANCE REFORMS (Oct 2022), https://mamh-web.files.svdcdn.com/production/files/MHParity_review.pdf?dm=1666014628.

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(5) The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Mental Health Parity and Addiction Equity Act"), and its amendments, sought to reduce many of these barriers to coverage and encouraged Americans to seek care for mental health and substance use disorders;[8]

(6) Many health benefit plans in the United States have nevertheless failed to comply with the parity requirements of the Mental Health Parity and Addiction Equity Act;[9] and

(7) [State] has a substantial interest in promoting quality health care and enforcing parity between mental health and substance use disorder benefits and medical/surgical benefits in health benefit plans.

(b) Purpose.—The purpose of this Act is to:

(1) Save lives and improve health and quality of life by expanding access to mental health and substance use disorder treatment;

(2) Require health benefit plans in this state to provide mental health and substance use disorder benefits on terms no more restrictive than those for medical/surgical benefits;

(3) Require health insurers to demonstrate compliance with the Mental Health Parity and Addiction Equity Act for all health benefit plans regulated by the [state insurance commission] that are subject to this Act; and

(4) Empower and direct the [state insurance commissioner] to implement and enforce this Act and the federal Mental Health Parity and Addiction Equity Act as it applies to health insurance in this state.

Commentary

In the 12-month period ending in November 2023, 105,384 Americans died of a drug overdose, according to data from the Centers for Disease Control and Prevention.[10] In the year

[8] 42 U.S.C.A. § 300gg-26 (West 2024); Mulvaney-Day, et al., *supra* note 6.
[9] Martin J. Walsh, et al., *Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage*, U.S. DEPT. OF LABOR (2022), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.
[10] F.B. Ahmad, et al., *Provisional Drug Overdose Death Counts*, NAT'L CTR. FOR HEALTH STAT., CTRS. FOR DISEASE CONTROL & PREVENTION (last reviewed April 17, 2024), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

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2022 alone (the most recent year for which there is data), 49,449 Americans died by suicide,[11] at least 46 percent of whom had a known, but untreated, mental illness at the time of death.[12] Treatment for mental health conditions and substance use disorders (SUD) can save lives, but historically, people who use drugs were less likely to have health insurance.[13] Even for those who had insurance, for many years mental health and SUD treatment was given unfavorable coverage in health insurance policies compared to treatment for physical health conditions.[14] Many policies did not include mental health or SUD benefits at all, and of those that did, many subjected those benefits to stricter annual or lifetime service limits, higher out-of-pocket costs, and more restrictive "nonquantitative treatment limitations" (NQTLs), including preauthorization requirements or "medical necessity" criteria before coverage was approved.[15]

Mental health and SUD parity means that health insurance coverage for mental health and SUD benefits is no more restrictive than that for medical/surgical benefits for physical health conditions and that plan members face no greater burden accessing mental health and SUD benefits than physical health benefits. In pursuit of that goal, the United States Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[16] In general, the MHPAEA does not mandate that insurance plans include mental health and SUD coverage, but only requires those plans that have chosen to offer mental health and SUD benefits provide those benefits without imposing financial requirements, quantitative treatment limitations (QTLs), or NQTLs that are no more restrictive than those applied to medical/surgical benefits.[17] The MHPAEA, as enacted, only applied to group health plans (and group health insurance coverage provided in connection with such plans) sponsored by large employers (employers with more than 50 employees), and Medicaid managed care plans, though amendments in the years since have expanded its protections.[18]

In 2010, the Affordable Care Act was enacted, and through the law's implementation generally extended parity requirements to individual and small group health insurance coverage, and it mandated that such coverage provide mental health and SUD benefits as part of essential health benefits.[19] After the MHPAEA's enactment in 2008, most health benefit plans eliminated impermissible financial requirements and QTLs on mental health and SUD benefits, and studies have indicated that its parity protections are positively associated with increased utilization of

