



**American  
Foundation  
for Suicide  
Prevention**

## Federal & State Laws: Mental Health Parity

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According to the latest (2018) data from the Centers for Disease Control and Prevention (CDC), suicide is the 10th leading cause of death in the United States (CDC, 2020). In 2018 alone, 48,344 people in the U.S. died by suicide (CDC, 2020). A recent CDC report found that from 1999 through 2018 the suicide rate increased 35%, with a significant increasing trend after 2006; the rate increased on average approximately 1% per year from 1999 to 2006 and by 2% per year from 2006 through 2018 (Hedegaard, Curtin, & Warner, 2020). While these statistics point to a serious public health problem, we do know that **suicide is preventable**.

Suicide and suicide attempts have a devastating impact on individuals, families, and communities across the country. Upwards of 90% of individuals who ultimately die by suicide were living with a diagnosable mental health condition at the time of their death, although these conditions often go undiagnosed or untreated. Illnesses like depression, anxiety, and substance problems, especially when unaddressed, can increase risk for suicide.

Assessment and treatment for mental health conditions can save lives, but only if individuals at risk can afford to obtain said care. This is why parity in insurance coverage for mental health is critical. “Parity” means that insurance coverage for mental health and substance use disorder treatments (collectively referred to as behavioral health services) should be no more restrictive than coverage for other medical conditions. A 2016 Kennedy Forum study sheds light on the severity of the problems surrounding access to care, stating that almost 90% of individuals with a substance use disorder and over 50% of individuals with mental illness do not receive appropriate treatment services (Butler, Clement, & Mauri, 2016).

Mental health and substance use disorders affect millions of Americans across all demographics and communities. A 2017 study from Mental Health America (MHA) found that 18.01% of adults, or 43.4 million Americans, struggle with a mental health problem annually. Of these individuals, 4.2 million live with an Anxiety Disorder and 16 million live with Major Depression. The percentage of adults reporting serious suicidal thoughts was 3.99%, or an estimated 9.6 million individuals. Furthermore, 8.47% of adults in America reported having a substance use or alcohol problem. In 2015 alone, more than 52,000 Americans died from a drug overdose, a number that has grown nearly nine-fold since 1980 (Parsons & Neath, 2017).

**Federal Overview of Mental Health Parity:** Disparities between insurance for behavioral health and general medical services were first addressed by Congress through passage of the Mental Health Parity Act of 1996 (see [P.L. 104-204](#)). Several policy updates have occurred since, resulting in two major pieces of legislation with significant implications for parity:

- The **Mental Health Parity and Addiction Equity Act (MHPAEA, see [P.L. 110-343](#))** was enacted in 2008. MHPAEA does not require that insurance plans offer mental health and substance use disorder benefits; however, for those that do, benefits must be the same as those offered for other medical and surgical services. To fully comply, plans must provide comparable types of care and equal treatment and financial services in their

coverage. The parity statute applies to large-group plans (employer-funded plans with more than 50 insured employees); Medicaid managed-care plans; and CHIP (the Children's Health Insurance Program).

- The **Patient Protection and Affordable Care Act (ACA)**, see [P.L. 111-148](#)) was enacted in 2010 and enhanced the parity law. ACA extended MHPAEA's protections to small-group plans (employer plans with 50 or fewer employees); individual market plans; Medicaid Alternative Benefit Plans (Medicaid expansion benefit); and plans offered through the health insurance exchanges.

The Affordable Care Act was a turning point for behavioral health care access in the United States and included multiple regulations that significantly expanded coverage. **Two of the most impactful provisions of the ACA (1) established ten categories of essential health benefits and (2) expanded Medicaid eligibility to participating states:**

