Mission

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

Vision

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

Core Impact Areas

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

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

Culturally Centered, Integrated Care. Continued development of best practice models for

Research

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

Policy

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

Programs

Integrated Care Leadership Program (ICLP). The ICLP provides clinical and administrative

Kennedy-Satcher Center for Mental Health Equity National Advisory Board

The Parity Leadership Coalition

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

The Coalition is guided by a commitment to:

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

Coalition Members

Robert Gebbia, MA

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Executive Summary

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Parity Law[1]) requires insurers to treat illnesses of the brain, such as depression or substance use disorders, the same way they treat illnesses of the body, such as diabetes or cancer. In other words, large group health plans are required to cover mental health and substance use disorder (MH/SUD) care in a way that is no more restrictive than coverage for physical or other medical conditions. The Patient Protection and A□ordable Care Act (ACA)

This policy analysis was designed to identify key elements of state legal codes relating to parity. By employing a systematic, replicable methodology of indexing and coding

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

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

Introduction

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

Under the Federal Parity Law, insurers may not impose higher co-pays, higher out-of-pocket costs, or different coverage limits on MH/SUD services when compared to services for the treatment of physical illnesses such as diabetes or hypertension. The Patient

State and Federal Shared Responsibility

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

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

The Importance of State Statutes

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

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

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

State-speci□c report cards can be downloaded at: *ParityTrack.org/anniversary.*

The Statutory Coding Instrument

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

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

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

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

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

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

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

Table 1. Statutory Coding Instrument Items (full instrument included in Appendix B)
1. Is there statutory language stating that coverage provided for MH/SUD services must

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

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

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

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

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

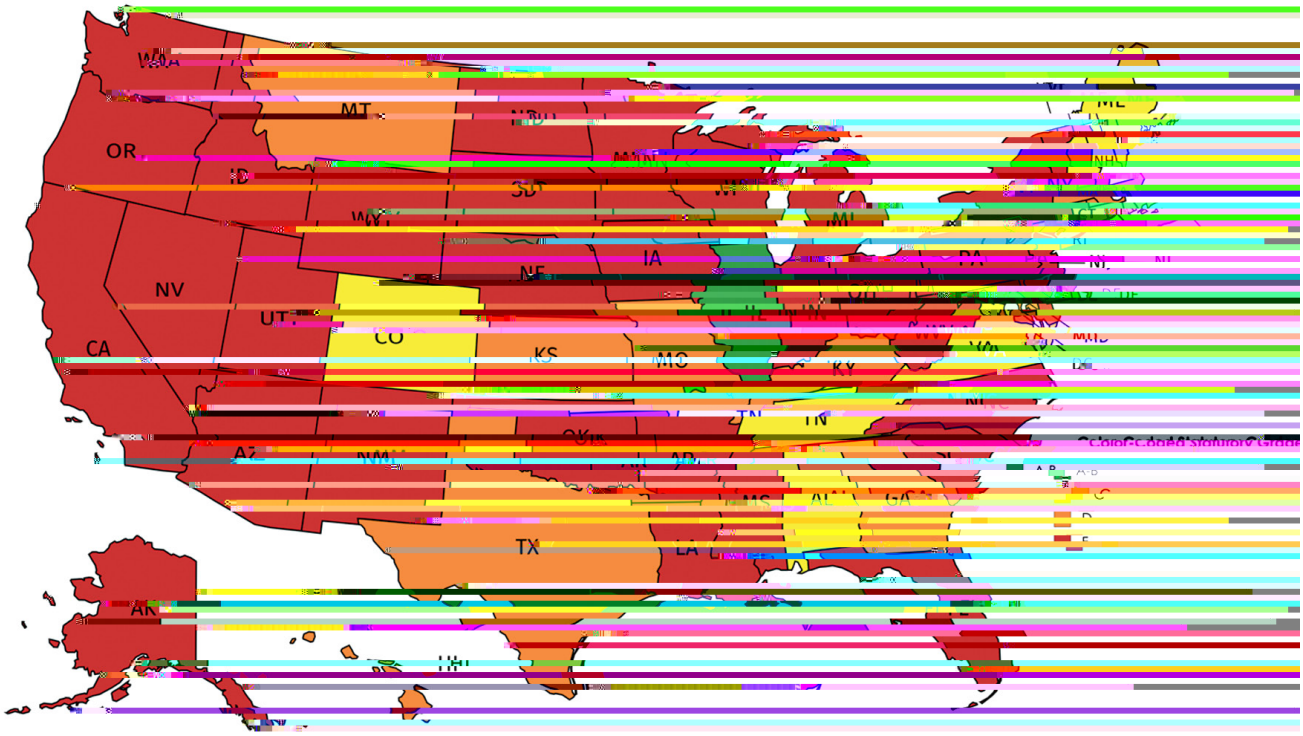
State Statutory Scores and Grades

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

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

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

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



Limitations

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

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

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

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

The Importance of Regulatory, Compliance, and Enforcement E□orts

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

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

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

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

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

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

Promising Practices

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

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

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

Market conduct examinations

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Network adequacy assessments