[11] *Suicide Data and Statistics*, NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION (last reviewed Nov. 29, 2023), https://www.cdc.gov/suicide/suicide-data-statistics.html.
[12] Deborah M. Stone, et al., *Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015*, MORBIDITY & MORTALITY WEEKLY REP. (June 8, 2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm?s_cid=mm6722a1.
[13] Julia Dickson-Gomez, et al., *Insurance barriers to substance use disorder treatment after passage of mental health and addiction parity laws and the affordable care act: A qualitative analysis*, 3 DRUG AND ALCOHOL DEPENDENCE REPTS (June 2022), https://www.sciencedirect.com/science/article/pii/S2772724622000294.
[14] Volk, et al., *supra* note 7.
[15] *Policy Priority: Mental Health Parity*, AMERICAN FOUNDATION FOR SUICIDE PREVENTION (January 9, 2023), https://www.datocms-assets.com/12810/1677181553-afsp-mental-health-parity-issue-brief.pdf; Dickson-Gomez, et al., *supra* note 13.
[16] Emergency Economic Stabilization Act of 2008, Pub. L. No. 110–343, 122 Stat. 3765 (2008).
[17] Dickson-Gomez, et al., *supra* note 13.
[18] Emergency Economic Stabilization Act of 2008, *supra* note 16.
[19] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

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mental health and SUD services.[20] Although state governments are the primary regulators of health insurers, further legislation has expanded the federal government's role in enforcing parity requirements. The Consolidated Appropriations Act of 2021 (CAA 2021) imposed a federal requirement for group health plans and health insurers offering group or individual health insurance coverage to conduct comparative analyses of NQTLs they apply to mental health or substance use disorder benefits and make these analyses available to state officials and the federal Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, "the Departments"), upon request.[21] It further established a process for the Departments to evaluate those plans' compliance with federal parity requirements.[22] DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans. HHS has enforcement authority for MHPAEA over health insurers selling products in the individual and fully insured group markets in states that fail to substantially enforce the MHPAEA with respect to insurers in the state, and over public sector employment-based group health plans (referred to as "non-federal governmental plans," such as state and local government plans).

States have a critical role to play in enforcing parity requirements with respect to health insurers. Noncompliance remains a major challenge: in its first report to Congress after enactment of the CAA 2021, the Departments reported that none of the comparative analyses requested from group health plans and health insurers contained sufficient information to meet the MHPAEA requirements.[23] Independent studies have indicated that disparate treatment limits still exist in health benefit plans in violation of federal parity requirements.[24] Looking just at the states, another study found that effective state-level parity enforcement was dependent on the priorities of specific governors, insurance commissioners, and legislatures, with minimal enforcement in states where there were no parity champions.[25]

This Model Act aims to empower effective enforcement of mental health and SUD parity standards at the state level. Section IV enshrines parity requirements similar to those of the MHPAEA at the state level, forbidding financial requirements and quantitative and nonquantitative treatment limits for mental health and SUD benefits that are not applied in parity with financial, quantitative, and nonquantitative limits on medical/surgical benefits. Section V directs health insurers to analyze their health benefit plans for parity compliance and to submit the results of that analysis in a report to the state insurance commissioner. Section VI requires the commissioner to evaluate those parity analyses of health benefit plans, collect and respond to public complaints of parity violations, and conduct periodic market conduct investigations of health insurers in the state.

[20] Mulvaney-Day, et al., *supra* note 6.
[21] 42 U.S.C.A. § 300gg-26 (West 2024).
[22] 42 U.S.C.A. § 300gg-26 (West 2024).
[23] *Id.*
[24] *See* Mulvaney-Day, et al., *supra* note 6, and Volk, et al., *supra* note 7
[25] Rachel Presskreischer, et al., *Factors Affecting State-Level Enforcement of the Federal Mental Health Parity and Addiction Equity Act: A Cross-Case Analysis of Four States*, 48 J. HEALTH POLIT. POLICY LAW (Feb. 1, 2023), https://doi.org/10.1215/03616878-10171062.

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SECTION III. DEFINITIONS.

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:[26]

(a) Aggregate lifetime limit.—"Aggregate lifetime limit" means a dollar limitation on the total amount of specified benefits that may be paid under a health benefit plan for any coverage unit;[27]

(b) Annual dollar limit.—"Annual dollar limit" means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health benefit plan for any coverage unit;[28]

(c) Benefits.—"Benefits" means the health care items or services covered by a health insurer under a health benefit plan, in accordance with applicable state and federal law;

(d) Classification of benefits.—"Classification of benefits" means inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, prescription drug benefits, and emergency care benefits;[29]

(e) [Commissioner].—"[Commissioner]" means the [state insurance commissioner];

(f) Department.—"Department" means the [state department of insurance];

(g) Evidentiary standards.—"Evidentiary standards" means any evidence, sources, or standards that a health insurer considered or relied upon in designing or applying a factor with respect to a nonquantitative treatment limitation, including specific benchmarks or thresholds, and which may be empirical, statistical, or clinical in nature.[30]