- The ACA further strengthens coverage under small-group and individual plans by including behavioral health services among a list of **essential health benefits** they are required to provide. While large-group employer plans are exempt from the requirement, their coverage has tended to include generous mental health and addiction treatment benefits pre- and post-ACA. All plan types must not place annual or lifetime caps on any of the essential health benefits they do provide (Norris, 2018).
- Before the ACA, only members of certain groups qualified for Medicaid coverage and the definitions for each category or group varied state to state by factors such as income level, household size, and family status, creating a complex patchwork of eligibility rules. The ACA **extended Medicaid eligibility** to all adults with incomes up to 138 percent of the federal poverty level, filling substantial gaps in coverage for many populations including low-income Americans with mental health and substance use conditions, who have been the single largest beneficiaries of the Medicaid expansion. Medicaid is the nation's single largest payer of mental health services, accounting for 25% of all mental health spending in the U.S. (Blue & Rosenberg, 2017). In 2015, despite only covering 14% of total adults, Medicaid covered 21% of adults with mental illness, 26% of adults with serious mental illness (SMI), and 17% of adults with substance use disorder (Kaiser Family Foundation, 2017). Overall, approximately 29% of persons who receive health insurance coverage through the Medicaid expansion either have a mental health condition, a substance use condition, or both (Blue & Rosenberg, 2017).

**State Overview of Mental Health Parity:** Most states have laws in place that require some level of parity and/or compliance with the federal parity law. Still, one out of five (20.1%) adults with a mental illness actively seeking services report they are not able to get the treatment they need (MHA, 2017). Many patients across the country continue to face several systemic barriers to care such as lack of insurance or adequate insurance; lack of available treatment providers or treatment types; and insufficient finances to cover out-of-pocket costs (copays, uncovered treatment types, or when providers don't take insurance).

In many states, treatment limitations like inpatient or outpatient day limits and annual or lifetime maximums for mental health and substance use disorder care are now a thing of the past. Yet, plans are still proving to be more restrictive and offer different terms and conditions in the area of “non-quantitative treatment limitations,” or NQTLs. Defined as any limitation that is not expressed numerically, NQTLs can include prior authorization or “fail first” requirements, medical necessity criteria, network provider standards, geographic restrictions, prescription formulary designs, and network tier designs.

The enforcement and oversight of parity laws has largely become the responsibility of the states and requires collaboration between state lawmakers and regulators. Comprehensive state parity reporting bills ensure federal and state laws are uniformly implemented by requiring (1) insurers and health plans to submit annual parity compliance analyses to state regulatory agencies, and (2) state regulators to implement and report on enforcement activities, such as market conduct examination and parity compliance audits. (*To learn more about coverage disparities between addiction and mental health vs. physical health within your state, [click here](#) for the 2019 Milliman Report.*)

### Current State Parity Reporting Laws:

- **Arizona:** [SB 1523](#) (enacted 3/3/20). Requires insurers to comply with the Federal Parity Law. Requires notation on insurance cards that “AZDOI” is the regulator. Requires insurers to submit a detailed report to the Department of Insurance every three years demonstrating its compliance with the Federal Parity Law and requires the Department to provide readily understandable information regarding parity on its public webpage for the benefit of consumers. Additionally, the Department must post an aggregated summary of its analysis of the insurer reports and summary of its efforts to implement, oversee, and enforce parity requirements.
- **Colorado:**
  - [HB 18-1357](#) (enacted 5/24/18). Requires the commissioner of insurance to report on compliance with mental health parity laws, establishes an office of the ombudsman to assist state residents in accessing behavioral health care, and appropriates \$94,000 to implement the bill.
  - [HB 19-1269](#) (enacted 5/16/19). Requires private health insurance and Medicaid plans to comply with the federal parity law and to demonstrate compliance through reporting requirements. Health insurers are required to report to the Division of Insurance (DOI) in the Department of Regulatory Agencies and, similarly, managed care entities (MCEs), which deliver Medicaid program health care services, are required to report to the Department of Health Care Policy and Financing (HCPF). The DOI and HCPF must review this parity reporting, conduct an analysis, and formulate an annual report by June 1, 2020, and each year thereafter, to be presented to the health committees of the General Assembly regarding behavioral, mental health, and substance use disorder parity.
- **Connecticut:** [HB 7125](#) (enacted 7/8/19). Enhances enforcement and reporting by requiring (1) health insurers to submit a detailed, annual parity compliance report to the Insurance Commissioner, Attorney General, Health Care Advocate, and the Executive

Director of the Office of Health Strategy, and (2) the Insurance Commissioner to submit to the insurance joint standing committee each of the health insurers' reports. Allows the joint standing committee to hold an annual public hearing concerning the health insurers' reports. Enhances coverage requirements and prohibits (1) individual and group health insurance policies from applying NQTLs on MH/SUD benefits that are not also equitably applied to medical/surgical benefits, and (2) the exclusion of coverage of MAT drugs or SUD services because the drugs or services were prescribed pursuant to a court order.