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

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

Oregon: Regulations with Greater Speci city than Federal Rule

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

Pennsylvania: Consumer Guide

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

Texas: Collecting and Publishing Health Insurer Data

The Texas Department of Insurance released a report in August 2018 comparing data on how insurance plans in the state covered MH/SUD versus medical and surgical care. Required by House Bill 10, passed in 2017, the report examined data relating to prior authorization

Conclusions

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

Key Issue	Legislative Recommendation
How mental health & substance use disorders are **de□ned**	Mental health and substance use disorders (MH/SUD) must be seen as broad as physical health conditions. As such, states should define MH/SUD to include all disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) with no exclusions.
How mental health & substance use disorders are **covered**	Conditions that share the same characteristics should be treated in the same way. As such, co-pays and out-of-pocket

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

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

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

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

Appendix A: Glossary of Terms

Behavioral Health: An all-encompassing term for both mental health and substance use disorders. This includes the full sp heal2 0 0 12 8hpf utrumTorican Poric0 scn/[(disor)Dendix8isssociationpf uanuanc

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

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

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

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Appendix B: Statutory Coding Instrument

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

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

    a. Yes (10 points)

    b. Yes, but explicitly allows certain things to be different (e.g., medical management, geographic restrictions, etc.) (5 points)

    c. No (0 points)

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

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

a. Behavioral health treatment services are a mandated benefit for health insurance/benefit plans (10 points)

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

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

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

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

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

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

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

a. Large group plans (2 points)

b. Small group plans (2 points)

c. Individual plans (2 points)

d. State and/or county/municipal employee plans (2 points)

e. Medicaid plans (2 points)

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

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

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

a. Yes (10 points)

b. No (0 points)

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

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

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

a. Includes all disorders listed in Diagnostic and Statistical Manual of Mental Disorders (DSM) or behavioral health disorders in International Classification of Diseases (ICD) (10 points)

b. Includes all disorders in DSM or behavioral health disorders in ICD with select exclusions (e.g., ca□eine, nicotine, marital problems) (8 points)

c. In a list that itemizes a limited number of behavioral health conditions OR includes

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

a. The statute explicitly uses the umbrella term NQTL in defining treatment limitation or otherwise and requires that NQTL are no more restrictive than those for physical/other medical benefits **OR** the statute refers to the MHPAEA (42 USC 300gg-5; 300gg-26; 29 USC 1185a) and/or the regulations (45 CFR 146.136; 29 CFR 2590.712) and requires health plans to comply* (10 points)

b. The statute does not explicitly use the umbrella term NQTL in defining treatment limitation or otherwise but requires that specified NQTLs are no more restrictive than those for physical/other medical benefits (8 points)

c. The statute does not explicitly use the umbrella term NQTL in defining treatment limitation, but generally requires that any treatment limitations must be comparable to those imposed on physical or other medical benefits (5 points)

d. The statute is silent as to NQTL or other treatment limitations (3 points)

e. The statute allows for treatment limitations that are di erent from those for physical/other medical benefits (0 points)

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

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

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

8. Does a state statute require, authorize, or prevent the state insurance department or other relevant state agency to enforce the Federal Parity Law and any relevant federal law, or to issue regulations regarding the Federal Parity Law or any other relevant federal law? (10 points available; only one answer may be selected)

a. State statute requires the state insurance department or other relevant state agency to

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

a. Yes, on a recurring basis (10 points)

b. Yes, but not on a recurring basis (5 points)

c. No (0 points)

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

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

a. Yes, on a recurring basis (10 points)

b. Yes, but not on a recurring basis (5 points)

c. No (0 points)

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

Appendix C: Parity Track and Proposed Legislation

Parity Track

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

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

Environmental scans identify proposed legislation and regulatory and enforcement activities using LexisNexis, LexisNexis StateNet, Thomson Reuters Westlaw, and expert opinion. The findings are housed on ParityTrack.org, which is a central resource for up-to-date parity information related to mental health and substance use disorders including legislation,

Notes