(h) Factors.—"Factors" means all information, including processes and strategies (but not evidentiary standards), that a health insurer considered or relied upon to design a nonquantitative treatment limitation, or to determine whether or how the nonquantitative treatment limitation applies to benefits under the plan or coverage.[31]

[26] Where a definition is based on, adapted from, or directly pulled from, language from enacted statute, proposed legislation, or other research material, the footnote referenced at the end of the definition provides that source. Additional information about the reasoning for certain definitions is included in the Section III commentary.
[27] Adapted from 45 C.F.R. § 146.136.
[28] *Id.*
[29] Adapted from MD. CODE ANN., INS. § 15-144 (West 2024).
[30] *Id* (for specific examples of evidentiary standards).
[31] *Id* (for specific examples of factors).

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(i) Financial requirements.—"Financial requirements" includes deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits;

(j) Generally recognized independent standards of current medical practice.—"Generally recognized independent standards of current medical practice" or "generally accepted standards of care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally recognized independent standards of current medical practice include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration;

(k) Health benefit plan.—"Health benefit plan," "health insurance coverage," "plan," or "coverage" means any hospital or medical policy or certificate, major medical expense insurance policy or certificate, any hospital or medical service plan contract, health maintenance organization or health service corporation subscriber contract, state or local government employee health plan, or any other similar health contract subject to the jurisdiction of the [Commissioner];[32]

(l) Health insurer.—"Health insurer" or "insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the [Commissioner], that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;[33]

[32] DEL. CODE ANN. tit. 18, § 3572 (West 2024).
[33] DEL. CODE ANN. tit. 18, § 3602 (West 2024).

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(m) Market conduct examination.—"Market conduct examination" means an examination conducted by the department to evaluate the practices and operations of a health insurer;[34]

(n) Medical/surgical benefits.—"Medical/surgical benefits" means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the health benefit plan or health insurance coverage and in accordance with applicable federal and state law but does not include mental health or substance use disorder benefits. Any condition or procedure defined by the health benefit plan or health insurance coverage as being or as not being a medical/surgical condition or procedure must be defined so that it is consistent with generally recognized independent standards of current medical practice;[35]

(o) Medically necessary.—"Medically necessary" means a healthcare professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that care is:[36]

(1) Consistent with generally recognized independent standards of current medical and clinical practice;

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider;

(p) Mental health benefits.—"Mental health benefits" means benefits with respect to items or services for mental health conditions, as defined under the terms of the health benefit plan or health insurance coverage and in accordance with applicable federal and state law;[37]

(q) Mental health or substance use disorder.—"Mental health or substance use disorder" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental, behavioral,

[34] DC CODE ANN. § 31-3175.01 (West 2024).
[35] 45 C.F.R. § 146.136.
[36] 215 ILL. COMP. STAT. ANN. 200/15 (West 2024).
[37] 45 C.F.R. § 146.136.

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and neurodevelopmental disorders chapter (or equivalent chapter) of the current edition of the International Classification of Diseases or that is listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders;[38]

(r) Mental Health Parity and Addiction Equity Act.—"Mental Health Parity and Addiction Equity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-26, as amended, and federal guidance or regulations issued under the act, including 45 C.F.R. Part 146.136, 45 C.F.R. Part 146.137, and 45 C.F.R. Part 147.160);

(s) Prior authorization.—"Prior authorization" means the requirement of and process for obtaining prior approval from a health insurer for the provision of prescribed procedures, services, or medications.[39]

(t) Processes.—"Processes" means actions, steps, or procedures that a health benefit plan or health insurance coverage uses to apply a nonquantitative treatment limitation, including actions, steps, or procedures established by the plan or coverage as requirements in order for a participant or beneficiary to access benefits, including through actions by a participant's or beneficiary's authorized representative or a provider or facility.[40]

(u) Step therapy.—"Step therapy" means a protocol established by a health benefit plan or health insurer that requires a specific service, procedure, or prescription drug, typically those that are lower in cost, to be used by a patient before a practitioner or prescriber's preferred service, procedure, or prescription drug to treat the insured or the enrollee is covered;

(v) Strategies.—"Strategies" means practices, methods, or internal metrics that a health benefit plan or health insurer considers, reviews, or uses to design a nonquantitative treatment limitation.[41]

(w) Substance use disorder benefits.—"Substance use disorder benefits" means benefits with respect to items or services for substance use disorders, as defined under the terms of the health benefit plan or health insurance coverage and in accordance with applicable

[38] 215 ILL. COMP. STAT. ANN. 370c1 (West 2024).
[39] D.C. CODE ANN. § 31-3175.01 (West 2024).
[40] 45 C.F.R. § 146.136.
[41] *Id*.