- **Delaware:** [SB 230](#) (enacted 8/29/18). Sets annual reporting requirements for insurance carriers and Medicaid managed care organizations on their compliance with the federal parity law.
- **District of Columbia:** [B22-0597](#) (enacted 1/16/19). Requires all health benefit plans offered by an insurance carrier to meet the requirements of the federal parity law. Also requires all plans to submit an annual report to the Department of Health Care Finance on or before October 1 of every calendar year.
- **Illinois:** [SB 1707](#) (enacted 8/22/18). Requires health plans to submit parity compliance analyses to the Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services, to be made available on a public website. Also requires expanded access to substance use disorder treatment and closes a loophole in Illinois law that allowed school district health plans to discriminate against mental health and substance use disorders.
- **Indiana:** [HB 1092](#) (enacted 3/30/20). Requires insurers to annually submit a report and analysis to the Department of Insurance to demonstrate compliance with federal parity laws, including the processes used: (1) to develop medical necessity criteria for coverage of services; and (2) to develop and apply nonquantitative treatment limitations. Requires DOI to submit report on enforcement activity to legislature annually.
- **New Jersey:** [A 2031](#) (enacted 4/11/19). Expands health insurance coverage for behavioral health care services and enhances enforcement and oversight of mental health parity laws by (1) requiring insurers to report annually on their compliance with federal and state parity requirements for both mental health and substance use disorder benefits, particularly about how they design and apply their complex medical management protocols; and (2) requiring the NJ Department of Banking and Insurance to enforce parity laws more aggressively.
- **New York:** [A 3694C](#) (enacted 12/21/18). Requires insurers and health plans to submit certain data to the Department of Financial Services (DFS) so it can evaluate their compliance with federal and state mental health and substance use parity laws. Network adequacy, cost sharing, rates of appeals, and reimbursement rates for both in-network and out-of-network mental health providers are among a list of items to be evaluated. DFS will use the data to prepare an annual mental health parity report for consumers.
- **Oklahoma:** [SB 1718](#) (enacted 5/19/20). Requires all health benefit plans to meet the requirements of the federal parity law and prohibits any NQTLs that apply to mental health/substance use benefits but not to other benefits. Requires all insurers that offer,

issue, or renew any individual or group health benefit plan providing mental health or substance use disorder benefits to submit an annual report to the Insurance Commissioner on compliance; the Commissioner must make reports available to the public including identification of noncompliant insurers and identify insurers that have failed in whole or in part to comply with the full extent of reporting requirements.

- **Tennessee:** [Pub. Ch. 1012](#) (SB 2165, enacted 5/23/18). Requires the Department of Commerce and Insurance to enforce parity and prohibits any NQTLs that apply to mental health/substance use benefits but not to other benefits. Also requires individual policies to follow the same parity rules as group policies, requires substance use treatment to be covered, and prohibits insurers from using any additional criteria for benefit determination. Requires the department to perform market-conduct examinations and parity compliance audits and issue a report on their enforcement activities to the General Assembly no later than January 31, 2020.
- **Virginia:** [SB 280](#) (enacted 4/7/20). Requires the Bureau of Insurance, in consultation with insurers, to develop reporting requirements regarding denied claims, complaints, appeals, and network adequacy. Annually, the Bureau must gather established data and generate a report; such report must be made available to the public and submitted to the House Committee on Commerce and Labor and the Senate Committee on Commerce and Labor.
- **West Virginia:** [SB 291](#) (enacted 3/16/20). Amends multiple sections of the Code of West Virginia to require insurers, including the Public Employees Insurance Agency, to comply with certain provisions of the Federal Parity Law and its implementing regulations. Creates guidelines concerning out of network providers to ensure network adequacy and access to timely care. Requires such insurers to submit a detailed report to the Committee on Government and Finance that demonstrates plans' compliance with parity requirements; insurers must first submit report no later than one year after rules are promulgated and any year thereafter in which significant changes are made to medical management design and application protocols.