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federal and state law. Any disorder defined by the health benefit plan or insurance coverage as being or as not being a substance use disorder must be defined so that it is consistent with generally recognized independent standards of current medical practice;[42]

(x) Treatment.—"Treatment" means services including, but not limited to, diagnostic evaluation, medical, psychiatric and psychological care, counseling, pharmacotherapy, and psychotherapy for mental health or substance use disorders rendered by a hospital, substance use disorder treatment facility, intermediate care facility, mental health treatment center, a physician, psychologist, licensed clinical social worker, licensed professional counselor, licensed substance use disorder treatment practitioner, licensed marriage and family therapist, clinical nurse specialist, or any other entity or individual licensed, registered, or certified to provide treatment for mental health or substance use disorders in this state;[43] and

(y) Treatment limitation.—"Treatment limitation" means limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. This includes both:[44]

(1) Quantitative treatment limitations, which are expressed numerically (such as fifty (50) outpatient visits per year); and

(2) Nonquantitative treatment limitations, which are generally not expressed numerically but which otherwise limit the scope or duration of benefits for treatment. Examples include:[45]

(A) Medical management standards (such as prior authorization) limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

[42] VA . CODE ANN. § 38.2-3412.1 (West 2024).
[43] *Id*.
[44] 42 U.S.C. § 300gg-26.
[45] 45 C.F.R. § 146.136.

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(D) Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage;

(E) Plan or issuer methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment; or

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;

(3) A complete exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for the purposes of this definition.

Commentary

Many of the definitions in this section are adapted from the MHPAEA or its implementing regulations, particularly 45 C.F.R. § 146.136. Where federal law or regulation requires a state to use a certain definition for a term, states should use the required definition.

SECTION IV. PARITY MANDATE.

(a) Parity generally.—Every health insurer that amends, delivers, issues, or renews a group or individual policy of health insurance providing coverage for medical/surgical benefits and for mental health or substance use disorder benefits shall ensure that: [46]

(1) The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial

[46] This subsection is adapted from 215 ILL. COMP. STAT. ANN. 370c1 (West 2024).

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requirements applied to substantially all medical/surgical benefits covered by the policy and that there are no separate financial requirements that are applicable only to mental health or substance use disorder benefits; and

(2) The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the policy and that there are no separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

(b) Nonquantitative limitations.—Consistent with paragraph (a)(2) of this section, in the case of a health insurer that amends, delivers, issues, or renews a group or individual policy of health insurance providing coverage for medical/surgical benefits and for mental health or substance use disorder benefits —

(1) A health benefit plan shall not impose a nonquantitative treatment limitation with respect to a mental health condition or substance use disorder for any classification of benefits unless, under the terms of the health benefits plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation with respect to medical/surgical benefits in the same classification.[47]

(2) To ensure that a nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification, in operation, is no more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical/surgical benefits in the classification, a health insurer must collect and evaluate relevant data, using standardized data collection and evaluation report templates developed by [Commissioner], in a manner reasonably designed to assess the impact of the nonquantitative treatment

[47] Adapted from DC CODE ANN. § 31-3175.04 (West 2024) and 45 CFR 146.136(c)(4)(i)).

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limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the plan's or issuer's evaluation.[48]

(3) To the extent the relevant data evaluated under paragraph (b)(2) of this section suggest that the nonquantitative treatment limitation contributes to material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits in a classification, such differences will be considered a strong indicator that the plan or issuer violates paragraph (b)(1) of this section.[49]

(c) Prior authorization and step therapy for prescription medication.—A health benefit plan shall not impose prior authorization requirements or step therapy requirements on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of mental health or substance use disorders unless it is consistent with generally recognized independent standards of current medical practice, such as the Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions established by the American Society of Addiction Medicine.[50]

(d) Aggregate lifetime limits.—In the case of a health insurer that amends, delivers, issues, or renews a group or individual policy of health insurance providing coverage for medical/surgical benefits and for mental health or substance use disorder benefits and subject to section 2711 of the Public Health Service Act (42 U.S.C. 300gg-11)—[51]

(1) If the health benefit plan does not include an aggregate lifetime limit on substantially all medical/surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(2) If the health benefit plan includes an aggregate lifetime limit on substantially all medical/surgical benefits, the plan or coverage shall either—

[48] Adapted from 45 C.F.R. § 146.136.
[49] *Id*.
[50] Adapted from 215 ILL. COMP. STAT. ANN. 370c (West 2024).
[51] Adapted from 42 U.S.C. 300gg-26 (West 2024).

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(A) apply the applicable lifetime limit both to the medical/surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical/surgical benefits and mental health and substance use disorder benefits; or

(B) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(e) Annual limits.—In the case of a health insurer that amends, delivers, issues, or renews a group or individual policy of health insurance providing coverage for medical/surgical benefits and for mental health or substance use disorder benefits and subject to section 2711 of the Public Health Service Act (42 U.S.C. 300gg-11)—[52]

(1) If the health benefit plan does not include an annual limit on substantially all medical/surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(2) If the health benefit plan includes an annual limit on substantially all medical/surgical benefits, the plan or coverage shall either—

(A) apply the applicable annual limit both to the medical/surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical/surgical benefits and mental health and substance use disorder benefits; or

(B) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(f) Out-of-network providers.—In the case of a health insurer that amends, delivers, issues, or renews a group or individual policy of health insurance providing coverage for medical/surgical benefits and for mental health or substance use disorder benefits , if the health benefit plan provides coverage for medical/surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or

[52] *Id*.

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substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(g) Services that could be covered by a public entitlement program.[53]

(1) An insurer shall not:

(A) Limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance; or

(B) Include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(2) Nothing in this subsection shall be construed to require an insurer to cover benefits that have been authorized and provided for a covered person by a public entitlement program, unless otherwise required by law.

(3) [State Medicaid program] plans are not subject to this subsection.

Commentary

This section mostly echoes the federal requirements from 42 U.S.C. § 300gg-26, which aim to prevent mental health and SUD benefits from being treated less favorably than medical/surgical benefits. Subsection (a) imposes a prohibition on financial requirements and treatment limitations that are not also applied to care for physical health conditions covered by medical/surgical benefits. Subsection (b) sets limitations on the use of NQTLs, with language drawn from federal regulations clarifying how to test that NQTLs for mental health and SUD benefits are applied comparably and no more stringently than those for medical/surgical benefits. Subsection (c), inspired by an Illinois statute, prohibits insurers from imposing prior authorization or step therapy requirements on prescription drug benefits for mental health or SUD conditions that are not consistent with independent standards of medical practice. Illinois mandated use of the American Society of Addiction Medicine's criteria, but this model permits alternatives. Subsections (d) and (e) require parity for plan lifetime and annual limits, respectively, and subsection (f) requires parity for out-of-network coverage.

Subsection (g), based on similar provisions in California and Illinois, further limits health insurers' ability to restrict medically necessary care, prohibiting any limitation of benefits based on the potential availability of a public entitlement program. If, for instance, a patient had

[53] Adapted from CA HEALTH & SAFETY CODE § 1374.72 (West 2024) and 215 ILL. COMP. STAT. ANN. 370c (West 2024).

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employer-sponsored health insurance and sought mental health or SUD care that was medically necessary and otherwise met all criteria for coverage, under the terms of this subsection the health insurer could not then deny coverage on the grounds that the patient qualified for the state's Medicaid program and could have obtained care under that program.

SECTION V. HEALTH INSURER REPORTING REQUIREMENTS.

(a) Parity compliance annual reports.—Not later than [March 1] of the year following the effective date of this Act, and by [March 1] annually thereafter, each health insurer shall submit a compliance report to the [Commissioner], in a form and manner prescribed by the [Commissioner], containing the following information for the calendar year immediately preceding:[54]

(1) All nonquantitative treatment limitation information required under the Mental Health Parity and Addiction Equity Act, subsection (b) of this section, and any applicable State regulations for relevant health benefit plans;

(2) The results of a comparative analysis demonstrating that, as written and in operation, the processes, strategies, evidentiary standards, and other factors that the health insurer used in designing and applying each nonquantitative treatment limitation to mental health and substance use disorder benefits in a classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying each nonquantitative treatment limitation to medical/surgical benefits in the benefits classification;

(3) A certification signed by the insurer's chief executive officer and chief medical officer that states that the insurer has completed a comprehensive review of the administrative practices of the insurer for the prior calendar year for compliance with the necessary provisions of relevant sections of state law and the Mental Health Parity and Addiction Equity Act; and

(4) Any other information necessary to clarify data provided in accordance with this section requested by the [Commissioner], including information that may be proprietary or have commercial value.