**Current Advocacy Efforts:** AFSP understands that assessment and treatment for mental health conditions can save lives, but only if individuals at risk can afford to obtain said care, making parity in insurance coverage for mental health critical. AFSP also acknowledges that insurers have succeeded in implementing major parts of parity law and that there has been a great deal of progress over the last decade. However, plans are often not in compliance with some of the more complex components and continue to apply managed care practices in ways that are more restrictive for mental health and substance use disorder treatment than for other types of medical treatment.

AFSP urges the enforcement and oversight of parity laws, recognizing that this has largely become the responsibility of the states and requires collaboration between state lawmakers and regulators. Currently, AFSP is focused on supporting the passage of comprehensive state-level

parity reporting legislation to ensure federal and state laws are uniformly implemented in all 50 states.

AFSP's Public Policy Team in Washington, DC ([advocacy@afsp.org](mailto:advocacy@afsp.org)) maintains connections with legislators and stakeholders in many of the states that have adopted parity reporting laws and can connect interested legislators and stakeholders to those individuals upon request.

### Resources:

Visit [ParityTrack](#) for reports on parity-related legislative, statutory, regulatory and legal activities in all 50 states.

To learn more about the policy and advocacy work being done around mental health care in America visit the [Kennedy Forum](#) where you can find the latest parity resources including toolkits, policy briefs, videos, and more.

The American Psychiatric Association has created [State Model Parity-Implementation Legislation Adapted to All 50 states and the District of Columbia](#). The legislation is designed to require transparency and accountability from insurers and state regulators. Each state has legislation that is tailored specifically for that state's terminology and formatting.

[Parity at 10](#) is a three-year campaign launched in November, 2017 that is working to unite local and national advocates in ten states to pursue full enforcement of the Parity Act. They plan to establish effective models for robust enforcement of the Parity Act and disseminate those models across the country.

[Mental Health for US](#) is a nonpartisan educational initiative led by a coalition of organizations from around the country, including the American Foundation for Suicide Prevention, focused on elevating mental health and addiction in national policy conversations by empowering grassroots advocates and improving candidate and policymaker health literacy. The full [Mental Health for US Policy Platform](#) addresses prevention, access and intervention, and recovery.

### Useful Terms Around Parity & Insurance:

- **Individual Plans:** insurance plans that people can purchase for themselves.
- **Group Health Plans:** insurance plans employers offer their employees. Examples include: small and large employer plans.
- **Small Employer Plans:** insurance plans offered by employers with 50 employees or less.
- **Large Employer Plans:** insurance plans large employers offer their employees. A large employer has 51 or more employees
- **In-network:** providers and healthcare facilities that are part of a health insurance plan's network.
- **Out-of-network:** providers and healthcare facilities that are not part of a health plan's contracted network and can set their own prices for the services they provide.

- **Quantitative Treatment Limitation:** a limitation on treatment that can be measured with numbers. Examples include: deductibles, copayment, inpatient visit limitations, and outpatient day limits.
- **Deductible:** the money a person must pay on their own, or out-of-pocket, before the insurance company starts to pay for care.
- **Copayment:** money that a person with insurance has to pay for services after a deductible has been met. A copayment is a flat dollar amount, like \$20 per visit, but may vary by type of doctor you see (for example a specialist may have a higher dollar amount.) For example, if your insurance plan's allowable cost for a doctor's office visit is \$100, and your copayment for a doctor visit is \$20, if you've paid your deductible, you pay \$20, usually at the time of the visit. If you haven't met your deductible, you pay \$100, the full allowable amount for the visit.
- **In-patient care:** services given in a hospital after admission with a written doctor's order.
- **Outpatient care:** treatment given to a person who can go home after care without being admitted in a hospital or treatment facility
- **Non-Quantitative Treatment Limitation:** a limitation that can't be measured with numbers. Examples include: prior authorization, step therapy, medical necessity criteria, network provider standards, geographic restrictions, prescription formulary designs, and network tier designs.
- **Prior Authorization:** occurs when a patient needs to get pre-approved for coverage of a treatment or medication; an insurance plan may not pay for care if the patient's condition does not meet certain standards.
- **Step Therapy:** a requirement that a patient try a less expensive treatment first before they get approval for the treatment their provider orders.

*More definitions in relation to mental health parity can be found [here](#), at ParityTrack.*

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