[54] This section is adapted in part from MD. CODE ANN., INS. § 15-144, CONN. GEN. STAT. ANN. § 38a-477ee, and 45 C.F.R. § 146.137.

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(b) Comparative analysis requirements.—In providing the analysis of each nonquantitative treatment limitation applicable to mental health or substance use disorder benefits required under subsection (a) of this section, a health insurer shall:

(1) Identify each nonquantitative treatment limitation and all mental health or substance use disorder benefits and medical/surgical benefits to which it applies and describe which benefits are included in each classification of benefits, as defined in this Act;

(2) Identify and define all factors and evidentiary standards used to design or apply the nonquantitative treatment limitation;

(3) Describe how factors are used to design and apply each nonquantitative treatment limitation, including:

(A) The evidentiary standards or other information sources (if any) for the factors;

(B) The factors that were relied upon and rejected; and

(C) If a factor was given more weight than another, the reason for the difference in weighting;

(4) Demonstrate that in any classification of benefits, under the terms of the health benefit plan as written, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation with respect to medical/surgical benefits;

(5) Demonstrate that in any classification of benefits, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits; and

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(6) Disclose the specific findings and conclusions reached by the insurer that indicate that the health benefit plan is in compliance with this section and the Mental Health Parity and Addiction Equity Act;

(c) Parity compliance reports on [Commissioner] request.—Each health insurer subject to this section shall provide the comparative analysis for each nonquantitative treatment limitation requested by the [Commissioner] within: [55]

(1) Fifteen (15) working days after a written request; or

(2) If adopted by the federal government, less than fifteen (15) working days to align with the federal rule or regulation;

(d) Burden of persuasion.—A health insurer shall have the burden of persuasion in demonstrating that its design and application of a nonquantitative treatment limitation complies with the Parity Act:[56]

(1) In any review conducted by the [Commissioner] under this Act; or

(2) In any complaint investigation or market conduct action undertaken by the [Commissioner] that involves the application of this Act or the Mental Health Parity and Addiction Equity Act.

(e) Parity compliance reports on plan member request.—Each health insurer subject to this section shall provide the comparative analysis for each nonquantitative treatment limitation and related in operation data analysis, if available and requested by a health plan member, within thirty (30) days of a written request.[57]

Commentary

The health insurer reporting requirements in this section largely track those of the MHPAEA, 42 U.S.C.. § 300gg-26, as amended by the Consolidated Appropriations Act of 2021, and implementing regulations. The federal statute directs health insurers to prepare comparative analyses demonstrating thorough efforts to comply with parity requirements and to provide them, as requested, to state regulators. The extensive documentation of health insurers' reasoning leaves fewer opportunities for insurers to conceal coverage limitations behind vague justifications. The reporting requirements in this section call for virtually the same information as the MHPAEA.

[55] Adapted from MD. CODE ANN., INS. § 15-144(c).
[56] Adapted from MD. CODE ANN., INS. § 15-144(l).
[57] Adapted from MD. CODE ANN., INS. § 15-144(c).

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One addition to the requirements, subsection (a)(3)'s requirement of a signed certification from health insurer's chief executive and chief medical officer, is adapted from a parity model written by the Kennedy Forum.[58] This provision increases accountability by certifying that the insurer's relevant authorities did review and approve its policies related to parity compliance. Subsections (c) through (e), adapted from Maryland's parity law, encourage stronger compliance by insurers and provide additional consumer protections.

SECTION VI. INSURANCE COMMISSIONER RESPONSIBILITIES.

(a) Duties of the [Commissioner].—The [Commissioner] shall implement and enforce applicable provisions of the federal Mental Health Parity and Addiction Equity Act and applicable state mental health and substance use disorder parity laws, including, but not limited to, this Act [and other existing state statutes], by:[59]

(1) Proactively ensuring compliance by individual and group health benefit policies, including by requiring that insurers submit comparative analyses, as set forth in Section V, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental health or substance use disorder benefits compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical/surgical benefits;

(2) Maintaining and regularly reviewing a publicly available consumer complaint log regarding mental health and substance use disorder coverage for possible parity violations;[60]

(3) Evaluating all consumer or provider complaints regarding mental health or substance use disorder coverage for possible parity violations;

(4) Performing parity compliance market conduct examinations of each health insurer not less than once every [two (2) years], or more frequently if noncompliance is found or suspected, with a focus on:

(A) Nonquantitative treatment limitations, including, but not limited to, prior authorization requirements, concurrent review, retrospective review, step

[58] *Model State Parity Legislation*, *supra* note **Error! Bookmark not defined.**.
[59] This subsection is adapted in part from MASS. GEN. LAWS ANN. ch. 26, § 8K (West 2024) and 215 ILL. COMP. STAT. ANN. 370c (West 2024).
[60] *Model State Parity Legislation*, *supra* note **Error! Bookmark not defined.**

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therapy, network admission standards, reimbursement rates, and geographic restrictions;

(B) Denials of authorization, payment, and coverage; and

(C) Other specific criteria as determined by the [Commissioner], including factors identified through consumer or provider complaints.

(D) The findings and the conclusions of the parity compliance market conduct examinations shall be made public.

(b) Penalties.—If the [Commissioner] determines that a health insurer has failed to submit a timely or sufficient report required under Section V or has failed to submit timely and sufficient data pursuant to a market conduct examination conducted pursuant to subsection (a)(4), the [Commissioner] shall impose a monetary penalty of up to [$] for each violation, unless the health insurer knew or reasonably should have known that he or she was in violation, in which case the monetary penalty shall be increased to an amount of up to [$] for each violation, and the [Commissioner] shall charge the insurer for any additional expenses incurred by the [Commissioner] to review additional compliance reports.[61]

(c) Penalty funds.—Moneys collected from penalties assessed pursuant to subsection (b) shall be deposited into the Parity Advancement Fund established in Section VII.[62]

(d) Remediation.—If a violation of the parity provisions of the Mental Health Parity and Addiction Equity Act or of state laws related to mental health and substance use disorder parity was likely to have caused denial of access to mental health or substance use disorder services, the [Commissioner] shall require health insurers to provide remedies for any failure to meet such requirements, which may include, but not be limited to:[63]

(1) Requiring the health insurer to change a plan's treatment limitations or benefit standard or practice, including updating plan language, with notice to plan members;

(2) Providing training to staff on any changes to benefits and practices;

[61] This subsection is adapted from GA. CODE ANN. § 33-1-27 (West 2024).
[62] This subsection is adapted from 215 ILL. COMP. STAT. ANN. 370c (West 2024).
[63] This subsection is adapted from MASS. GEN. LAWS ANN. ch. 26, § 8K (West 2024).

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(3) Requiring the health insurer to reprocess and pay all inappropriately denied claims to affected plan members, notify members of their right to file claims for services previously denied and for which members paid out-of-pocket, and reimburse for services eligible for coverage under corrected standards;

(4) Requiring the health insurer to notify plan members of the specific violations of the Mental Health Parity and Addiction Equity Act or of state laws related to mental health and substance use disorder parity that the insurer has committed and any remedial action the insure is taking;

(5) Requiring the health insurer to submit periodic data related to the conduct or practice in violation of parity law; or

(6) Requiring the health insurer to submit to ongoing monitoring to verify compliance.

(e) Legislative report.—Not later than January 1 of each year, the [department] shall issue a report to the [legislature] and provide an educational presentation to the [legislature]. The report and presentation shall:[64]

(1) Cover the methodology the [department] uses to check for compliance with the Mental Health Parity and Addiction Equity Act;

(2) Cover the methodology the [department] uses to check for compliance with this Act;

(3) Identify market conduct examinations conducted or completed during the preceding twelve (12) month period regarding compliance with parity in mental health or substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations. This shall include:

(A) The number of market conduct examinations initiated and completed;

(B) The benefit classifications examined by each market conduct examination;

(C) The subject matter of each market conduct examination, including quantitative and nonquantitative treatment limitations; and

[64] This subsection is adapted in part from 215 ILL. COMP. STAT. ANN. 370c1 (West 2024) and TENN. CODE ANN. § 56-7-2360 (West 2024).

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(D) A summary of the basis for the final decision rendered in each market conduct examination.

(E) Individually identifiable information shall be excluded from the reports consistent with federal privacy protections;

(4) Detail any educational or corrective actions the [department] has taken to ensure compliance with the Mental Health Parity and Addiction Equity Act and this Act;

(5) Describe health insurer compliance with the Mental Health Parity and Addiction Equity Act and this Act, trends in non-compliance among insurers, and recommendations to improve compliance and enforcement; and

(6) Describe how the department examines any provider or consumer complaints related to denials or restrictions for possible violations of the Mental Health Parity and Addiction Equity Act and this Act.

(7) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the [department] finds appropriate, posting the report on the [department's] website.

(f) Parity website.—On or before January 1 of the year following the enactment of this Act, the [department] shall develop a web page that provides the following information in non-technical and readily understandable language: [65]

(1) Consumer-friendly information concerning the scope and applicability of the mental health and substance use disorder parity requirements that apply to health insurers that issue health plans in this state and guidance on a consumer's right to obtain documentation from their health plan on the plan's compliance with the Mental Health Parity and Addiction Equity Act and this Act;

(2) A step-by-step guide with supporting information that explains how consumers can file an appeal or complaint with the [department] concerning an alleged violation of this Act. The guide must also prominently display a link to the United States Department of Labor's website, or a related website, that provides information on appeals or complaints by consumers who are covered by self-insured plans that are regulated by the Employee Retirement Income Security Act

[65] This subsection is adapted from ARIZ. REV. STAT. ANN. § 20-3503 (West 2024).

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of 1974 (29 U.S.C. § 1001, et seq.) and a link to the United States Department of Health and Human Service's website, or a related website, that provides information on appeals or complaints by consumers who are covered by non-federal governmental plans that are regulated by the Public Health Service Act (42 U.S.C. § 300gg, et seq.); and

(3) A list of parity violations identified by the [department] that includes the nature of the violation(s) identified, the insurer/plan involved in the violation, corrective actions required, and the current compliance status.

Commentary

Some state insurance commissioners may have the power to enforce the parity provisions of the MHPAEA without a specific authorizing statute, but to avoid the inconsistences in enforcement that exist when states lack parity advocates, this section directs the Commissioner to perform a series of specified actions. The Commissioner must obtain and review parity reports prepared by insurers, collect and address public complaints on parity violations, perform periodic market conduct examinations of insurers, impose monetary penalties on noncomplying insurers and establish remediation plans to address violations, prepare a legislative report and presentation, and manage a consumer-focused informational parity website. To encourage health insurer compliance, states should impose appropriate monetary penalties for violations of parity requirements. States should look to their current existing health insurance statutes for guidance in setting a penalty amount to create an effective deterrent against violations. The language of the insurance commissioners' enforcement responsibilities is derived primarily from the Illinois and Massachusetts parity statutes and the Kennedy Forum model.

The consumer complaint log provision is included because consumer complaints related to possible parity violations are a valuable asset to alert the insurance commissioner to the need for enforcement actions, and consumers are often unaware of mental health and SUD parity protections or how to report violations of their rights.[66] The establishment of a step-by-step consumer guide for parity rights and complaints, adapted from an Arizona statute, serves a similar purpose. The power to impose monetary penalties helps to strengthen enforcement and promote compliance.

SECTION VII. PARITY ADVANCEMENT FUND

(a) Establishment of Fund.—The Parity Advancement Fund is created as a special fund in the State treasury.

(b) Source of funds.—Moneys from fines and penalties collected from insurers for violations of this Act shall be deposited into the Fund.

[66] Volk, et al., *supra* note 7.

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(c) Purpose of funds.—Moneys deposited into the Fund for appropriation by the [legislature] to the [Department] shall be used for the purpose of supporting consumer parity education campaigns, consumer assistance programs, parity compliance advocacy, and other initiatives that support parity implementation and enforcement on behalf of consumers.[67]

Commentary

The establishment of a dedicated fund to support public awareness and advocacy for state parity standards is derived from the Illinois parity statute. This section guarantees that funds obtained from noncomplying insurers are directed toward advancing parity compliance within the state rather than to other purposes.

SECTION VIII. RULES AND REGULATIONS.

The [Director] shall adopt rules to effectuate this Act and any provisions of the Mental Health Parity and Addiction Equity Act that relate to the business of insurance.

SECTION IX. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

SECTION X. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

[67] This subsection is adapted from 215 ILL. COMP. STAT. ANN. 370c1 (West 2024).

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The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

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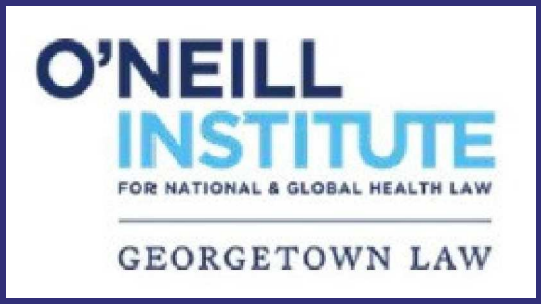
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